Oregon Health Authority

2019 CCO Readiness Review

for

Health Share of Oregon

September 2019

Interim Report

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 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 Health Share of Oregon (HSO), 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.

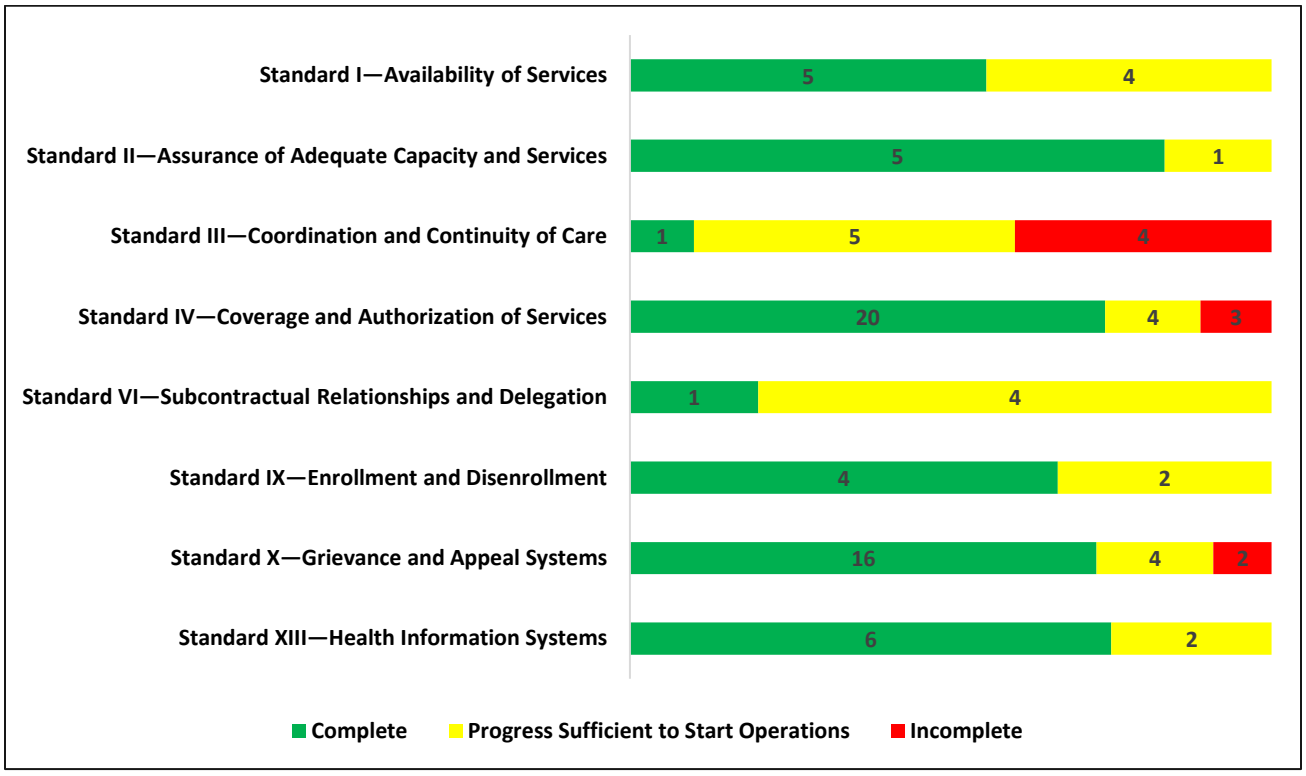
2. Phase 1 Results

Across all eight standards, HSO's overall percentage of complete elements is 62.4 percent. The CCO demonstrated:

- *Complete* ratings for 58 of the 93 total elements.
- *Progress Sufficient to Start Operations* ratings for 26 elements across eight standards.
- *Incomplete* ratings for nine elements across three standards, indicating areas of greater deficiency. These areas *require action* to ensure readiness prior to providing services.

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

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



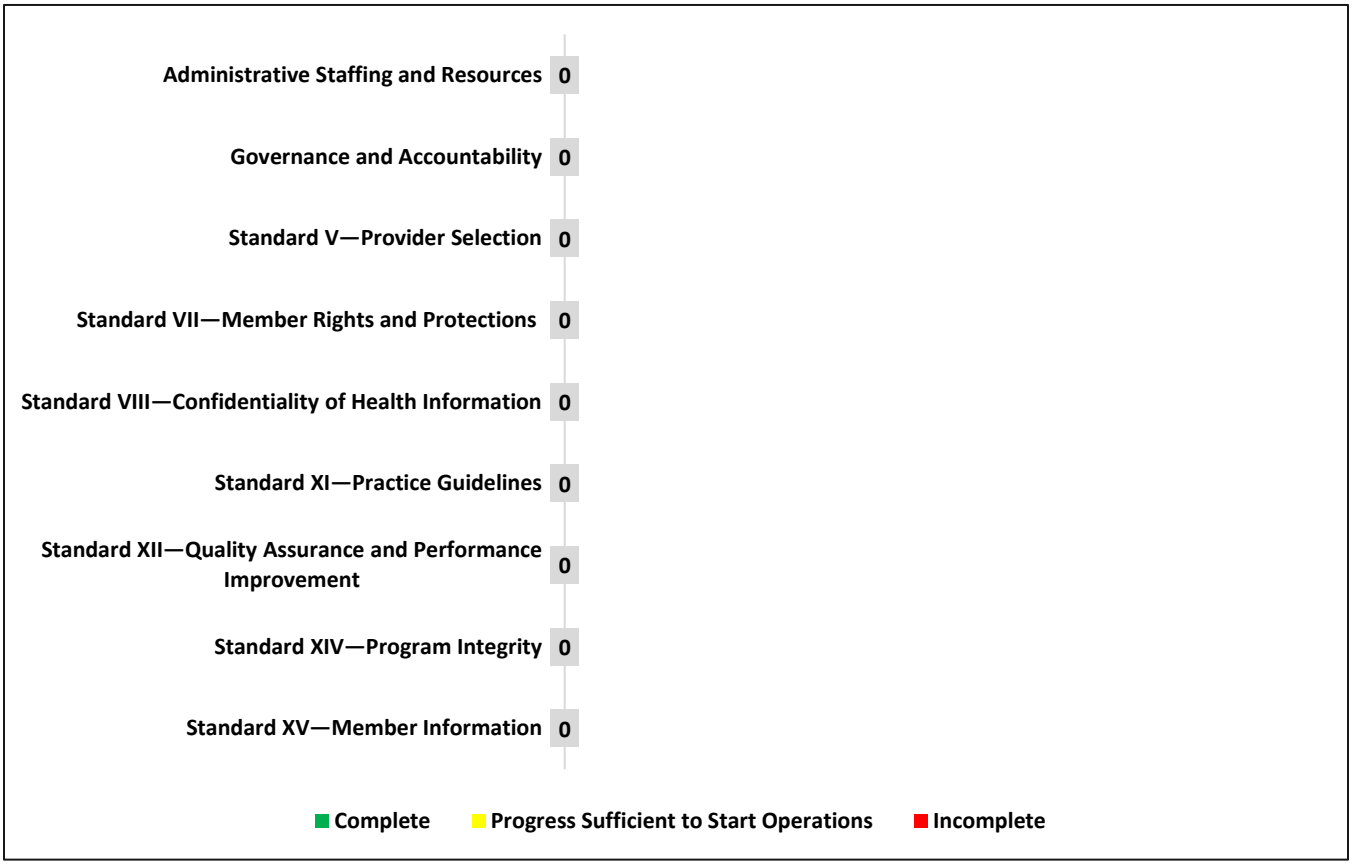
3. Phase 2 Results

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

Across all eight standards, HSO'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—HSO 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 HSO'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)*	• CORP-02: Delegated Functions and Oversight, Policy Section I, page 1 • QUAL-10 Access to Care: – Purpose (page 1) – Policy Section 1.A. (p. 1) re: available and accessible Covered Services – Policy Section II (pp.1- 2) re: timely access – Policy Section III (p. 2) re: access plan – Policy Section V (p. 2) re: 24/7 access for inquiries, triage of urgent/emergent care • UM-01 Utilization Management 2019, Policy Sections 1 and II, p. 1 • BH Access Report Overview_February 2019, p. 1 (*written procedure*) • ABA Access Report Overview_February 2019 (*written procedure*)	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: HSO's Access and Utilization Management policies described how it works with its delegates to ensure the timely coverage of services; however, the CCO's member handbook did not clearly distinguish between those services covered under the State plan and those services available through the CCO. Further, neither the policy nor handbook described the CCO's mechanisms to by which members could access services covered by Oregon Health Plan (OHP) and not the CCO.		
Required Actions: HSAG recommends that the CCO update its member handbook to include information on all covered services, including the distinction between those covered by OHP and those covered by the CCO, and how to access those services, respectively.		
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	• Provider Participation Agreement Template (*written agreement*)	☒ Complete ☐ Progress Sufficient to Start Operations

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	• Oregon Health Plan Addendum_January 2018 (*written agreement*) • CORP-02: Delegated Functions and Oversight, Policy Section I, p. 1 • CCO 2.0 DSN Narrative_FINAL – Composition of Provider Network and use of verification resources (p. 1) – Assurance that members have access to at least one provider/facility for each specialty type within established time and distance standards (p. 2) – Network monitoring (p. 4) – Access to interpreter services and communications in members' language of choice (p. 5). • Health Share CCO Contract_2019 DSN Narrative_FINAL – Sec. 2.8 re: THWs (p. 17-19) – Sec. 2.10.3 re: network availability/adequacy of alternative therapy providers (p. 24) – Appendix A: Provider to Member Ratios (p. 55-56), esp: – alternative therapies (p. 56) Health Share CCO 2.0 DSN Capacity Report_FINAL_Rev: *illustrates range of all provider types in Health Share Network, esp:*	☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• NEMT (Facilities worksheet, **ServCat:** NEMT) • THWs (Providers worksheet, **ServCat:** THW) • QUAL-10 Access to Care – Policy Section I.C. (p. 1) re: access standards and choice – Policy Section V. (p. 2) re: monitoring appointment and after-hours accessibility as assurance of access – Policy Section VII. (p. 2) re: scheduling and wait time standards consistent with OAR – Policy Section VIII. (p. 2) re: network adequacy monitoring/reporting system • Health Share Provider Directories on Website *illustrate range of all provider types in Health Share's delegated partner Networks* • NEMT-01 Non-Emergent Medical Transportation Program • Provider Participation Agreement Template	
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)*	• Health Share CCO Contract_2019 DSN Narrative_FINAL – Appendix A: Provider to Member Ratios, esp. "Women's Specialty Medicine" (p. 55) • QUAL-10: Access to Care. See Sec. IX (page 3). "A Quick Guide to Project Nurture" Flyer re: services to pregnant women who are struggling with SUD	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: While the CCO's Access to Care policy identified the requirement to provide direct access to women's healthcare services and its applicability to the CCO's delegates, its member handbook only defined direct access for well-women visits where no referral was required. This provision is narrower than required by CFRs which providers female members in need of direct access to women's healthcare services.		
Required Actions: HSAG recommends that the CCO update its member handbook to ensure its policies and member handbook to reflect female members' direct access to a women's health specialist for initial and follow-up visits for covered services unique to women and not limited to well-woman visits. Moreover, documentation should be clear that direct access is in addition to the female member's designated source of primary care, if that source is not a women's health specialist.		
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)*	• QUAL-10: Access to Care. See Sec. IV and XI (page 2 & 3). BH Provider Manual_2019.07.01, "Second Opinions" See pages 19-20 re: the responsibility of providers to allow, and if necessary arrange for members to obtain a second opinion.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
5. If the CCO is unable to provide medically necessary covered services to a particular member using contract providers, the CCO shall adequately and timely cover these services for that member using non-contract providers for as long as the CCO's provider network is unable to provide them. a. The CCO shall coordinate payment with out-of-network providers and ensure that the cost to the member is no greater than it would be if services were provided within the network. *42 CFR §438.206(b)(4-5)* *Contract: Exhibit B Part 4 (4)(g)*	QUAL-10: Access to Care. See Sec. IV (page 2).	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	**The DSN Capacity Report** includes taxonomy codes 261QA0005X, 261Q00000X, and 261QF0050X which are specific to family planning providers. Four of the 13 facilities with one of these Taxonomy codes are in the tri-County region. Other provider types in the network--e.g. FQHCs (170 of 210 are in region), SHCs (25 of 27 in region), and 222 individual women's health care providers—also deliver family planning services. QUAL-10: Access to Care. See Section. X, p. 3.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
7. The CCO ensures its provider network observe the timely access to services provisions and complies with the following requirements: 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.	N/A	☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
e. Monitor network providers regularly to determine compliance. f. Take corrective action if there is a failure to comply by a network provider. *42 CFR §438.206(c)(1)* *Contract: Exhibit B Part 4 (2)(a)* *Contract: Exhibit B Part 4 (13)(b)(3), (4)*		
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		
8. The CCO demonstrates that its network includes sufficient specialty behavioral health providers to ensure timely access to covered specialty behavioral health services for the following priority populations in accordance with the timeframes below, with access prioritized in accordance with OAR 309-019-0135 and 410-141-3220. a. If a timeframe cannot be met due to lack of capacity, the member must be placed on a waitlist and provided interim services within 72 hours of being put on a waitlist. Interim services should be as close as possible to the appropriate level of care and may include referrals, methadone maintenance, compliance reviews, HIV/AIDS testing, outpatient services for substance use disorder, risk reduction, residential services for substance use disorder, withdrawal management, and assessments or other services described in OAR 309-019-0135. b. Pregnant women, veterans and their families, women with children, unpaid caregivers, families, and children ages birth through five years, individuals with HIV/AIDS or tuberculosis, individuals at the risk of first episode psychosis	• Health Share CCO Contract_2019 DSN Narrative_FINAL – Section 2.10.1 re: continuum of BH care for adults and children, including intensive outpatient and residential MH (pp. 22-23) – Section 2.10.2 re: MAT and SUD continuum of services (p. 23). – Appendix A: Provider to Member Ratios (p. 55-56) • QUAL-10 Access to Care – Section III (p. 2) • BH Provider Manual_2019.07.01, "Access" (pp. 13-14) re: MH and SUD timeframes between request, intake and appointment. • "A Quick Guide to Project Nurture" Flyer re: services to pregnant women who are struggling with SUD	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
and the I/DD population: Immediate assessment and intake. If interim services are necessary due to capacity restrictions, treatment at appropriate level of care must commence within 120 days from placement on a waitlist. c. IV drug users: Immediate assessment and intake. Admission required within 14 days of request, or, if interim series are necessary due to capacity restrictions, admission must commence within 120 days from placement on a waitlist. d. Opioid use disorder: Assessment and intake within 72 hours. e. Medication assisted treatment: No more than 72 hours for assessment and induction, with efforts to do such as soon as possible. f. Children with serious emotional disturbance: Any limits that the Authority may specify in the contract or in guidance. g. Routine behavioral health care for other populations: Seen for an intake assessment within seven days from date of request, with second appointment within 14 days and 4 appointments (including the second appointment) within 48 days. Appointments must be therapeutic in nature and expand beyond administrative activities. *Contract: Exhibit B Part 4 (2)* *Contract: Exhibit M*	• Health Share Provider Directories on Website *illustrate range of all provider types in Health Share's delegated partner Networks* • Multnomah County Health Dept_Health Services Agreement_2018-07-01_Executed, (Sec. 2.1, p. 2; Sec. 2.2, p. 2; Sec. 2.4, p. 3; Sec. 2.7, pp. 3-4; SOW, pp. 29-32), *re: providers serving members with TB and/or HIV/AIDs*. • SUD MAT OBOT, see section B, number 4, pages 1-3, re: appropriate delivery of SUD MAT services • SUD MAT OTP, see section B, number 4, page 1, re: appropriate delivery of SUD MAT services • SUD MAT OTP, see section B, number 5, page 2, re: compliance with OARs. • Psychiatric Res Tx Svcs Guidelines_01.01.2019, see page 1, re: wraparound services being provided to high needs youth in residential treatment • See Gap Analysis and Supplemental Document_Health Share 2020 Readiness Review Gaps page 1 New/Revised Policies and Procedures #2	
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.	• CORP-02: Delegated Functions and Oversight, Sec. I, p. 1 • QUAL-10 Access to Care Section VII (p. 2) • Health Share CCO Contract_2019 DSN Narrative_FINAL	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
b. *Urgent care:* Within seventy-two (72) hours or as indicated in the initial screening for urgent care. c. *Emergency care:* Immediately or referred to an emergency department depending on the member's condition. d. *Emergency oral care:* Seen or treated within twenty-four (24) hours. e. *Urgent oral care:* Within one (1) to two (2) weeks or as indicated in the initial screening. f. *Routine oral care:* Within eight (8) to twelve (12) weeks, or the community standard, whichever is less. g. *Non-urgent behavioral health treatment:* Seen for an intake assessment within two (2) weeks of the request. *42 CFR §438.206(c)(1)(i)* *Contract Exhibit B Part 4 (2)(a)*	• Sec. 2.4.1 re: assurance of 24/7 care access (p. 9-10)	
HSAG Findings: The CCO's Provider Network Timely Access policy included timeliness requirements, but its behavioral health delegate contract identified emergency care timeliness as appointments provided within 24 hours of initial contact and did not include the provision of ***immediate*** emergency care.		
Required Actions: HSAG recommends that the CCO ensure its delegate contracts include immediate timeliness provisions for emergency care.		
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)*	2019 DSN Narrative —see esp. Sec. 2.8 re: THWs (pp. 15-19); Sec. 2.10 re: County contracts with culturally-specific CBOs to undertake outreach and engagement (p. 22); Sec. 3.1 re: matching enrollee characteristics with provider assignments (pp. 25-26); Sec. 4.1 re: enrollee feedback on network adequacy (pp. 31-33); Sec. 4.4 describing Health Share's commitment to culturally and linguistically appropriate services (pp. 38-40); Sec. 5.1.4 re: contracting and coordination with NARA (p. 42).	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	2020 Member Handbook DRAFT COPY_R1 indicates how to access services (p. 20) Final HS_CHNA Report_ Pages (*2018-2020 Community Health Needs Assessment (CHNA)—in its entirety)*	
HSAG Findings: While HSO's documentation identified the promotion of culturally competent care through its member handbook, comprehensive community health needs assessments, and collaborative efforts that inform its Clinical Advisory Panel, the CCO's provider documentation (e.g., provider agreements and the provider manual) did not consistently identify or promote culturally appropriate care or nondiscrimination.		
Required Actions: HSAG recommends that the CCO update its provider agreements and manual to include the requirement that providers deliver culturally appropriate care and nondiscrimination of members.		
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)*	N/A	☐ 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	**4**
Incomplete	**0**
Not Applicable (NA)	**2**

