Oregon Health Authority

2019 CCO Readiness Review

for

Jackson Care Connect

September 2019

Interim Report

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Overview 1-1
Background 1-1
Methodology 1-1
Phase 1—Critical Areas Readiness Review 1-2
Phase 2—Operations Policy Readiness Review 1-3
Results 1-3

2. Phase 1 Results 2-1

3. Phase 2 Results 3-1

Appendix A. Phase 1 Evaluation Tool A-1

Appendix B. Delivery System Network (DSN) B-1
Quality of DSN Provider Capacity Reporting B-1
Provider Network Capacity B-3
Provider Accessibility B-5
Geographic Distribution B-6

Appendix C. Phase 2 Evaluation Tool C-1

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 Jackson Care Connect (JCC), 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.

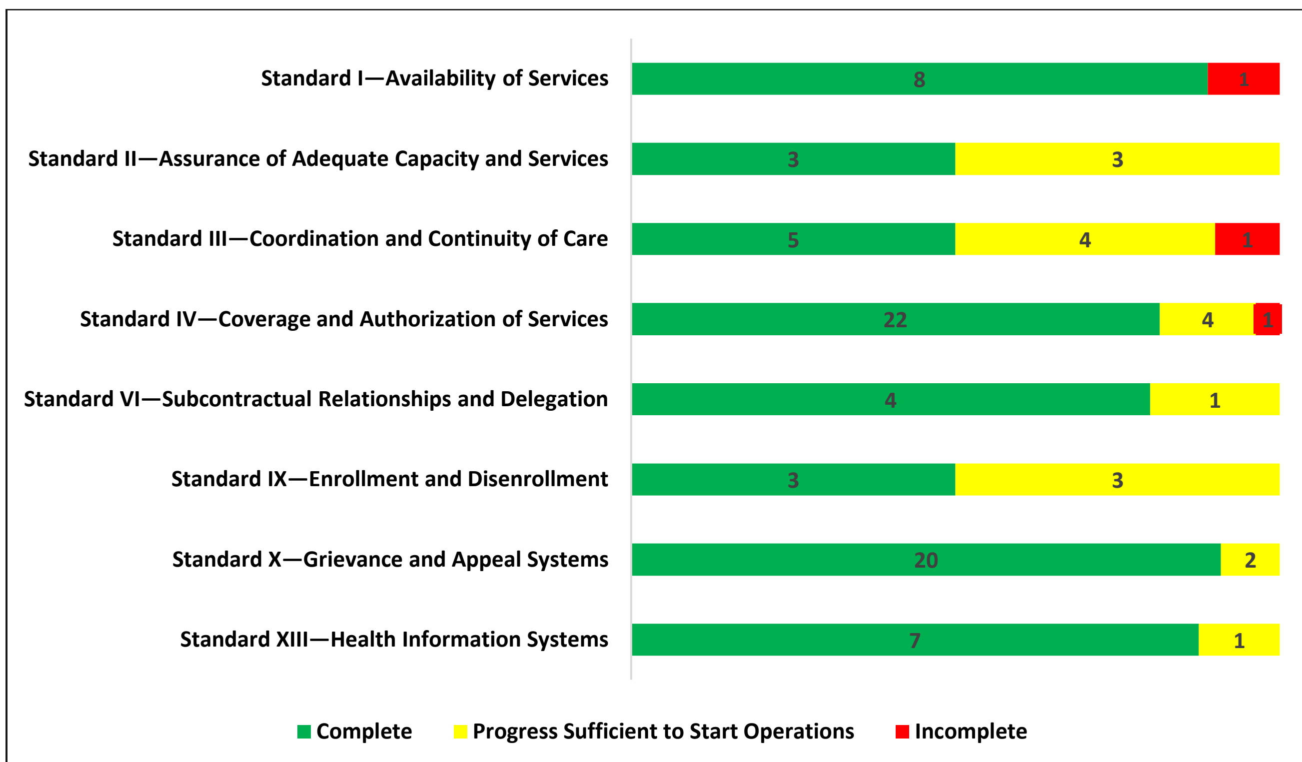
2. Phase 1 Results

Across all eight standards, JCC's overall percentage of complete elements is 77.4 percent. The CCO demonstrated:

- *Complete* ratings for 72 of the 93 total elements.
- *Progress Sufficient to Start Operations* ratings for 18 elements across eight standards.
- *Incomplete* ratings for three elements across eight 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—JCC Phase 1—Critical Areas Readiness Review Results