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. The CCO submits documentation to the State, in a format specified by the State, to demonstrate that it complies with the following requirements: a. Offers an appropriate range of preventive, primary care, specialty services, that is adequate for the anticipated number of enrollees for the service area. b. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area. *42 CFR §438.207(b)(1-2)* *Contract: Exhibit G*	QUAL-10 Access to Care • Policy Section I.A. (p. 1) CCO Contract 2019_Reporting Requirements_Updated 2019-03-13: Contained within DSN Management Folder—*this document is sent to all delegated entities outlining deadlines of all Contractually-required reports, including the DSN* (Rows 5, 22, 42, 77-80, 86 and 114) Program Specialist_Updated PD_FINAL_2019.03.01: Contained within DSN Management Folder—*this document illustrates the responsibilities of the Centralized Program Specialist to develop and deliver the DSN. (p. 1-2)* Health Share CCO 2.0 DSN Capacity Report_FINAL_Rev: *illustrates range of all provider types in Health Share Network* Health Share 2019 Contract_2019 DSN Narrative_FINAL: • **Appendix A:** Provider Type to Member Ratios (p. 55)—illustrates appropriate range of providers and services 2018 DSN Exhibit 1_Provider Type to Member Ratios—*illustrates appropriate range of providers and services* RE Health Share of Oregon 2019 DSN Capacity and Narrative Reports—*OHA confirmation of receipt e-mail illustrates timely submission of DSN to the state in the format required by the 2019 CCO Contract*	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	PCC-04 Provider Selection and Credentialing, Section V.A. (p. 2) Health Share Provider Directories on Website *illustrate range of all provider types in Health Share's delegated partner Networks*	
2. The CCO submits the documentation described above as specified by the State, but no less frequently than the following: a. At the time it enters into a contract with the State. b. On an annual basis. c. At any time there has been a significant change (as defined by the State) in the CCO's operations that would affect the adequacy of capacity and services, including: i. Changes in the CCO's services, benefits, geographic service area, composition of or payments to its provider network; or ii. Enrollment of a new population. *42 CFR §438.207(c)(1-3)* *Contract: Exhibit G*	RE Health Share of Oregon 2019 DSN Capacity and Narrative Reports—*OHA confirmation of receipt e-mail illustrates timely submission of DSN to the state in the format required by the 2019 CCO Contract* FamilyCare Transition Examples: *illustrate internal analysis in preparation for FamilyCare transition of Members with SUD, specialty and ancillary service needs.* Dental Plan Transition Examples: *illustrate internal analysis and external communications re: streamlining and strengthening 2018-2019 dental health options* BH Provider GeoMap Examples: *illustrate internal analyses of 1) 2017 ABA provider locations; 2) 2017 specialty BH provider locations in relation to members with SPMI; and 3) ability of the Bridge platform to identify demographic information about a pediatric population in Hillsboro, based on zip codes* See Gap Analysis.pdf and Supplemental Document_Health Share 2020 Readiness Review Gaps page 1 New/Revised Policies & Procedures #1	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	QUAL-10 Access to Care • Policy Section II, (page 1, 2) Health Share CCO 2.0 DSN Capacity Report_FINAL_Rev • pp. 2-4 in Word document Health Share 2019 Contract_2019 DSN Narrative_FINAL: • pp. 6-7 • **Table 1:** Time and Distance Standards (p. 54)	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: HSO's Access to Care policy identified the required time and distance standards for select provider types but not for obstetrical/gynecological (OB/GYN) and behavioral health providers.		
Required Actions: HSAG recommends that the CCO update its policy to include time and distance standards for OB/GYN and behavioral health providers.		
4. Adult & Pediatric Specialty Care Access Standards— Time and Distance: a. In urban areas - Thirty (30) minutes or thirty (30) miles from the personal residences of members. b. In rural areas – Sixty (60 minutes) or sixty (60) miles from the personal residence of members. *42 CFR §438.68* *42 CFR §438.206(c)(1)(i)* *Contract: Exhibit B (2)(a)*	QUAL-10 Access to Care • Policy Section II, (page 1, 2) Health Share CCO 2.0 DSN Capacity Report_FINAL_Rev • pp. 2-4 in Word document Health Share 2019 Contract_2019 DSN Narrative_FINAL: • pp. 6-7 • **Table 1:** Time and Distance Standards (p. 54)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
5. Hospital and Emergency Services Access Standards—Hospitals—Time and Distance: a. In urban areas - Thirty (30) minutes or thirty (30) miles from the personal residences of members. b. In rural areas – Sixty (60 minutes) or sixty (60) miles from the personal residence of members. *42 CFR §438.68* *42 CFR §438.206(c)(1)(i)* *Contract: Exhibit B (2)(a)*	QUAL-10 Access to Care • Policy Section II, (page 1, 2) Health Share 2019 Contract_2019 DSN Narrative_FINAL: • pp. 6-7 • **Table 1:** Time and Distance Standards (p. 54)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
6. Pharmacy—Time and Distance: a. In urban areas - Thirty (30) minutes or thirty (30) miles from the personal residences of members. b. In rural areas – Sixty (60 minutes) or sixty (60) miles from the personal residence of members. *42 CFR §438.68* *42 CFR §438.206(c)(1)(i)* *Contract: Exhibit B (2)(a)*	QUAL-10 Access to Care • Policy Section II ("…and other services as needed to assure access to high quality care for Health Share Members."), (page 1, 2) Health Share 2019 Contract_2019 DSN Narrative_FINAL: • pp. 6-7 • **Table 1:** Time and Distance Standards (p. 54)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

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

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. The CCO ensures that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member. a. The member must be provided information on how to contact their designated person or entity. b. The CCO implements a standardized approach to effective transition planning and follow-up. *42 CFR §438.208(b)(1)* *Contract: Exhibit B Part 4 (2)(k)*	Health Share members are given information in the Member Handbook that provides our Customer Service phone number as well as information on how to access Primary Care and Patient Centered Health Homes (PCPCH). They are able to call Customer Service Monday through Friday during normal business hours 8:00 a.m. to 5:00 p.m. with questions about their plans and for assistance in finding or changing health plans or providers. Each health plan partner has their own process for assigning members to a person-centered health home. If none is chosen by the member, they are required to enroll the member with a primary care provider within 30 days or less. **The New Member Handbook (pages 30, 33)** provides contact information to Care Managers (Care Helpers) affiliated with the Delegated Entity to which they have either been assigned or chosen. They also can contact Health Share directly. Each Delegated Entity has a Case Manager that is able to work directly with Members to care coordination and transition planning. **See CIW Contact List-Updated 7.22.2019.** This contact list is updated every other month at our Care Integration Workgroup so all plans can reach out to the affiliated Delegated Entity (physical, behavioral and oral) to begin care coordination and transition planning seamlessly and more expeditiously.	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	Many of our PCPCHs have in clinic case managers that also work with their Members who can reach out to Health Share and assist with transition planning. Health Share has effectively managed two transitions of care between FamilyCare and Health Share and our reduction in dental-delegated entities last fall. Both times care transition was a priority and information were transferred efficiently. See Gap Analysis and Supplemental Document_Health Share 2020 Readiness Review Gaps page 1 New/Revised Policies and Procedures #4	
HSAG Findings: Newly enrolled members assigned to HSO are assigned to one of the CCO's delegated physical health, behavioral health, and dental health plans using an algorithm based on each member's previous history and demographic location. Members are also able to request initial plan assignments and plan changes by calling HSO. The delegated health plans implement their own individualized processes for assigning members to a primary care provider (PCP). Health plan and PCP information is provided to each member on the HSO insurance card. Members can contact their respective health plan to request PCP changes. HSO did not provide any policies, procedures, or workflows related to member transitions of care. During the remote interview session, HSO staff members described previous transition of care activities related to a reduction in provider groups/delegates. HSO staff members stated that they are in the process of developing a transition of care policy and procedure.		
Required Actions: HSAG recommends that the CCO develop policies and procedures specifying processes and expectations for member transitions of care. Once finalized, HSAG recommends that the CCO disseminate the policies and procedures to its delegates and conduct oversight and monitoring activities to ensure delegates are meeting the CCO's expectations.		
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;	Policy UM-02 Integrated Care Management- Section IV Health Share delegates coordination of care to our health plans. That said we host a bi-monthly Care Integration Workgroup that is attended by all of our Delegated entities. Contact information is updated at each meeting	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	and is provided to each of our Delegated entities and community partners for the purpose of care coordination. Through the work of this workgroup, our plans have the contact information to be able to case manage the member across the continuum from outpatient to short term, long term and institutional stays. When a member is being discharged from the Oregon State Hospital, Care Managers from our behavioral health plans have already worked with the social workers at the OSH to facilitate continuity of care immediately after the member has been discharged back to the community. Health Share hosts our own version of an eligibility portal. This portal allows all of our Delegated entities to identify the appropriate health plan partner such as physical, mental or dental. The plan needing coordination is able to look up the member in our portal and identify the affiliate plan the member is enrolled with and use the contact information that Health Share provides to contact that plan and coordinate as needed. In connection with our MOU for LTSS, our steering committee is currently working on the connection between Care Managers within AAA and APD that will also reach out to Delegated Entity Care Managers to further the coordination of services along the continuum. See Gap Analysis.pdf and Supplemental Document_Health Share 2020 Readiness Review Gaps page 1 New/Revised Policies and Procedures #4	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: HSO delegates care coordination to several subcontracted health plans. HSO facilitates a bimonthly Care Integration Workgroup meeting with all delegates to facilitate the sharing of information related to coordination of care and case management. While the Integrated Care Management policy provided by the CCO stated that delegated entities are responsible for ensuring member access to coordinated care services, no other documentation was provided to explain how the CCO coordinates care of services furnished to members or the expectations for the delegates. HSO provided a gap analysis and supplemental documentation, which identified the need for the creation of a procedure describing processes for coordinating member care.		
Required Actions: HSAG recommends that the CCO develop written policies and procedures that explain how the CCO coordinates the services furnished to members or the expectations for its delegates in sufficient specificity to ensure the delegate understands the expectations. Once finalized, HSAG recommends that the CCO disseminate the policies and procedures to its delegates and conduct oversight and monitoring activities to ensure delegates are meeting the CCO's expectations.		
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)*	2019 Care Coordination Audit Tool Initial Health Screening Example 1 Initial Health Screening Example 2 Initial Health Screening Example 2 If a member is identified or referred for care management services a comprehensive assessment is completed which identifies the interdisciplinary care team. The team may consist of the member, primary care provider, specialty providers, caregiver, community peer support, behavioral health and/or oral health. Collaboration with members' primary health care provider is essential in successful care plan and treatment plan implementation. The care coordinator will coordinate with the primary health care provider routinely throughout the duration of care management services. Information from care management assessments including gaps in care, medication adherence, appointment setting, condition management,	☐ Complete ☐ Progress Sufficient to Start Operations ☒ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	and obtaining services are all communicated to the care team in order to develop and maintain an active and accurate longitudinal plan of care. If the need is identified through a behavioral health assessment, the member will have their biopsychosocial needs evaluated at both a behavioral health provider level and at the plan level. When physical health needs are present, the care coordinator will ensure that the member is assigned to a PCP and receiving treatment to address the condition. In situations where the member's mental health condition is interfering with their ability to access or participate in treatment, the care coordinator will contact the care coordinator for the physical health plan. At times, staffing involving health care providers and mental health providers will be conducted to develop integrated approaches to meeting the member's needs. Our dental plans identify the medical home and appropriate the behavioral health provider. Contacting the correct provider directly for follow up care or assessment is completed by telephone or mail. Coordinators open a care plan when more complicated cases are identified.	
HSAG Findings: The narrative information and examples provided by HSO did not explain the process used by the CCO or the expectations of its delegates for conducting the initial assessment of all newly enrolled members. During the remote interview session, HSO staff members stated that each delegate implements its own processes and tools for conducting the initial screening. When asked what HSO's expectations were of its delegates in making a "best effort" to complete the initial screening, staff members stated they expect three attempts using two different contact methods. When asked if this was documented in policy or procedure, HSAG was referred to policy UM-02; however, this policy only stated that delegated entities shall provide for an initial health risk screening for each new member within the time frames set by OHA. HSO staff members stated that expectations were		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
communicated to delegates during the Care Integration Workgroup meetings and that oversight of each delegate was performed during the formal annual delegation audit. HSO did not articulate or provide evidence of any ongoing monitoring activities (weekly, monthly, quarterly) to ensure that the delegates were completing the initial assessment timely and accurately.		
Required Actions: The CCO should develop written policies, procedures, and/or processes explaining how the CCO conducts the initial assessment on all newly enrolled members or its expectations of its delegates, including time frames, number of attempts, documentation, and any CCO requirements for the screening tools being used. Once finalized, HSAG recommends that the CCO disseminate the policies and procedures to its delegates and conduct oversight and monitoring activities (more frequently than annually) to ensure delegates are meeting the CCO's expectations.		
4. The CCO's service agreements with specialty and hospital providers must: i. Address the coordinating role of patient-centered primary care; ii. Specify processes for requesting hospital admission or specialty services; and iii. Establish performance expectations for communication and medical records sharing for specialty treatments: – At the time of hospital admission; or – At the time of Hospital discharge for the purpose of facilitating after-Hospital follow up appointments and care. *Contract: Exhibit B Part 4 (9)*	Health Share delegates this to our Delegated entities because they have the service agreements with specialty and hospital providers. Health Share reviews these agreements through our delegation oversight function. Providence_Provider Contract Template i. Section 3.21 (page 6) ii. Sections 3.19, 3.20, 3.22, 3.23 (page 6) and Section 4.12 (page 8) iii. Section 4.12 (page 8) and section 3.17 (page 6)	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: HSO provided a Providence Health Plan Provider Agreement, which included all required language. During the remote interview session, HSO staff members stated that they were in the process of updating the subcontractor delegation agreements to include the requirements for specialty and hospital provider service agreements and will review provider service agreements as part of the delegation oversight audits.		
Required Actions: HSAG recommends that the CCO provide evidence to OHA that subcontractor agreements have been updated to include the requirements for specialty and hospital provider service agreements.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	UM-02 Integrated Care Management Section VII (page 2)	☐ Complete ☐ Progress Sufficient to Start Operations ☒ Incomplete ☐ NA
HSAG Findings: HSO's Integrated Care Management policy stated that delegated entities are required to have policies and procedures in place to ensure that members are supported during transitions of care. During the remote interview session, HSO staff members stated that they are in the process of developing a Transitions of Care policy and procedure. HSO staff members stated that delegate expectations related to transitions are communicated during the Care Integration Workgroup meetings. The CCO did not have any documented policies, procedures, or processes in place to ensure that hospital, specialty, and PCPs are responsible for achieving successful transitions of care. It is unclear how HSO would evaluate a delegate when HSO has not established expectations.		
Required Actions: The CCO should develop policies, procedures, and processes that explain how it will ensure successful transitions of care or the expectations of its delegates for ensuring that hospital, specialty, and PCPs are responsible for achieving successful transitions of care. Once finalized, HSAG recommends that the CCO disseminate the policies and procedures to its delegates and conduct oversight and monitoring activities to ensure delegates are meeting the CCO's expectations.		
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)*	UM-02 Integrated Care Management - Section II B (page 1) UM-03 Intensive Care coordination for Special Health Members- Sections IV and VI (page 2) Health Share and our Delegated entities utilize the HIE PreManage and Health Share Bridge as a technological backbone to facilitate information sharing across plans to support care coordination, reduce duplication of	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	services and medication errors, and identify opportunities for preventive and primary care. For providers who use Epic and affiliated electronic health systems Care Everywhere provides clinical data such as allergies, medications, problem lists, medical history, visit summaries, test results and immunization history. PreManage is accessible to all providers in the region and provides inpatient and ED information that can be used to schedule follow-up care and support transitions of care among provider settings. Health Share Bridge is our interactive reporting-based tool that contains all of an individual's claims information and is available to all Health Share providers. To minimize gaps in information exchanges between providers and other health plans, serving members, Care Managers share relevant information, including individual care plans, across the health care system and other organizations involved in meeting a member's needs as appropriate, including particularly vulnerable populations such as members receiving long-term care (LTC) services or members with severe and persistent mental illness (SPMI). The primary care providers, particularly those certified as PCPCH, play a central role in coordinating the member's care needs. We have a strong suite of tools currently in place, and we continue to expand our ability to share data and clinical information to further strengthen relationships among systems caring for high-risk patient populations.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: HSO's Integrated Care Management policy stated that delegated entities are required to participate in the development of infrastructure support for sharing information, coordinating care, and monitoring results, including participation in Health Share sponsored care management collaboratives. The Intensive Care Coordination for Special Health Members policy stated that Health Share delegates the responsibilities of care coordination staff members as described in Oregon Administrative Rule 410-141-6870 (8) through (11) and requires that delegated entities ensure intensive care coordination services are provided consistent with the administrative rule. During the remote interview session, HSO staff members stated that expectations of delegates related to information sharing is communicated during the Care Integration Workgroup meetings.		
Required Actions: While information sharing among HSO, delegates, and providers was taking place, HSAG recommends that HSO revise policies and procedures to include more specificity as to the CCO's expectations of its delegates' responsibilities in sharing member information to prevent duplication of assessment activities and services. Once finalized, HSAG recommends that the CCO disseminate the policies and procedures to its delegates and conduct oversight and monitoring activities to ensure delegates are meeting the CCO's expectations.		
7. The CCO ensures that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards. *42 CFR §438.208(b)(5)* *Contract: Exhibit B Part 8 (1)(d-f)*	**N/A**	☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		
8. The CCO ensures that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable. *42 CFR §438.208(b)(6)* *Contract: Exhibit B Part 4 (1)(a)*	Policy UM-02 Integrated Care Management Section VII (page 2)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	DRAFT 2019 TRI County IC3 Request Form & Coordinated Care Plan.pdf Health Share receives files monthly from our Innovator Agent for LTSS. These files contain the completed assessments of all Members receiving LTSS services as well as the date the last assessment was performed. We are in the process of identifying ways to extract this information to a usable format for our delegated entities to use. This information will inform the screening, assessment and reassessment process and facilitate the updated care plan development to inform a course of treatment specifically designed for the special needs member through the Interdisciplinary Care Coordination Conference.	☐ Complete ☐ Progress Sufficient to Start Operations ☒ Incomplete ☐ NA
HSAG Findings: HSO did not provide any policies and procedures describing the processes for conducting the comprehensive assessment on all members identified as needing long-term services and supports (LTSS) or having a special healthcare need. During the remote interview session, HSO staff members stated that the comprehensive assessment is delegated and that each risk-accepting entity/delegate utilizes its own assessment tools and care management systems. HSO staff members stated that the CCO expects its delegates to complete the comprehensive assessment within 30 days of identification of a care coordination or special healthcare need. HSO staff members also stated that expectations were communicated during the Care Integration Workgroup meetings. The 2019 Care Coordination Audit Tool used by HSO to review a sample of care coordination records annually included an evaluation of assessment information obtained by each delegate, but there was no evidence that HSO routinely monitored or tracked its delegates' performance and timeliness.		
Required Actions: The CCO should develop policies and procedures that describe the processes for conducting the comprehensive assessment or the expectations of its delegates in conducing the comprehensive assessment, and how the CCO will oversee the delegates' performance. Once finalized, HSAG recommends that the CCO disseminate the policies and procedures to its delegates and conduct oversight and monitoring activities (more frequently than annually) to ensure delegates are meeting the CCO's expectations.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
10. The CCO has written policies and procedures for identifying, assessing and producing a treatment plan for each member identified as having a special healthcare need. *Contract: Exhibit B Part 4 (10)(a)(4)*	UM-03 Policy Intensive Care Coordination for Special Health Members Policy-Section I (page 1) UM -02 Integrated Care Management Policy- Section IV (page 2) Through delegation oversight, Health Share staff review policies and procedures of our delegated entities to ensure they have an aligned policy and procedure for screening, assessment, development of a care and treatment plan for our members with special health care needs. Care Plan Assessment and Reassesment Example 1 Care Plan Assessment and Reassesment Example 2 Care Plan Assessment and Reassesment Example 3	☐ Complete ☐ Progress Sufficient to Start Operations ☒ Incomplete ☐ NA
HSAG Findings: The policies and procedures provided by HSO were general in nature, lacked specificity, and stated that delegated entities were to conduct care coordination activities consistent with Oregon Administrative Rules. The policies did not include processes for conducting activities, timelines, or delegate performance expectations. During the remote interview session, HSO staff members stated that they review delegates' policies annually to ensure they are in alignment with HSO's expectations, but it is unclear what HSO's expectations are as they were not documented in policy or procedure.		
Required Actions: The CCO should revise current policies and procedures or create new policies and procedures to include specificity and describe the CCO's processes or expectations of its delegates for identifying, assessing, and producing a treatment plan for each member identified as having a special healthcare need. Policies and procedures should include timeliness, responsibilities, and process expectations. Once finalized, HSAG recommends that the CCO disseminate the policies and procedures to its delegates and conduct oversight and monitoring activities (more frequently than annually) to ensure delegates are meeting the CCO's expectations.		

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

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
13. For members with special health care needs determined through an assessment to need a course of treatment or regular care monitoring, the CCO must have policies or procedures in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs. *42 CFR §438.208(c)(4)* *Contract: Exhibit B Part 4 (2)(f)(2)*	Policy UM-03 Intensive Care Coordination for Special Health Members- Section VI (page 2)	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: HSO's Intensive Care Coordination for Special Health Members policy stated that HSO ensures members receiving intensive care coordination services who have special healthcare needs have direct access to a specialist, such as through a standing referral, as appropriate for the member's condition and identified needs. During the remote interview session, HSO staff members stated that direct access expectations were communicated during the Care Integration Workshop meetings. Monitoring of delegates related to direct access was reactive in nature and included reviewing quarterly grievance reports from delegates and annual review of the delegates' policies and procedures.		
Required Actions: HSAG recommends that the CCO revise its policies and procedures to include more specificity surrounding the implementation of direct access and expectations of its delegates. In addition, HSAG recommends that the CCO develop and implement more proactive monitoring mechanisms to ensure members with special healthcare needs can directly access a specialist through the delegate health plan. Once finalized, HSAG recommends that the CCO disseminate the policies and procedures to its delegates and conduct oversight and monitoring activities (more frequently than annually) to ensure delegates are meeting the CCO's expectations.		

Standard III—Coordination and Continuity of Care	
	Total #
Complete	**1**
Progress Sufficient	**5**
Incomplete	**4**
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)*	Authorizations Review Tool NOABD review tool example a. UM-01 Utilization Management Policy-Section IV A-D (page 2) b. UM-06 Service Authorization Policy-Section II B (page 1)	☒ 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	a. UM-01 Utilization Management Policy- Section II and IV (page 1 & 2) b i. UM-01 Utilization Management Policy- Section II and IV D (page 1&2) ii UM-03 Intensive Care Coordination Policy- Definitions (page 1); UM-02 Integration & Coordination of Care Policy- Section IV iii DRAFT 2020 Member Handbook page-33	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
iii. Family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used consistent with §441.20 of this chapter. *42 CFR §438.210(a)(4)(i-ii)* *Contract: Exhibit B Part 2*		
3. The CCO has processes to ensure that utilization or prior authorization standards for mental health or substance used disorder benefits and access to both in-network and out-of-network providers providing these benefits are no more stringent then the standards that are applied to medical/surgical benefits. *Contract: Exhibit E (22)*	Mental Health Parity Action Plan- Health Share Comparability KPI Clinical-Element 3.pdf Health Share OON OOS NQTL v 7-9-18 DRAFT Parity Policy –Section I b i-iii (page 3)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
4. The CCO has processes to ensure that any financial requirements or treatment limits to mental health or substance use disorder benefits in any classification are no more restrictive then the financial requirements or treatment limits to medical/surgical benefits in the same classification (whether or not the benefits are furnished by the CCO). *Contract: Exhibit E (22)*	Comparability KPI Financial-Element 4.pdf DRAFT Parity Policy – Section 1 a v and vi (page 3)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
5. The CCO must furnish medically necessary services as defined in the Contract and in a manner that: a. Is no more restrictive than that used in the State Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and b. Addresses:	a. UM-06 Service Authorization Policy- Section IV Health Share UM NQTL v 7-25-18 b. UM-06 Service Authorization Policy- Section II, III (page 1) DRAFT Parity Policy – Section I b iii (page 3)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
i. The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability. ii. The ability for a member to achieve age-appropriate growth and development iii. The ability for a member to attain, maintain, or regain functional capacity. *42 CFR §438.210(a)(5)(i-ii)* *Contract: Exhibit B Part 2 (2)(b)*		
6. The CCO establishes and adheres to written policies and procedures for both the initial and continuing service authorization requests consistent with utilization control requirements of 42 CFR Part 456. Policies and procedures must include: a. Mechanisms to ensure consistent application of review criteria for authorization decisions; b. Consultation with the requesting provider for medical services when appropriate. c. A process to ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs. *42 CFR §438.210(b)(1-3)* *Contract: Exhibit B Part 2 (3)(a & f)* *Contract: Exhibit B Part 2 (2)(c)*	UM-01 Utilization Management Policy-entirety a. UM-06 Service Authorization Policy- Section I (page 1) b. Section IV (page 2) c. Section IV (page 2)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	UM-06 Service Authorization Policy- Section VI (page 2)	☒ 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)*	UM-01 Utilization Management Policy Section V (page 2)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
9. The CCO notifies the requesting provider, and gives the member written notice of any decision by the CCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. *42 CFR §438.210(c)* *Contract: Exhibit B Part 2 (3)(h)*	QUAL-05 Adverse Benefit Determination Appeals and Contested Case Hearings **Desk Procedure**- Section I A & C 2 (pages 1-2).	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
10. The written notice of adverse benefit determination must be consistent with the provisions under 42 CFR 438.10(c) and must include: a. The date of the notice; b. CCO name, address, phone number; c. Name of the member's Primary Care Practitioner, Primary Care Dentist, or behavioral health practitioner, as applicable;	Sample NOABDs COMP-09 NOABD Audit **Desk Procedure** (page 1) 2019 NOABD Review Tool QUAL-05 Denials Appeals and Contested Case Hearings **Desk Procedure**- Section I C. Section 1 C a , b and c (page 1 & 2) 1 C d 1 C e	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
d. Member's name, address, and ID number e. Service requested or previously provided and adverse benefit determination the CCO made or intends to make; f. Date of the service or date service was requested by the provider or member; g. Name of the provider who performed or requested the service; h. Effective date of the adverse benefit determination if different from the date of the notice; i. Whether the CCO considered other conditions if the service was below the funding line of the OHP Prioritized List of Health Services; j. The reasons for the adverse benefit determination, including reference to the specific statutes and administrative rules to the highest level of specificity for each reason and specific circumstances identified in the notice that include, but is not limited to: k. The right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. 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	1 C e 1 C f 1 C g 1 C h and i 1 C j 1 C p QUAL-05 Denials Appeals and Contested Case Hearings **Desk Procedure** -Section II A 2 (page 3) and Section III A (page 6), III E (page 7) QUAL-05 Denials Appeals and Contested Case Hearings **Desk Procedure** -Section II B (page 3 & 4) QUAL-05 Denials Appeals and Contested Case Hearings **Desk Procedure**-Section II E (page 4)	