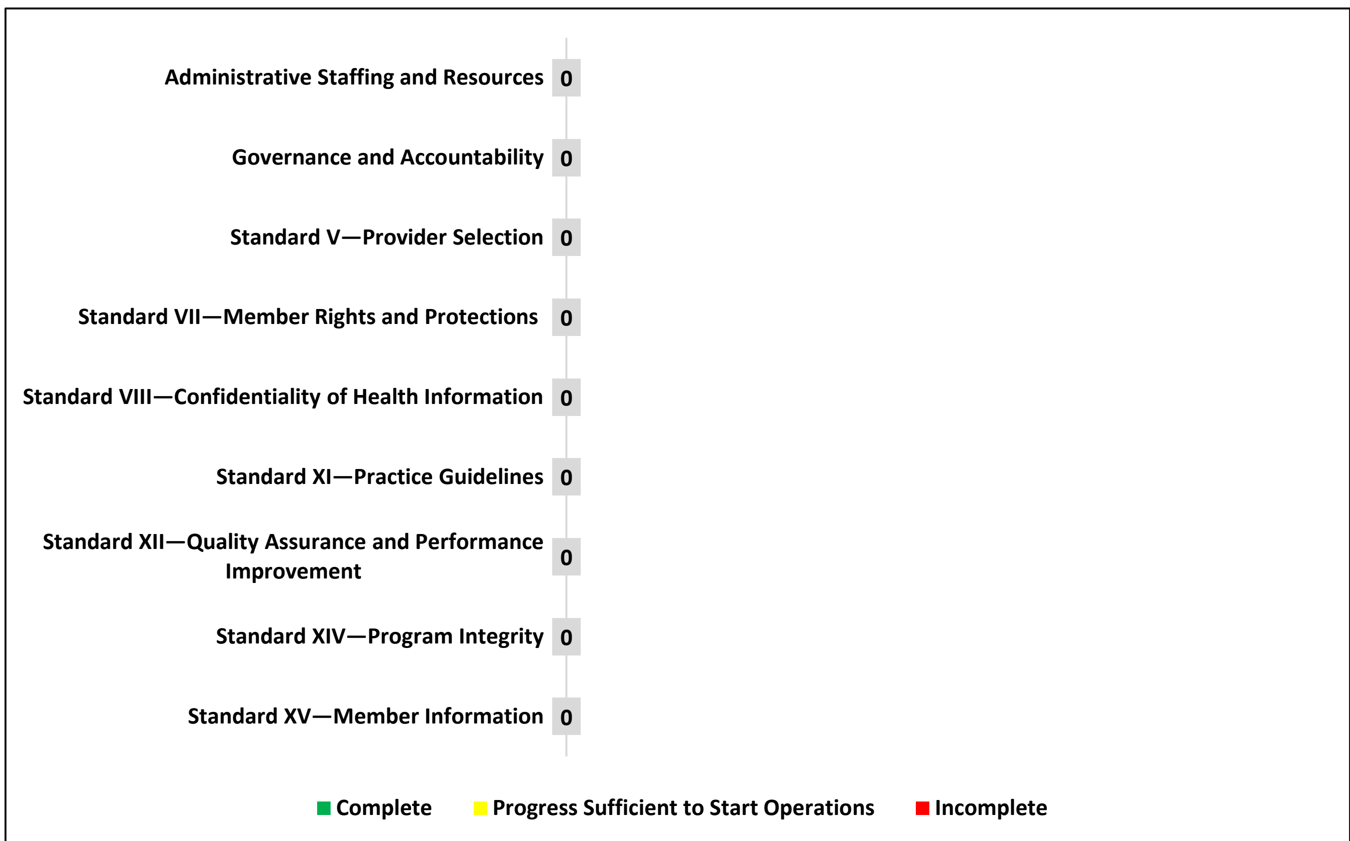
3. Phase 2 Results

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

Across all eight standards, JCC'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—JCC 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 JCC'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)*	The CCO uses the Quest Analytics Adequacy Tool to validate network adequacy following CMS rules, with our overlapping networks this provides validation of our OHP network as well. The Quest tool employs geocoding analysis that assists us with network evaluation using time and distance standards. Quest also allows for researching and identifying contracting opportunities if gaps in services occur. • Refer to the Network Adequacy Policy, specifically areas A-F in the policy • Refer to the Network Adequacy Steering Committee Policy • Provider Manual – pages 25-27 – https://www.careoregon.org/docs/default-source/providers/manuals-and-formulary/careoregon-provider-manual-web.pdf?sfvrsn=2bdae56e_16 – Refer to Accessibility of Services policy	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
2. The CCO maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract (inclusive of non-emergent medical transportation, alternative therapies [e.g., acupuncture, chiropractic medicine, massage, yoga], and access to traditional health care workers) for all members, including those with	**Maintaining and Monitoring** The CCO uses the Quest Analytics Adequacy Tool to monitor and validate network adequacy across primary care and all covered services. Members may also receive care from non-contracted providers when appropriate. The Quest also allows for researching and identifying contracting opportunities if gaps in services occur were to occur.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	• Refer to the Network Adequacy Policy • Refer to the Network Adequacy Steering Committee Policy **Written Agreements** The CCO contracts directly with a variety of specialty providers, including acupuncturists, chiropractors to ensure network adequacy. In addition, the CCO contracts with Northwest Rehab Alliance (NWRA) who creates a single network of private practice therapy clinics. NWRA has built an accessible and geographically dispersed panel of provider locations to find unique and a varied niche services for health plans and members. Outside of our contracted provider network, the CCO maintains a various agreement a variety of partners. One example is a community-based program Acupuncture service with several locations which offer a group setting for acupuncture treatment. Due to the unique structure of these group treatment settings as well as locations across multiple counties, access to acupuncture services is increased. Services that members receive through Working Class Acupuncture do not fall under an authorization or claims based reporting methodology; monthly invoices are sent by the provider to the CCO for utilization management purposes. **Traditional Health Workers** Internally, The CCO's Health Resilience Specialists are embedded with in high volume primary care	