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*		
HSAG Findings: The Denials, Appeals and Contested Case Hearings Desk Procedure included a section titled *Notices of Adverse Benefit Determination—Content*, which listed the information that is required to be included in each notice. The list contained appeal and State fair hearing rights but did not include the time frame for each.		
Required Actions: HSAG recommends that the CCO revise the *Notices of Adverse Benefit Determination—Content* section of its Denials, Appeals and Contested Case Hearings Desk Procedure to include the time frame requirements for a member to file an appeal and State fair hearing.		
11. For standard authorization decisions, the CCO shall provide notice as expeditiously as the member's condition requires and within 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days: a. The member, or the provider, requests extension; or	2019 NOABD Review Tool QUAL-05 Denials Appeals and Contested Case Hearings **Desk Procedure**- Section I D (page 2 & 3)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
b. The CCO justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest. *42 CFR §438.210(d)(1)(i-ii)* *Contract: Exhibit B Part 2 (3)(h)*		
12. For cases in which a provider indicates, or the CCO determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the CCO must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service. a. The CCO may extend the 72-hour time period by up to 14 calendar days if the member requests an extension, or if the CCO justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest. *42 CFR §438.210(d)(2)(i-ii)* *Contract: Exhibit B Part 2 (3)(i)*	QUAL-05 Adverse Benefit Determination Appeals and Contested Case Hearings Policy- Procedure Section VI (page 3) 2019 NOABD Review Tool QUAL-05 Denials Appeals and Contested Case Hearings **Desk Procedure**- Section II B 3 & 4 (page 3 & 4)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
13. For all covered outpatient drug authorization decisions, provide notice as described in section 1927(d)(5)(A) of the Act. a. Provides response by telephone or other telecommunication device within 24 hours of a request for prior authorization. *42 CFR §438.210(d)(3)* *Sec. 1927. [42 U.S.C. 1396r-8] (d)(5)(A)* *Contract: Exhibit B Part 2 (3)(j)*	QUAL-05 Denials Appeals and Contested Case Hearings **Desk Procedure**- Section I D 2 (page 3)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
14. For reduction, suspension, or termination of a previously authorized Medicaid-covered service, the CCO gives notice at least ten (10) days before the date of action except: • The CCO gives notice on or before the date of action if: – The agency has factual information confirming the death of a member. – The agency receives a clear written statement signed by the member that he/she no longer wishes services or gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information. – The member has been admitted to an institution where he/she is ineligible under the plan for further services. – The member's whereabouts are unknown, and the post office returns agency mail directed to him/her indicating no forwarding address. – The agency establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth. – A change in the level of medical care is prescribed by the member's physician. – The notice involves an adverse determination made with regard to the preadmission screening requirements. • If probable member fraud has been verified, the CCO gives notice five (5) calendar days before the date of action. *42CFR438.404(c), 42CFR431.211, 42CFR431.213(a)-(g), 42CFR431.214(a)* *Contract: Exhibit I (3)(c)*	QUAL-05 Denials Appeals and Contested Case Hearings **Desk Procedure**- Section I D c (pages 2,3)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	QUAL-12 Emergency and Post Stabilization Care Services Policy; Definitions (page1) Member handbook page 22-Emergencies	☒ 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)*	QUAL-12 Emergency and Post Stabilization Care Services Policy; Definitions (page1)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
17. The CCO: a. Covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the CCO; and b. Does not deny payment for treatment obtained under either of the following circumstances: i. A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in paragraphs (a), (b), and (c) of the definition of emergency medical condition in paragraph (a) of this section. 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)*	QUAL-12 Emergency and Post Stabilization Care Services Policy; Section II, III, IV and V (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**
HSAG Findings: The CCO's Emergency and Post Stabilization Care Services policy included the required information for this element with one exception: the CCO may not deny payment for treatment if a representative of the CCO instructed the member to seek emergency services. This would apply to the CCO's delegates as well.		
Required Actions: HSAG recommends that the CCO revise its Emergency and Post Stabilization Care Services policy to include a statement that the CCO (or its delegated entities) do not deny payment for treatment if a representative of the CCO (or delegated entity) instructs the member to seek emergency services.		
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)*	QUAL-12 Emergency and Post Stabilization Care Services Policy; Section IV (page 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)*	QUAL-12 Emergency and Post Stabilization Care Services Policy; Section V (page 2)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
20. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in	QUAL-12 Emergency and Post Stabilization Care Services Policy; Section VI (page 2)	☒ Complete ☐ Progress Sufficient to Start Operations

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
paragraph (b) of this section as responsible for coverage and payment. *42 CFR §422.114(d)(3)* *Contract: Exhibit B Part 2 (4)(a)(9)*		☐ Incomplete ☐ NA
21. Poststabilization care services are covered and paid for in accordance with provisions set forth at 42 C.F.R. §422.113(c). a. The CCO is financially responsible (consistent with §422.214) for post-stabilization care services obtained within or outside the CCO's network that are pre-approved by a plan provider or other organization representative; b. The CCO is financially responsible for post-stabilization care services obtained within or outside the CCO's network that are not pre-approved by a plan provider or other organization representative, but administered to maintain the member's stabilized condition within 1 hour of a request to the CCO for pre-approval of further post-stabilization care services; c. The CCO is financially responsible for post-stabilization care services obtained within or outside the CCO's network that are not pre-approved by a plan provider or other organization representative, but administered to maintain, improve, or resolve the member's stabilized condition if: i. The CCO does not respond to a request for pre-approval within 1 hour; ii. The CCO cannot be contacted; or iii. The CCO's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for	QUAL-12 Emergency and Post Stabilization Care Services Policy; Section VI (page 2)	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
consultation. In this situation, the CCO must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in §422.113(c)(3) is met. d. Must limit charges to members for post-stabilization care services to an amount no greater than what the organization would charge the member if he or she had obtained the services through the CCO's network. For purposes of cost sharing, post-stabilization care services begin upon inpatient admission. *42 CFR §438.114(e)* *42 CFR §422.113(c)(2)(i-iv)* *Contract: Exhibit B Part 2 (4)(a)(6&8)*		
HSAG Findings: The CCO's Emergency and Post Stabilization Care Services policy did not include a complete description of the CCO's financial responsibility for post-stabilization care services. The policy should include information regarding the CCO's responsibility when the CCO's representative and treating physician cannot reach an agreement concerning the member's care plan and a plan physician is not available for consultation.		
Required Actions: HSAG recommends that the CCO update its Emergency and Post Stabilization Care Services policy to include a complete description of the CCO's financial responsibility for post-stabilization care services, specifically, when the CCO and the treating physician cannot reach an agreement concerning the member's care plan and a plan physician is not available for consultation.		
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;	QUAL-12 Emergency and Post Stabilization Care Services Policy; Section VI	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*		
HSAG Findings: The CCO's Emergency and Post Stabilization Care Services policy did not include a thorough description of when its financial responsibility for post-stabilization care services that it has not pre-approved ends. Specifically, it did not include a statement that financial responsibility ends when a CCO representative and the treating physician reach an agreement concerning the member's care.		
Required Actions: HSAG recommends that the CCO revise its Emergency and Post Stabilization Care Services policy to include a complete description of when its financial responsibility for post-stabilization care services that it has not pre-approved ends.		
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-01 Non-Emergent Medical Transportation Program Procedure Section I A (page 3); IV B (page 3,4) Member Eligibility Verification Procedure-in entirety Transport of Children Under 12 & Persons with Special Needs Policy Section 5 Procedure (page 2 & 3) Secured Transportation Policy and Procedure Section 5 Procedure (page 2 & 3) Advance Notice Trip Policy-entirety Out of Area Transportation Policy and Procedure Section 5 Procedure (page 2 & 3) Ground and Air Ambulance Transport Policy Provider Availability and Utilization Procedure-Section 4 Procedure (page 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**
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-02 Non-Emergent Medical Transportation Call Center Operations Weekly employee shift schedule 050819	☒ 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)*	QUAL-12 Emergency and Post Stabilization Care Services Policy; Section I (page1)	☐ Complete ☐ Progress Sufficient to Start Operations ☒ Incomplete ☐ NA
HSAG Findings: The CCO submitted its Emergency and Post Stabilization Care Services policy, which did not include the required information to demonstrate compliance with this element. The policy did not describe when treatment of an emergent or urgent dental condition should be provided in a dental office versus hospital setting.		
Required Actions: The CCO should develop a policy that includes information on when emergent and urgent dental services should be provided in a dental office or hospital setting.		
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)*	See Gap Analysis.pdf and Supplemental Document_Health Share 2020 Readiness Review Gaps page 1 New/Revised Policies and Procedures #4	☐ Complete ☐ Progress Sufficient to Start Operations ☒ Incomplete ☐ NA
HSAG Findings: The CCO submitted its 2020 Readiness Review Gaps and Gap Analysis documents, which indicated the CCO is aware that it does not currently meet this requirement and is planning to develop a policy regarding emergency behavioral health services.		

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Required Actions: The CCO should develop written policies and procedures and monitoring systems for an emergency response system that provides immediate, initial, or limited duration response for emergency behavioral health services.		
27. The CCO ensures that all members have access to Mobile Crisis Services to promote stabilization in a community setting rather than arrest, presentation to an emergency department, or admission to an acute psychiatric care facility. *Contract: Exhibit M (2)(g)(2)*	See Gap Analysis.pdf and Supplemental Document_Health Share 2020 Readiness Review Gaps page 1 New/Revised Policies and Procedures #4 OHP Member Handbook page 23	☐ Complete ☐ Progress Sufficient to Start Operations ☒ Incomplete ☐ NA
HSAG Findings: The documentation submitted by the CCO did not address the availability of Mobile Crisis Services. The gap analysis documents indicated that the CCO is developing a policy pertaining to these services.		
Required Actions: The CCO should 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. In addition, it should develop policies to describe how it will ensure this is taking place.		

Standard IV—Coverage and Authorization of Services	
	Total #
Complete	**20**
Progress Sufficient	**4**
Incomplete	**3**
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)*	CORP-02 Delegated Functions and Oversight, Policy Section I (page 1) and Procedure Section VII.(p. 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)*	Evidence submitted reflects current state. The policy cited below, CORP-02, is in process of being updated to reflect new requirements. Additionally, new subcontractor agreements are being drafted and will include what is already contained in the current Risk Accepting Entity Agreements as well as all new requirements related to subcontractor agreements. Health Share will share new subcontracts with OHA. *See attached Gap Analysis re: process for updating the policies and contracts.* CORP-02 Delegated Functions and Oversight Risk Accepting Entity (RAE) Agreement, Template • Sec. VI: Interpretation and Administration of Agreement (p. 3); and Sec. VIII: Performance of Agreement (p. 3), re: RAE-as-Subcontractor agreements to perform delegated activities. • Exhibit B, Part 2 in its entirety (pp. 7-9); and especially: – Sec. 4 re: excepting BH services from delegated activities (p. 8).	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Contract: Exhibit B Part 4 (12), (13)(a)(1) and (13)(b)(1)(a-j), Exhibit M(1)	• Exhibit B, Part 4 in its entirety (pp. 12-18); and especially: – Sec. 1 re: integration and coordination of service delivery (p. 12-13). – Sec. 10 re: Subcontract Requirements (p. 17) – Sec. 11 re: Adjustments in Service Area or Enrollment (pp. 17-18) • Exhibit D: – Sec. 3.b. re: RAE's agreement to be subject to "Independent Contractor" provisions (p. 31) – Sec. 10 re: Default; Remedies; and Termination addresses revocation of delegation (p. 34).	
HSAG Findings: HSO provided a Delegated Functions and Oversight policy and a sample subcontractor agreement. Neither have been updated to include all the required elements for subcontractor agreements. HSO provided a gap analysis and supplemental documentation that indicated it is aware that updates to the subcontractor agreements need to be made and was in the process of doing so. During the remote interview session, HSO staff members stated that they are on track to complete the updates to the subcontractor agreements before January 1, 2020.		
Required Actions: HSAG recommends that HSO 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)*	CORP-02 Delegated Functions and Oversight, esp. Policy Sections II and IV (p. 1), and Procedure I and II (p. 2). New Health Share subcontractors will undergo a readiness evaluation, pursuant to this requirement, as part of subcontractor readiness project plan. Health Share will provide a copy of the evaluation to OHA.	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	See Gap Analysis.pdf and Supplemental Document_Health Share 2020 Readiness Review Gaps page 1 New/Revised Policies & Procedures #6	
HSAG Findings: While HSO was aware of the requirement to provide subcontractor pre-delegation assessments to OHA when it enters into a new delegation agreement, policies and procedures had not been updated to reflect this requirement. HSO provided documentation identifying which policies and procedures needed to be updated prior to the effective date of the CCO contract. During the remote interview session, HSO staff members stated that they are in the process of updating policies and the pre-delegation assessment tool, and anticipate conducting readiness reviews of the delegates in October/November 2019.		
Required Actions: HSAG recommends that HSO update its Delegated Functions and Oversight policy to include the specific reporting requirements as outlined in the final CCO contract with OHA.		
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)*	CORP-02 Delegated Functions and Oversight, Policy Section III (page 1) and Procedure Section III (page 2) 2019 Plan Partner Oversight Planner, in its entirety RAE Agreement, Exhibit B, Part 9, Sec. 12: Monitoring and Compliance Review (p. 24)	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: HSO's Delegated Functions and Oversight policy stated that HSO will conduct an annual delegation audit of delegated entities to ensure compliance with HSO policies, requirements of the CCO contract, Oregon Administrative Rules, and all other related State and federal rules and regulations relevant to the functions delegated. HSO provided a 2019 Oversight Planner, which demonstrated the annual delegate audit schedule. While the Delegated Functions and Oversight policy stated that HSO will conduct ongoing monitoring of its delegates, no other specific information was included as to what ongoing monitoring activities would be conducted, such as weekly, monthly, and quarterly reporting and the evaluation of delegate performance. During the remote interview session, HSO staff members stated that the CCO reviews quarterly reports from delegates related to grievances and appeals and daily and weekly reports from its non-emergent medical transportation (NEMT) delegate, Gridworks.		
Required Actions: HSAG recommends that HSO update policies, procedures, and processes to ensure ongoing oversight activities are conducted on delegates in addition to the formal annual audit.		

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
5. Whenever deficiencies or areas of improvement are identified, the CCO and subcontractor shall take corrective action. *Contract: Exhibit B Part 4(13)(a)(15-17)*	RAE Agreement, Exhibit I, Section 1 (p. 52)	☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		
6. The Contractor must provide to OHA, annually and within 30 days of any change in subcontractor, the Subcontractors and Delegated Entities Report. The report should identify any activities the Contractor has agreed to perform under the contract that have been subcontracted or delegated, and include information related to the subcontracted work including: • The legal name of the Subcontractor; • The scope of work being subcontracted; • Copies of ownership disclosure form, if applicable; • Copies of all written agreements with Subcontractors to ensure all contracts meet the requirements outlined in 42 CFR 438.230; • Any ownership stake between the Contractor and Subcontractor. *Contract: Exhibit B Part 4(13)(a)(5-6)*	CORP-02 Delegated Functions and Oversight to be updated to reflect new requirements. See Gap Analysis.pdf and Supplemental Document_Health Share 2020 Readiness Review Gaps page 1 New/Revised Policies & Procedures #6 Health Share RFA Submission, Attachment 6, Subcontractors and Delegated Entities Report	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: HSO was aware of the requirement to provide subcontractor information to OHA annually and within 30 days of any change in subcontractor; however, policies and procedures had not been updated to reflect this requirement. HSO provided documentation identifying which policies and procedures needed to be updated prior to the effective date of the CCO contract.		

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Required Actions: HSAG recommends that HSO update its Delegated Functions and Oversight policy to include the specific reporting requirements as outlined in the final CCO contract with OHA.		
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)*	N/A	☐ 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	**1**
Progress Sufficient	**4**
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)*	QUAL-03 Non-Discrimination Section I and II (page 1) OPS-07 Member Enrollment & Disenrollment, Section I (page 1)	☒ 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)*	OPS-07 Member Enrollment & Disenrollment, Section II, (page1)	☒ 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)*	OPS-07 Member Enrollment & Disenrollment, Section II(B) (page 1)	☒ 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. ii. At least once every 12 months thereafter. iii. Upon automatic reenrollment under paragraph (g) of this section, if the temporary loss of Medicaid	OPS-07 Member Enrollment & Disenrollment, Section II(C) (page 2)	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IX—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*		
HSAG Findings: The policy OPS-07-Member Enrollment and Disenrollment identified that the CCO allows a member to request disenrollment under the following circumstances: • for cause, at any time • without cause, at the following times: (1) during the 90 days following the date of a member's initial enrollment into the CCO, (2) at least once every 12 months, (3) upon automatic reenrollment, if the member experienced a temporary loss of Medicaid eligibility. The policy did not specify that a member is allowed to request disenrollment when the State imposes the intermediate sanction per 42 CFR §438.702(a)(4) and the OHA contract.		
Required Actions: HSAG recommends that the CCO update its policies and procedures to ensure that all the federal and contract requirements identified in this element are included.		
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)*	OPS-07 Member Enrollment & Disenrollment, Section II(C)	☒ 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	OPS-07 Member Enrollment & Disenrollment, Section II(B)	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IX—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the CCO**	**Score**
same time; not all related services are available within the provider network; and the member's primary care provider 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)*		
HSAG Findings: The policy OPS-07-Member Enrollment and Disenrollment did not specify all of the reasons for "cause" for disenrollment as required in federal regulations and in the CCO's contract with OHA; Elements 6.b through 6.e were omitted from the CCO's documentation.		
Required Actions: HSAG recommends that the CCO update its policies and procedures to ensure that all the federal and contract requirements identified in this element are included.		

Standard IX—Enrollment and Disenrollment	
	Total #
Complete	**4**
Progress Sufficient	**2**
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*	Policy QUAL-01 Grievance System Overview QUAL-04 Member Grievances QUAL-05 Adverse Benefit Determinations, Appeals, and Contested Case Hearings See Gap Analysis.pdf and Supplemental Document_Health Share 2020 Readiness Review Gaps page 1 New/Revised Policies and Procedures #5	☐ Complete ☐ Progress Sufficient to Start Operations ☒ Incomplete ☐ NA
HSAG Findings: The CCO submitted its policies regarding the grievance, appeals, and State fair hearing process, which included its expectations of its delegated entities. The policies indicated, and the CCO acknowledged during the remote interview session with HSAG, that it fully delegated the grievance and appeals process. This included the adjudication of appeals and, therefore, the CCO is out of compliance with its contract with the State. The CCO stated during the remote interview session that it is in the process of developing systems and structures to bring the appeal adjudication process in-house.		
Required Actions: The CCO should develop and implement the necessary policies, procedures, and systems to be the adjudicator of all appeals.		
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)*	**Desk Procedure** QUAL-01 Grievance System Overview Desk Procedure-Section II (page 1) **Desk Procedure** QUAL-05 Denials, Appeals and Contested Case Hearings Desk Procedure- Section II A 2 (page 3) ; Section III E (page 7)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
3. The CCO defines an Adverse Benefit Determination as: a. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. b. The reduction, suspension, or termination of a previously authorized service. c. The denial, in whole or in part, of payment for a service. d. The failure to provide services in a timely manner, as defined by the State. e. The failure of the CCO to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals. f. For a resident of a rural area with only one CCO, the denial of a member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network. g. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities. *42 CFR §438.400(b)* *42 CFR §438.52(b)(2)(ii)* *RFA: Appendix A (C)*	Policy QUAL-05 Adverse Benefit Determinations, Appeals and Contested Case Hearings –Definitions (page1)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
4. The CCO defines Appeal as a review by the CCO of an Adverse Benefit Determination. *42 CFR §438.400(b)* *RFA: Appendix A (H)(11)*	Policy QUAL-01 Grievance System Overview-Definitions (page 1) Policy QUAL-05 Adverse Benefit Determinations, Appeals and Contested Case Hearings –Definitions (page 1) Procedures will be updated to incorporate new contract changes and rule changes for 2020	☐ Complete ☐ Progress Sufficient to Start Operations ☒ Incomplete ☐ NA
HSAG Findings: The documentation submitted by the CCO defined "appeal" as "a request for a review of an action," not *a review by the CCO* of an adverse benefit determination.		
Required Actions: The CCO should revise its definition of an appeal to "a review *by the CCO* of an adverse benefit determination."		
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)*	Policy QUAL-01 Grievance System Overview-Definitions (page 1)	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: The CCO's Grievance System Overview policy defined grievance as "a Member's expression of dissatisfaction to Health Share of Oregon, a Delegated Entity, or a provider about any matter other than an action." Examples of grievances (i.e., quality of care or services provided) were not included. In addition, the definition did not include reference to a grievance including a member's right to dispute an extension proposed by the CCO to make an authorization decision.		

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Required Actions: HSAG recommends that the CCO expand its definition of grievance in its applicable policies to include examples of types of grievances and a member's right to dispute an extension proposed by the CCO to make an authorization decision.		
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)*	Policy QUAL-04 Member Grievances-Section III (page1) **Desk Procedure** QUAL-04- Member Grievances Desk Procedure- Section I-B (page1) **Desk Procedure** QUAL-01 Grievance System Overview Desk Procedure - Section IA (Page 1)	☒ 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)*	Policy QUAL-05 Adverse Benefit Determinations, Appeals and Contested Case Hearings –Section II (page 1) 2020 Member Handbook DRAFT COPY_R1 page 40	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
8. The CCO must acknowledge receipt of each grievance and appeal. *42 CFR §438.406(b)(1)* *Contract: Exhibit I (4)(a)(1)*	Desk Procedure QUAL-01 Grievance System Overview **Desk Procedure**-Section III A (page 1)	☒ 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	I believe this is the same as number 7 above. Policy QUAL-05 Adverse Benefit Determinations, Appeals and Contested Case Hearings –Section II	☐ Complete ☐ Progress Sufficient to Start Operations

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
resolution, an oral appeal must be followed by a written, signed appeal. *42 CFR §438.402(c)(2)(ii), (c)(3)(ii)* *Contract: Exhibit I (1)(b)(2), (1)(c)(2-3)*		☒ Incomplete ☐ NA
HSAG Findings: This element was a duplicate of element #7.		
Required Actions: None.		
10. The CCO resolves each grievance in writing and provides notice as expeditiously as the member's health condition requires. Within five (5) business days from the date of the CCO's receipt of the grievance, the CCO: a. Notifies the member that a decision on the grievance has been made and what the decision is; or b. Acknowledges receipt of the grievance and notifies the member that there will be a delay in the CCO's decision of up to 30 days. c. Notice to the member must be in a format and language that may be easily understood by the member. *42 CFR §438.408(a)-(b)(1), (d)(1)* *Contract: Exhibit I (2)(h)*	Policy QUAL-04 Member Grievances-Policy Section V-Procedure Section III, IV, V; Desk Procedure QUAL-04- Member Grievances-Section I B, a. Desk Procedure QUAL-04- Member Grievances-Section III A, b. QUAL-04 Member Grievance Desk Procedure-Section III A c. QUAL-04 Member Grievances Policy- Procedure section III (page 2)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
11. In handling grievances and appeals, the CCO must give members any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-	Policy QUAL-01 Grievance System-Section V (page 2) **Desk Procedure** QUAL-01 Grievance System-Section VIII (age 2) QUAL-04 Member Grievances Desk Procedure Section IV A (page 2)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
free numbers that have adequate TTY/TTD and interpreter capability. *42 CFR §438.406(a)* *Contract: Exhibit I (1)(c)(4)*		
12. The CCO ensures that the individuals who make decisions on grievances and appeals are individuals who: • Were not involved in any previous level of review or decision-making nor a subordinate of any such individual. • Have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease if deciding any of the following: • An appeal of a denial that is based on lack of medical necessity. • A grievance regarding the denial of expedited resolution of an appeal. • A grievance or appeal that involves clinical issues. • Take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. *42 CFR §438.406(b)(2)* *Contract: Exhibit I (1)(c)(6-7)*	**Desk Procedure** QUAL-01 Grievance System-Section III C,D (page 1)	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: The applicable section of the CCO's Grievance System Desk Procedure did not include all the required information for this element. It noted that individuals who make decisions on grievances and appeals may not be individuals who were involved in any previous level of review of decision making; however, it must also include a statement that they cannot be a subordinate of any such individual. The following information was also		

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
not included: Individuals must have the appropriate clinical expertise in deciding an appeal of a denial that is based on lack of medical necessity or a grievance regarding the denial of an expedited resolution of an appeal.		
Required Actions: HSAG recommends that the CCO update its Grievance System Desk Procedure to include the following: (1) individuals who make decisions on grievances and appeals may not be a subordinate of an individual who was involved in a previous level of review or decision making; (2) individuals must have the appropriate clinical expertise in deciding an appeal of a denial that is based on lack of medical necessity or a grievance regarding the denial of an expedited resolution of an appeal.		
13. The CCO's appeal process must provide: a. That oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the member or the provider requests expedited resolution. b. The member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The CCO must inform the member of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in §438.408(b) and (c) in the case of expedited resolution. c. The member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the CCO (or at the direction of the CCO) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals. d. That included, as parties to the appeal, are:	a. Policy QUAL-05 Adverse Benefit Determinations Appeals and Contested Case Hearings- Policy section II (page 1); b. **Desk Procedure** Qual-05 Denials, Appeals and Contested Case Hearings-Section II A 3 (page 3) ; c. **Desk Procedure** Qual-05 Denials, Appeals and Contested Case Hearings-Section I C. 1 p (page 2) d. **Desk Procedure** Qual-05 Denials, Appeals and Contested Case Hearings-Section II C (page 4)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	**Desk Procedure** Qual-05 Denials, Appeals and Contested Case Hearings-Section II A 2.b (page 3); II B3 (page 3) ; II B5 (page 4); II D1 (page 4) QUAL-04 Policy Member Grievances Procedure Section III (page 2)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
15. The CCO may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if: • The member requests the extension; or • The CCO shows (to the satisfaction of the State, upon request) that there is need for additional information and how the delay is in the member's interest. • If the CCO extends the timeframes, it must—for any extension not requested by the member:	**Desk Procedure** QUAL-01 Grievance System Overview- Section V Desk Procedure Qual-01 (page2); **Desk Procedure** Denials, Appeals and Contested Case Hearings-Section II A2b (page 3); III E (page7)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
– 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)*		
16. The written notice of appeal resolution must include: The results of the resolution process and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing (contested case hearing), and how to do so. – The right to request that benefits/services continue while the hearing is pending, and how to make the request. – That the member may be held liable for the cost of these benefits if the hearing decision upholds the CCO's adverse benefit determination. *42 CFR §438.408(e)* *Contract: Exhibit I (4)(c)(4)*	**Desk Procedure** Qual-05 Denials, Appeals and Contested Case Hearings-Section II E (page 4)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
17. The member may request a State fair hearing (contested case hearing) after receiving notice that the CCO is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of resolution. • The parties to the State fair hearing (contested case hearing) include the CCO, as well as the member and his or her representative or the representative of a deceased member's estate. *42 CFR §438.408(f)* *Contract: Exhibit I (5)*	**Desk Procedure** Qual-05 Denials, Appeals and Contested Case Hearings-Section III A (page 6) ; III C (page 6)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
18. The CCO maintains an expedited review process for appeals, when the CCO determines, or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. The CCO's expedited review process includes: • The CCO ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. • If the CCO denies a request for expedited resolution of an appeal, it must: – Transfer the appeal to the time frame for standard resolution. – Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and follow-up within two calendar days with a written notice. *42 CFR §438.410* *Contract: Exhibit I (4)(c)(3)(e)*	**Desk Procedure** Qual-05 Denials, Appeals and Contested Case Hearings-Section II B 2 (page 3); II B 8 (page 4) II B 4 (page 3) and 7 ; II B 5 (page 4)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
19. The CCO provides for continuation of benefits/services while the CCO-level appeal and the State fair hearing (contested case hearing) are pending if: • The member files timely* for continuation of benefits—defined as on or before the later of the following: – Within 10 days of the CCO mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. • The services were ordered by an authorized provider. • The original period covered by the original authorization has not expired. • The member requests an appeal in accordance with required timeframes. **Note: This definition of timely filing only applies when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced. The provider may not request continuation of benefits on behalf of the member.* *\42 CFR §438.420(a)-(b)* *Contract: Exhibit I (6)(a)-(b)*	**Desk Procedure** Qual-05 Denials, Appeals and Contested Case Hearings- Section IV A 1 a-e (page 7)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
20. If, at the member's request, the CCO continues or reinstates the member's benefits while the appeal or State fair hearing (contested case hearing) is pending, the benefits must be continued until one of following occurs:	**Desk Procedure** Qual-05 Denials, Appeals and Contested Case Hearings-Section IV A 2 a-c; IV A 3 (page 7)	☒ Complete ☐ Progress Sufficient to Start Operations

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• The member withdraws the appeal or request for State fair hearing. • The member fails to request a State fair hearing and continuation of benefits within 10 calendar days after the CCO sends the notice of an adverse resolution to the member's appeal. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR §438.420(c)* *Contract: Exhibit I (6)(c)*		☐ Incomplete ☐ NA
21. If the final resolution of the appeal is adverse to the member, that is, upholds the CCO's adverse benefit determination, the CCO may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. *42 CFR §438.420(d)* *Contract: Exhibit I (6)(d)*	**Desk Procedure** Qual-05 Denials, Appeals and Contested Case Hearings-Section IV A 3 (page 7)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
22. Effectuation of Reversed appeal resolutions: • If the CCO or the State fair hearing (contested case hearing) officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the CCO must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than seventy-two (72) hours from the date it receives notice reversing the determination.	**Desk Procedure** Qual-05 Denials, Appeals and Contested Case Hearings-Section IV A 4,5 and 6 (page7)	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• If the CCO 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)*		
HSAG Findings: The CCO's Denials, Appeals and Contested Case Hearings policy included the following statement, "If the decision to deny authorization of services is reversed and the member received the disputed services while the appeal was pending the member will not be charged for the services." Although the member may not be charged for the services, the requirement is that the CCO pays for the services.		
Required Actions: HSAG recommends that the CCO revise the language in its Denials, Appeals and Contested Case Hearings policy to clarify that, 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 must pay for those services.		
23. The CCO maintain records of all member grievances and appeals. The record must be accurately maintained in a manner accessible to the State and available upon request to CMS. The record of each member grievance or appeal must contain, at a minimum, all of the following information: • A general description of the reason for the appeal or grievance; • The date received; • The date of each review or, if applicable, review meeting; • Resolution at each level of the appeal or grievance, if applicable; • Date of resolution at each level, if applicable;	N/A	☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• Name of the covered person for whom the appeal or grievance was filed, member ID number, and date the member filed the grievance or appeal; • Notations of oral and written communications with the member; and • Notations about appeals and grievances the member decides to resolve in another way if the CCO is aware of this. *42 CFR §438.416* *Contract: Exhibit I (9)*		
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		
24. The CCO provides the information about the grievance appeal, and fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing (contested case hearing) after the CCO has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes. • The member's right to have a provider or authorized representative file a grievance and/or an appeal on his or her behalf, provided he or she has provided written consent • The toll-free numbers to file a grievance or an appeal	Policy QUAL-01 Grievance System Overview Section VII (page 2) and VIII (page 2) Oregon Health Plan Addendum Contract 2018 (page2)	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

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

Standard X- Grievance and Appeal Systems	
	Total #
Complete	**16**
Progress Sufficient	**4**
Incomplete	**2**
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)*	The following citations refer to the process by which we request information from our partners to be assembled by our EDI vendor and distributed to Health Share. General system overview in the "Health Share EDI Blueprint Manual 2017.Dec.21.0 Notated.doc" pages 3-7. Data descriptions: • SFTP Structure, "RAE Integration Requirements Handbook 20190723 Notated .docx" pages 17-18 • SFTP folder structure, "RAE Integration Requirements Handbook 20190723 Notated .docx", pages 26-27 a. Claims and encounters "Health Share EDI Blueprint Manual 2017.Dec.21.0 Notated.doc" pages 8-12; "RAE Integration Requirements Handbook 20190723 Notated .docx" pages 19-23, 33-36, 47-57 b. Grievances, appeals and hearing records – "Health Share EDI Blueprint Manual 2017.Dec.21.0 Notated.doc" page 26, Data managed by the hearings and appeals team c. Disenrollment for other than loss of Medicaid eligibility "Health Share EDI Blueprint Manual 2017.Dec.21.0 Notated.doc" page 23; "RAE Integration Requirements Handbook 20190723 Notated .docx" pages 19-20	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	d. Member characteristics "RAE Integration Requirements Handbook 20190723 Notated .docx" pages 20, 23 i. Race – "Health Share EDI Blueprint Manual 2017.Dec.21.0 Notated.doc" page 27, "Portal File Layouts Notated.xlsx" page 1 ii. Ethnicity – "Portal File Layouts Notated.xlsx" page 1 iii. Preferred Language – "Portal File Layouts Notated.xlsx" page 1 iv. Names and phone number of the member's PCP or Clinic – "PCP-PDP Assignment File Format Notated.docx" pages 1-2, "PCPCR Assignment and Affiliation File Formats Notated.docx" pages 2-4, "Health Share EDI Blueprint Manual 2017.Dec.21.0 Notated.doc" pages 14, 19-20, 22 2. Attestation of member rights and responsibilities – Health Share members are informe of their rights through the Health Share Member Handbook, Notice of Action (NOA) and grievance and appeals process documents. Enrollee Rights can also be found in the member section of Health Share's website. When receiving either phone or in-person inquires, Health Share's customer service staff educate and assist members on issues relating to enrollee rights. Health Share's Quality Assurance team provides delegation oversight to ensure delegated	

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	entities have policies and procedures for informing members of their rights. e and f. MOTS and LTPC requirements are currently delegated to our behavioral health Delegated Entities. In 2020 as this benefit transitions to our Integrated Care Network, new work flow processes will be developed. See "Fifth Amendment & Restated Behavioral Health RAE Agreement", page 3.	
HSAG Findings: Through its policies, procedures, information systems documentation, and remote demonstrations, the CCO provided evidence of its ability to capture, analyze, and report required Medicaid program elements except Measures and Outcome Tracking System (MOTS) information and Long-Term Psychiatric Care (LTPC) determination forms. While the CCO currently requires its behavioral health providers (via contracts) to collect, store, and report MOTS and LTPC 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 procedures to support the collection, storage, and reporting of MOTS data and LPTC Determination Forms. At a minimum, CCO policies and procedures should describe how MOTS data and LTPC determination forms are used by the CCO to support the management of members' health along with mechanisms used to access them (e.g., direct extracts [when available], provider-level data extracts, patient-level documentation from providers).		
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)*	a. "Portal File Layouts Notated.xlsx" page 1 b. "RAE Integration Requirements Handbook 20190723 Notated .docx" page 19, "Health Share EDI Blueprint Manual 2017.Dec.21.0 Notated.doc" pages 23-27, EDI Process section 1.2 page 6. "Health Share EDI Blueprint Manual 2017.Dec.21.0 Notated.doc" pages 6-12, "Health Share EDI Blueprint Manual 2017.Dec.21.0 Notated.doc" page 13, "Health Share EDI Blueprint Manual 2017.Dec.21.0 Notated.doc" pages 14-19,	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	a. "Portal File Layouts Notated.xlsx" page 1 b. "RAE Integration Requirements Handbook 20190723 Notated .docx" page 19, "Health Share EDI Blueprint Manual 2017.Dec.21.0 Notated.doc" pages 23-27, EDI Process section 1.2 page 6. c. "Health Share EDI Blueprint Manual 2017.Dec.21.0 Notated.doc" pages 6-12, "Health Share EDI Blueprint Manual 2017.Dec.21.0 Notated.doc" page 13, "Health Share EDI Blueprint Manual 2017.Dec.21.0 Notated.doc" pages 14-19,	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
4. Contractor shall ensure that data received from providers, either directly or through a third party, is accurate, truthful, and complete in accordance with OAR 410-120-1280 and OAR 410-141-3420 by: a. Verifying the accuracy and timeliness of data reported b. Screening the data for completeness, logic, and consistency c. Submitting the certification to verify current member eligibility for fully dual eligible members using the AVR system or MMIS Web Portal. 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.	• https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=239708 • https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=240794 a. "RAE Integration Requirements Handbook 20190723 Notated .docx" page 17, "Health Share EDI Blueprint Manual 2017.Dec.21.0 Notated.doc" page 10, 11, 12, 25 b. "Unencountered Claim File Format Notated", "Health Share EDI Blueprint Manual 2017.Dec.21.0 Notated.doc" pages 10, 16 c. "Health Share COBA Claim Processing Notated.docx", "COBA Claim File Format Noitated.docx", "COBA Claim Reconciliation File Format Notated.docx"..	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
42 CFR §438.242(b)(3)(i-iii) *Contract: Exhibit J(3)*	"RAE Integration Requirements Handbook 20190723 Notated .docx" pages 30-32, "RAE Integration Requirements Handbook 20190723 Notated .docx" pages 33-36, "RAE Integration Requirements Handbook 20190723 Notated .docx" pages 47-57, "Health Share EDI Blueprint Manual 2017.Dec.21.0 Notated.doc" pages 9, 15-16, 22-23, 27, 29	
HSAG Findings: Through specific guidelines for Risk Accepting Entities (RAEs), the CCO defined its expectations for each RAE's processing and validation of claims and encounter data. However, neither the CCOs policies and procedures nor staff member responses identified ongoing prospective monitoring of claims or encounter accuracy, timeliness, or completeness. Instead, the CCO confirmed it performed encounter data quality checks on the All Payer All Claims files it received from its RAEs and conducted regular reconciliation relative submitted 837 encounter files.		
Required Actions: HSAG recommends that the CCO develop policies and procedures (at the CCO level) for conducting ongoing validation of the accuracy, timeliness, and completeness of claims and encounters.		
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)*	This is available on demand and per request to individuals or parties with the appropriate authorization. All data is collected in Health Share's EDW environment. Reports are provided in a variety of formats as specified by requestor.	☒ 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
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		

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

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
b. Submit member encounter data to OHA at a frequency and level of detail to be specified by CMS and OHA, based on program administration, oversight, and program integrity needs. c. Submit all member encounter data that the State is required to report to CMS under §438.818. d. Specifications for submitting encounter data to the Agency in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate. *42 CFR §438.242(c)(1-4)*		☒ NA
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		
9. Contractor shall develop IS contingency planning in accordance with 45 C.F.R. §164.308. Contingency plans shall include: a. Data Backup plans b. Disaster Recovery plans c. Emergency Mode of Operation plans d. Application and data criticality analysis and testing; and revisions procedures shall also be addressed within the required contingency plans. *45 CFR §164.308*	a. Business Continuity Plan, section 8 b. Business Continuity Plan, section 9 c. Business Continuity Plan, section 6 d. Business Continuity Plan, section 8.3 & 8.5	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete

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

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
ii. Pays the annual HIT Commons assessments subject to the payment terms of the HIT Commons MOU iii. Serves, if elected, on the HIT Commons Governance Board, or one of its committees iv. Participates in OHA's HITAG, at least annually d. Report the EHR(s) vendor/product used by its contracted providers and its progress on EHR adoption targets via the Performance Expectations report e. Report the HIE tool(s) used by its contracted providers and its progress on HIE access targets via the Performance Expectations report f. Report on its use of HIT to administer VBP arrangements and support its contracted providers with VBP arrangements. g. Report on its use of HIT to support population health management *Contract: Exhibit J(2)(b, k)*		
HSAG Findings: This element will be reviewed by the OHA HIT for the readiness review.		
Required Actions: None.		
12. The CCO shall: a. Participate as a member in good standing of the HIT Commons b. Maintain an active, signed HIT Commons MOU c. Adhere to the terms of the HIT Commons MOU d. Pay the annual HIT Commons assessments subject to the payment terms of the HIT Commons MOU	We have had turnover of our IT leadership, however, the current leadership will be attending the HIT Commons, actively engaging and adhering to the terms of the HIT Commons MOU.	☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
e. Serve, if elected, on the HIT Commons governance board or one of its committees. *Contract: Exhibit J(2)(d)*		
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 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)*	The information to provide the report resides as follows within our Tableau applications which draws its information from our internal data warehouse. All of the data is available and we will work with the OHA to determine the layout of the information to be reported: a. Our tableau application Community Care offers both state and incentive measures for the plans and providers, see "Community Care Information page.doc". https://tableauprod.healthshareoregon.org/#/views/CommunityCare_0/Information b. A member's providers can readily be accessed using Health Share's Population Explorer	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	application in Tableau. Information page "Population Explorer Information Page.doc" is attached and application location page https://tableauprod.healthshareoregon.org/#/views/PopulationExplorer_1/Welcome which is based on the accurate medical, behavior health, NEMT and pharmacy records collected on each of our members. The claims contain information on the rendering and billing provider as well as the procedures performed. c. Our tableau application Community Care offers both state and incentive measures for the plans and providers, see "Community Care Information page.doc". In addition, there is a tab that has member level detail as to what member is a part of what numerator and denominator so that partners can use this tab to print a member work list for engaging members in accordance with the standards. https://tableauprod.healthshareoregon.org/#/views/CommunityCare_0/Information d. Actionable member information can readily be accessed using Health Share's Patient Stratification application in Tableau. . Information page "Patient Stratification Information Page.doc" is attached and application location page https://tableauprod.healthshareoregon.org/#/views/PatientStratification_1/Welcome.	

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	e. Our tableau application Community Care offers both state and incentive measures for the plans and providers, see "Community Care Information page.doc". In addition, there is a tab that has member level detail as to what member is a part of what numerator and denominator so that partners can use this tab to print a member work list for engaging members in accordance with the standards. https://tableauprod.healthshareoregon.org/#/views/CommunityCare_0/Information	
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)*	a. Member utilization characteristics can readily be evaluated using Health Share's Population Explorer application in Tableau. Information page "Patient Stratification Information Page.doc" is attached and application location page https://tableauprod.healthshareoregon.org/#/views/PatientStratification_1/Welcome b. Risk stratifying members can be readily accessed using Health Share's Patient Stratification application in Tableau. Information page is attached "Patient Stratification Information Page.doc" and the application https://tableauprod.healthshareoregon.org/#/views/PopulationExplorer_1/Welcome c. We bring Wakely risk scores aligned with the VBP model and providers and make this available on demand for each of our partners as	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	well as providing the Charlson-Deyo, CMS-HCC and HHS-HCC risk scores at the member level for our VBP providers and non VBP providers within the Patient Stratification tableau application. Information page is attached "Patient Stratification Information Page.doc" is attached and application location page https://tableauprod.healthshareoregon.org/#/views/PatientStratification_1/Welcome	

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 HSO's Provider Capacity Reports were good with a few data quality issues across both individual practitioners and facility and service providers.

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

DSN Data Field	DSN Quality Metrics		
	% Present	% Valid Format	% Valid Values
Accepting New Medicaid Enrollees	100.0	100.0	
Address #1	100.0		
Provider's Capacity	24.4	100.0	
City	100.0		
Status of Medicaid Contract	100.0	100.0	
County	100.0		
Credentialing Date	88.7	100.0	98.6
DMAP (Medicaid ID)	97.6	99.8	

DSN Data Field	DSN Quality Metrics		
	% Present	% Valid Format	% Valid Values
Provider First Name	100.0		
Group/Clinic Name	98.6		
Non-English Language 1	5.6		
Non-English Language 2			
Non-English Language 3			
Provider Last Name	100.0		
Provider Network Status	100.0	99.8	
Provider NPI	100.0	100.0	100.0
Number of Members Assigned to PCPs	26.1	100.0	
PCP Indicator	96.2	100.0	
PCPCH Tier	17.1	100.0	
Phone Number	99.9		
Provider Category	100.0	100.0	100.0
Provider Service Category	100.0	100.0	100.0
Provider TIN	78.7	100.0	
Provider Taxonomy	100.0	100.0	100.0
Zip Code	100.0		

In general, key DSN data fields in the individual practitioner capacity report were populated with a couple of exceptions including: DMAP ID (97.6 percent), Group/Clinic Name (98.6 percent), PCP Indicator (96.2 percent), and Provider TIN (78.7 percent). Additionally, most of the populated fields contained valid formats and values. The overall average completeness was 84.0 percent across both required and conditional[B-1] fields and increased to 98.4 percent when excluding conditional fields. Of note, only 5.6 percent of providers were associated with a non-English language.

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

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

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

DSN Data Field	DSN Quality Metrics		
	% Present	%Valid Format	% Valid Values
Status of Medicaid Contract	100.0	100.0	
County	100.0		
DMAP (Medicaid ID)	86.1	100.0	
Facility NPI	94.6	100.0	99.9
Phone Number	99.8		
Provider Category	100.0	100.0	100.0
Provider Service Category	100.0	100.0	100.0
Facility TIN	92.0	100.0	
Facility or Business Taxonomy	94.4	99.1	99.1
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 an overall average completeness of 97.4 percent across all data fields. Of note, only 86.1 percent of the records were populated with a DMAP ID.

Provider Network Capacity

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

Table B-3—HSO 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	4,166	24.5	4,166	100.0	0	0.0
Specialty Provider	7,991	47.0	7,991	100.0	0	0.0
Dental Service Provider	989	5.8	989	100.0	0	0.0
Mental Health Provider	3,304	19.4	3,304	100.0	0	0.0
SUD Provider	420	2.5	420	100.0	0	0.0
Certified or Qualified Health Care Interpreters	0	0.0	0	0.0	0	0.0

Provider Specialty Category	Total		Contract Status = Yes		Contract Status = PEND	
	Number	Percent	Number	Percent	Number	Percent
Traditional Health Workers	123	0.7	123	100.0	0	0.0
Alcohol/Drug	16	0.1	16	100.0	0	0.0
Health Education, Health Promotion, Health Literacy	0	0.0	0	0.0	0	0.0
Palliative Care	0	0.0	0	0.0	0	0.0
Facility/Service Practitioners						
Hospital, Acute Psychiatric Care	5	0.8	5	100.0	0	0.0
Ambulance and Emergency Medical Transportation	1	0.2	1	100.0	0	0.0
Federally Qualified Health Centers	114	18.1	114	100.0	0	0.0
Home Health	37	5.9	37	100.0	0	0.0
Hospice	0	0.0	0	0.0	0	0.0
Hospital	75	11.9	75	100.0	0	0.0
Imaging	0	0.0	0	0.0	0	0.0
Indian Health Service and Tribal Health Services	4	0.6	4	100.0	0	0.0
Mental Health Crisis Services	10	1.6	10	100.0	0	0.0
Community Prevention Services	3	0.5	3	100.0	0	0.0
Non-Emergent Medical Transportation	12	1.9	12	100.0	0	0.0
Pharmacies	80	12.7	80	100.0	0	0.0
Durable Medical Providers	146	23.2	146	100.0	0	0.0
Post-Hospital Skilled Nursing Facility	90	14.3	90	100.0	0	0.0
Rural Health Centers	20	3.2	20	100.0	0	0.0
School-Based Health Centers	5	0.8	5	100.0	0	0.0
Urgent Care Center	27	4.3	27	100.0	0	0.0

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

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

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

Provider Accessibility

The provider accessibility domain evaluated the degree to which contracted services are accessible to the beneficiary population based on the number of providers who are accepting new patients and that provide services in an non-English language. Figure 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—HSO 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	4,166	2,935	70.5	382	9.2
Specialty Provider	7,991	6,365	79.7	573	7.2
Dental Service Provider	989	981	99.2	170	17.2
Mental Health Provider	3,304	3,060	92.6	241	7.3
SUD Provider	420	408	97.1	18	4.3
Certified or Qualified Health Care Interpreters	0	0	0.0	0	0.0
Traditional Health Workers	123	123	100.0	5	4.1
Alcohol/Drug	16	16	100.0	2	12.5
Health Education, Health Promotion, Health Literacy	0	0	0.0	0	0.0
Palliative Care	0	0	0.0	0	0.0
TOTAL	**17,009**	**13,888**	**81.7**	**1,391**	**8.2**

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

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

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

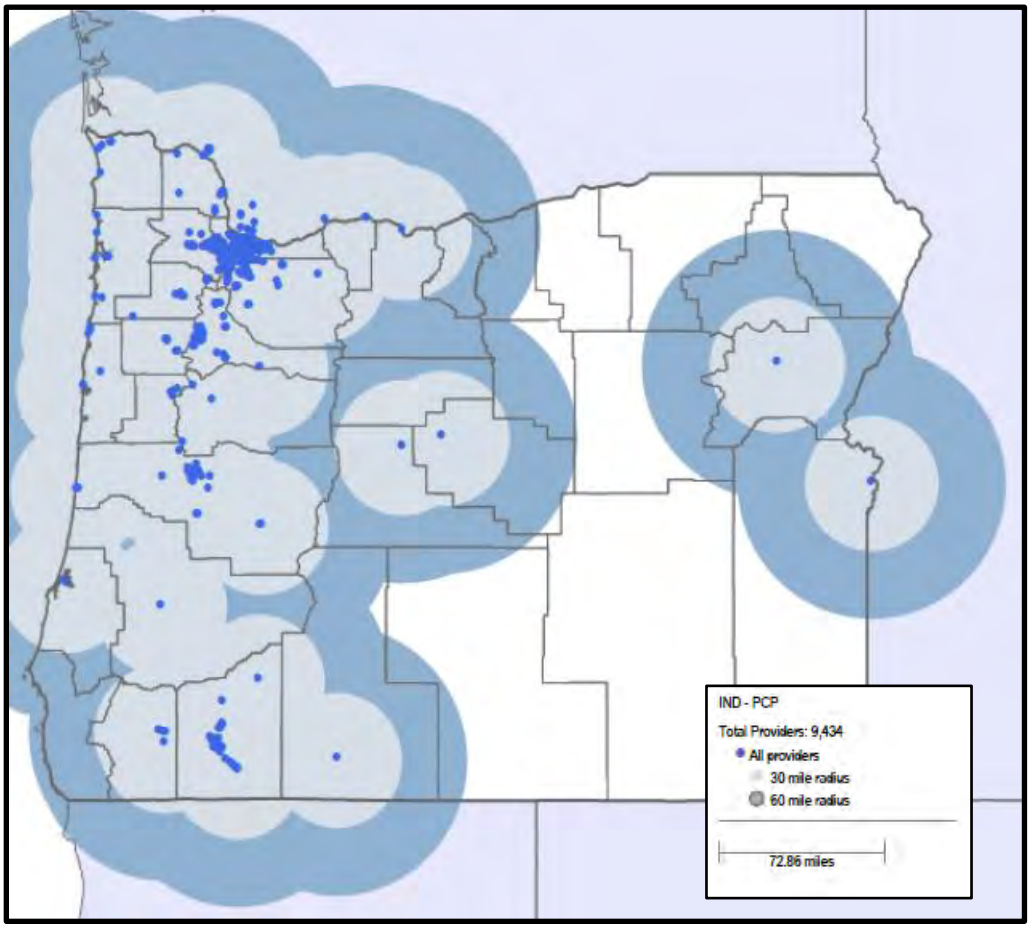
Overall, 81.7 percent of the HSO's provider network was accepting new patients according to the CCO's DSN submission, including HSO's core providers (i.e., physical, oral, and mental health). While the percent of dental, mental health, and SUD providers accepting new patients exceeded 90 percent, the percent was lower for primary care and specialty providers (i.e., 70.5 percent and 79.7 percent, respectively). Of its individual practitioners, only 8.2 percent noted speaking a language other than

English with all core specialty categories reporting less than 10 percent of the providers speaking a non-English language except for dental service providers (17.2 percent).

Geographic Distribution

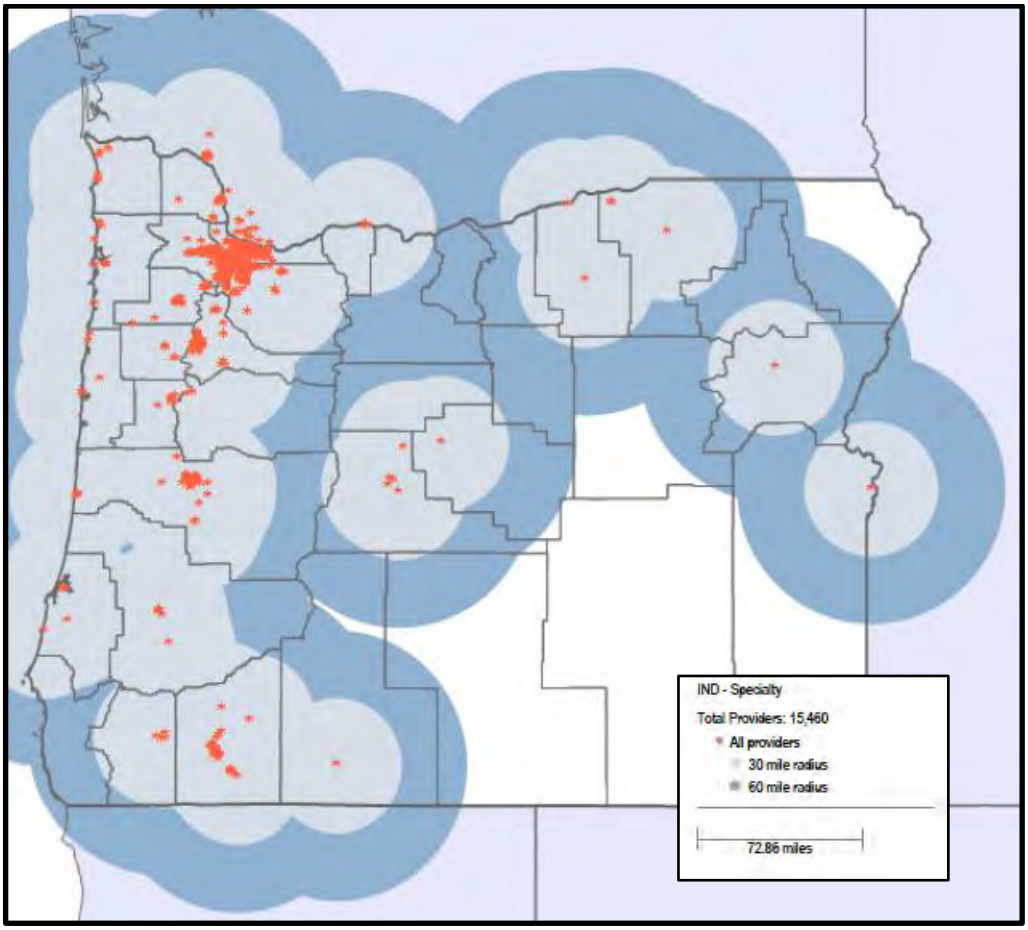
The geographic distribution of providers relative to member populations assessed whether or not the practitioner and facility locations were spread proportionately across the beneficiary population. Since beneficiary data was not available at the time of this analysis, the geospatial maps display the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

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



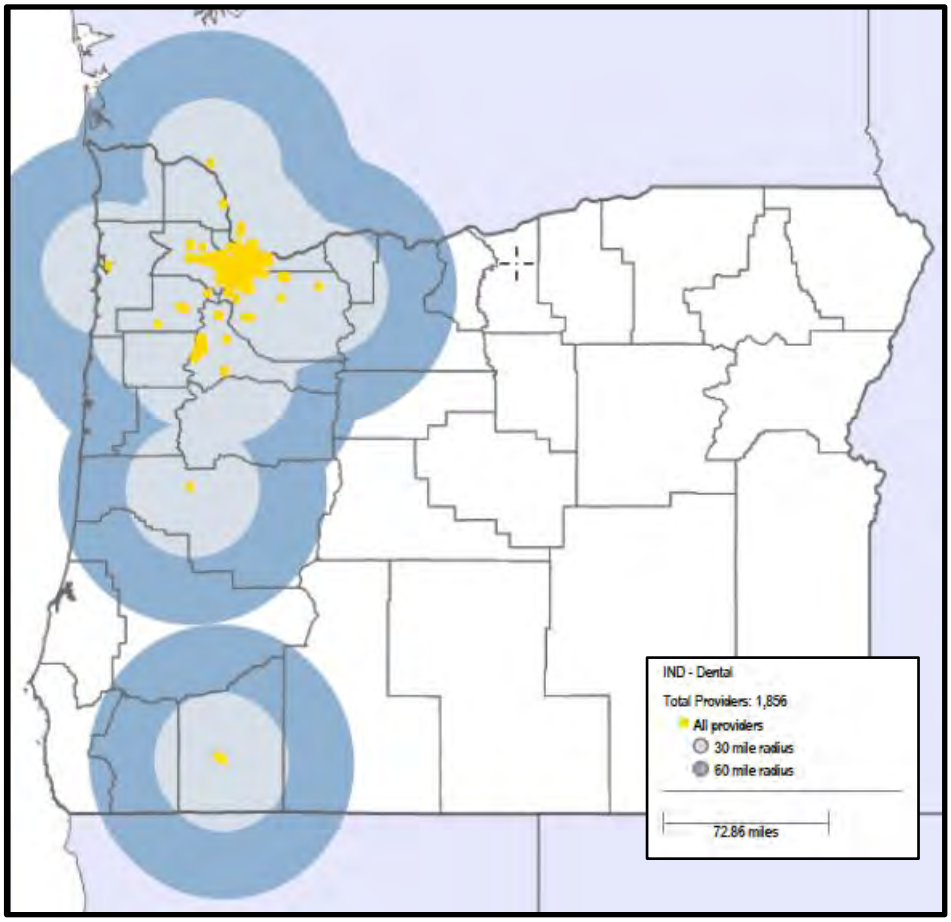
As shown in Figure B-1, the distribution of HSO's network of PCPs is sufficient to cover the CCO's service area. Most of the regions in the CCO's service area are within 30 miles of a primary care provider, except for rural parts of southeastern Clackamas County where provider coverage is within 60 miles.

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



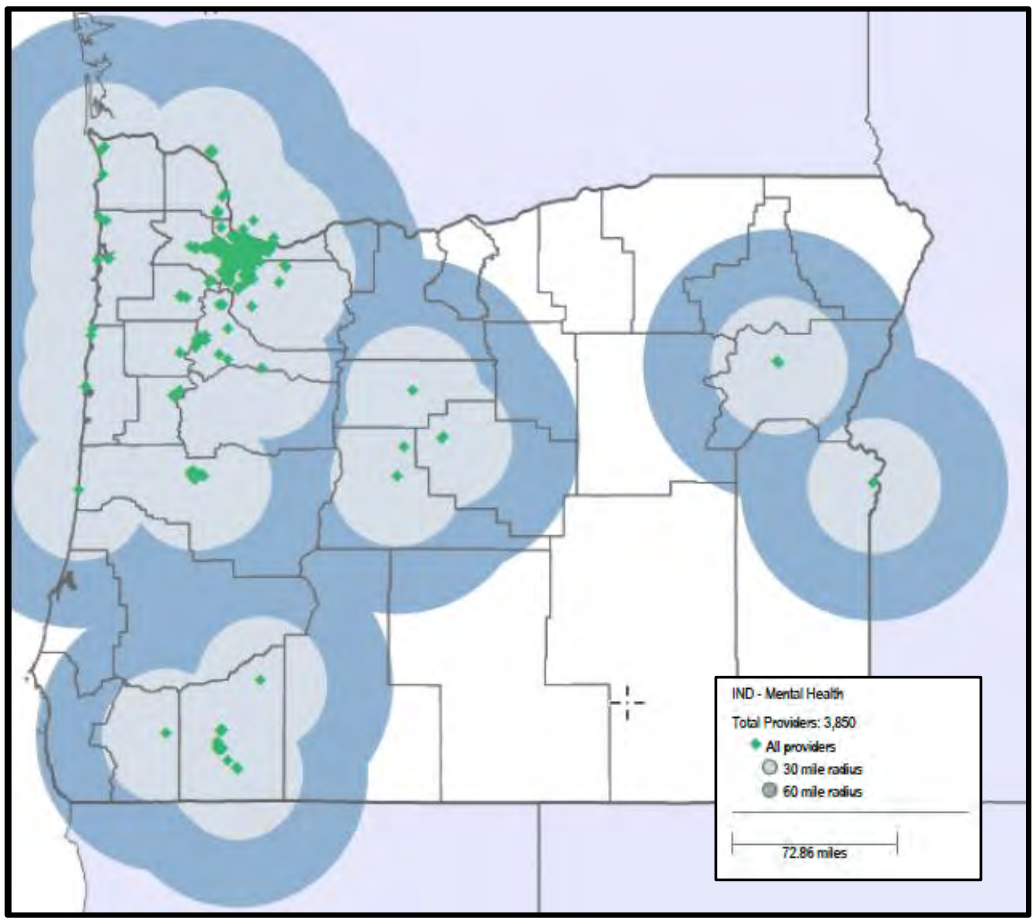
As shown in Figure B-2, the distribution of HSO's specialty providers is sufficient to cover the CCO's service area. Most of the regions in the CCO's service area are within 30 miles of a specialty provider, except for rural parts of eastern Clackamas County where provider coverage is within 60 miles.

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



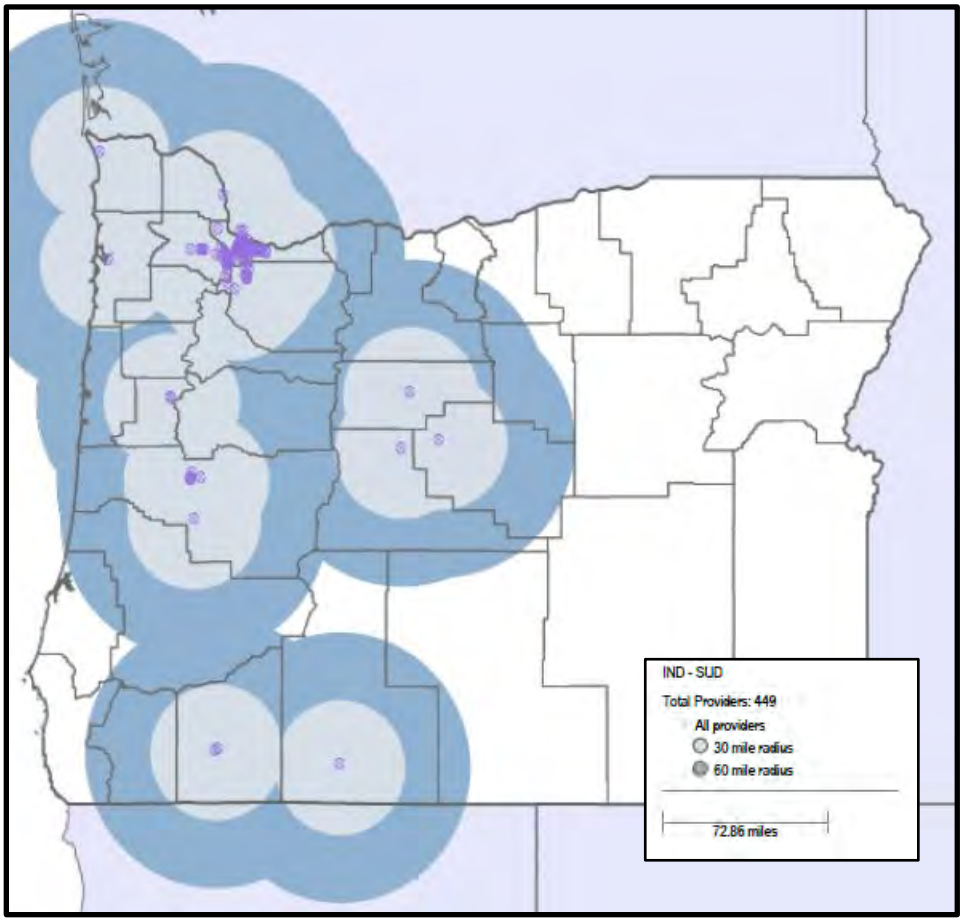
As shown in Figure B-3, the distribution of HSO's dental service providers is sufficient to cover the CCO's service area. Most of the regions in the CCO's service area are within 30 miles of a dental provider, except for rural parts of southeastern Clackamas where provider coverage is within 60 miles.

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



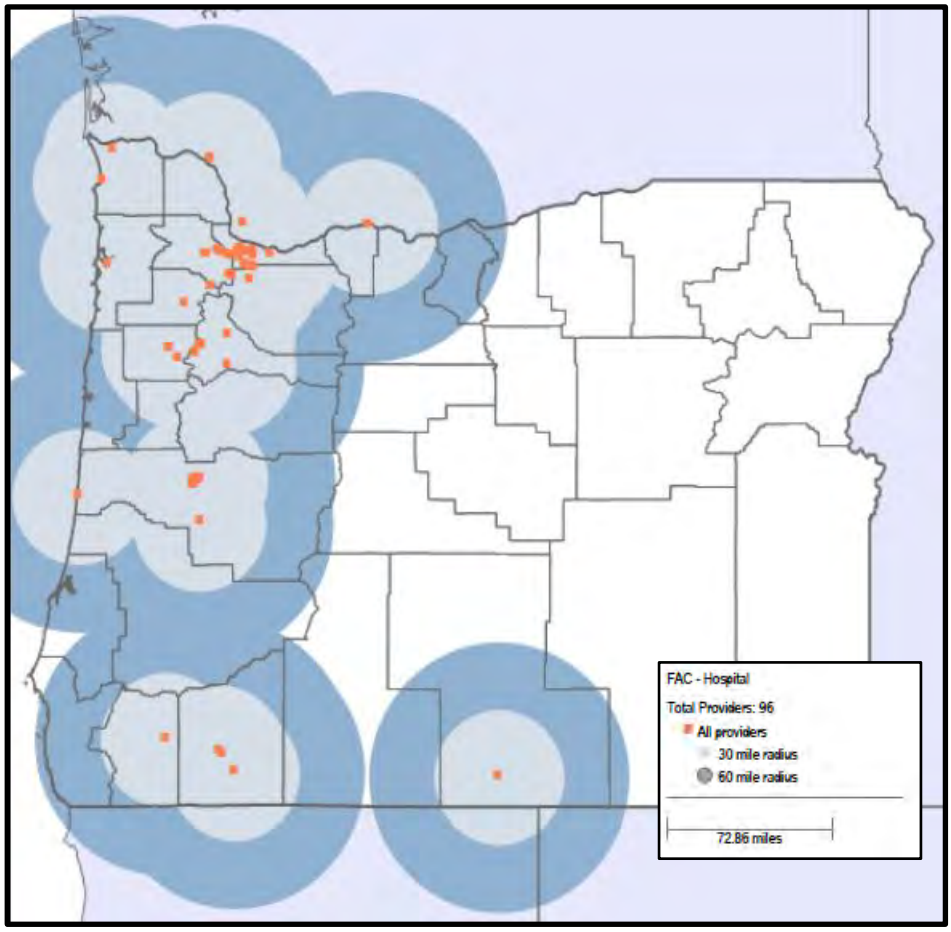
As shown in Figure B-4, the distribution of HSO's mental health providers is sufficient to cover the CCO's service area. Most of the regions in the CCO's service area are within 30 miles of a mental health provider, except for rural parts of eastern Clackamas County where provider coverage is within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

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



As shown in Figure B-5, the distribution of HSO's SUD providers is sufficient to cover the CCO's service area with most of the regions in the CCO's service area being within 30 miles of a SUD provider, except for rural parts of eastern Clackamas County where provider coverage is within 60 miles.

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



As shown in Figure B-6, the distribution of HSO's hospital facilities is sufficient to cover the CCO's service area with most of the regions in the CCO's service area being within 30 miles of a hospital facility, except for rural parts of southeastern Clackamas County where provider coverage is within 60 miles.

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

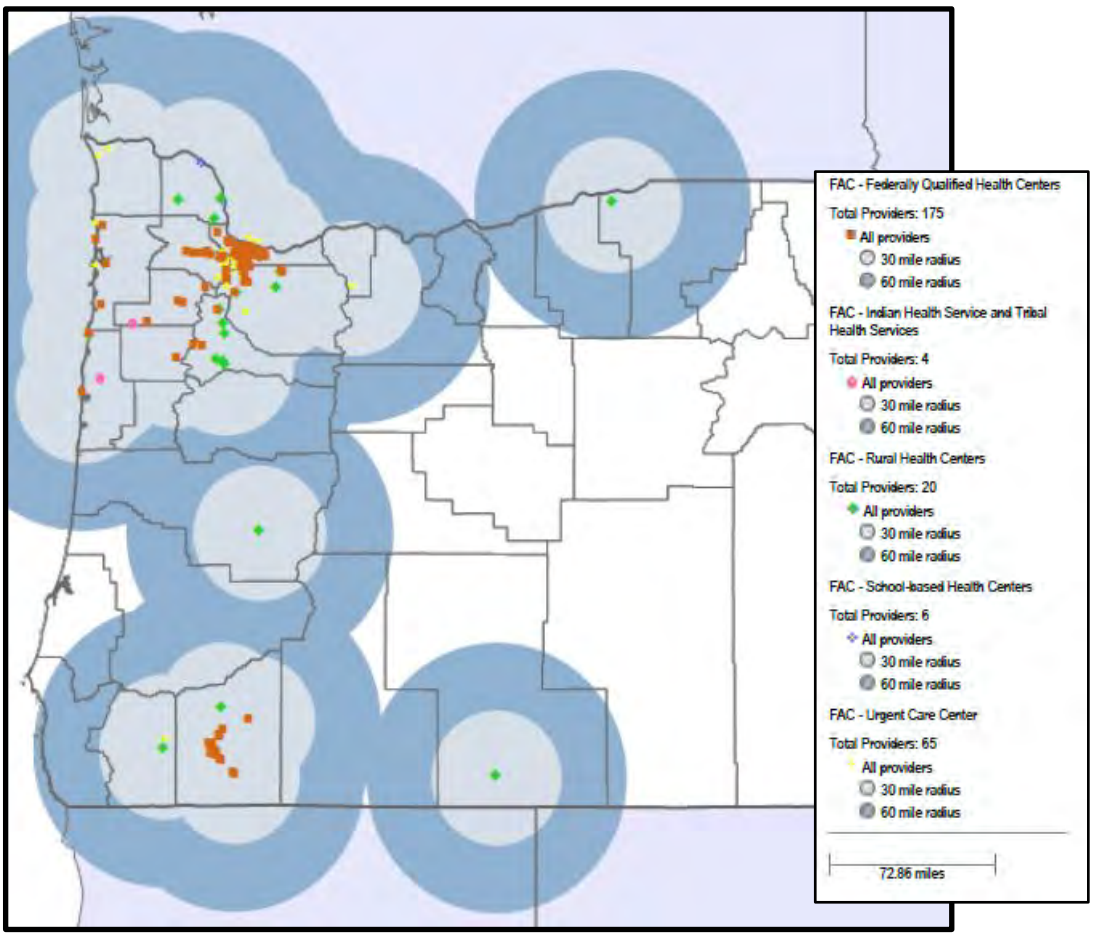


Figure B-7 displays the distribution of several clinic-based facilities within HSO's service areas, including FQHCs, Indian Health Services and Tribal Health Services, Rural Health Centers, School-Based Health Centers, and Urgent Care Centers. The map shows that the distribution of clinic-based facilities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

Appendix C. Phase 2 Evaluation Tool

[Pending completion of the Phase 2 RR]