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	clinics. They are deployed based on level of need and as such, some clinics have multiple HRS's. They work with high utilizing members and specifically maintain a low case load, so they can provide individualized care. HRS's are trained in motivational interviewing and trauma informed care. They are highly trained to ensure that members culturally specific needs are met and they are connected to appropriate culturally specific serves. They work very closely to those community-based organizations that provide culturally specific services and receive routine training on how to access these programs. Finally, when we are able, we hire and embed culturally specific and multi lingual staff specifically in clinics with high volumes of diverse populations. Externally, the CCO recognizes Doula services as a covered benefit to improve birth outcomes and infant health, strengthen families and establish supports to ensure ongoing family success. Doulas provide emotional, physical, and educational support during the birth experience. A doula acts as an advocate for the member and helps connect members with local health resources. To increase access to these services Doulas are not required to contract directly with the CCO. The CCO bases Doula eligibility on the Oregon Health Authority standards which include the Traditional Health Worker Registry, OAR 410-180-0375 regarding Doula certification and curriculum standards and obtaining a DMAP ID/NPI number.	

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	Our Maternal Child Health Program Manager worked over the last couple of years to integrate Doulas within the obstetrics community. Next steps are to create a Doula Hub in the CCO to create a robust program to increase positive health outcomes for mom and baby while continuing to support the Doula Hub with the obstetrics community. Our contracted provider network (PCPs and BH) embeds Traditional HealthCare Workers such as Community Health Workers, Personal Health Navigators, Peer Wellness Specialists, Family Support Specialists, Youth Support Specialists in clinic operations and settings. **NEMT Services** The NEMT brokerage is responsible for screening for physical and mental health issues that would prevent an individual who would need specific and alternative modes of transportation as part of their disabilities and/or special needs. As part of that screening process member profiles are created to documented to provide the right transport type based on any reported physical and/or behavioral health need. The CCO provides support through the telephonic care coordination access line to refer and provide information to community resources assisting members to access additional transportation options. If there are no community resources members are provided an access point through their medical providers to request the CCOs assistance in transportation solution options. This is administered	

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	through the Health-Related Services policy and procedures. The CCO considers transportation/access adequate to meet the needs of Members with disabilities or special needs through the Non-Emergent Medical Transportation benefit but not overall transportation access across the service area to fill gaps for other non-medical destinations. **ADA considerations** An onsite visit is a contract requirement for Primary Care Physicians. Clinics/facilities must pass the site visit for the contract to proceed. Requirements include ADA accessibility. Any changes or modifications to the clinics/facilities to meet ADA requirements must be completed for a contract to become effective. • Refer to JCC Standard I Provider Site Visit Tool We have also recently partnered with a vendor to collect and ADA information on a quarterly basis from our entire contracted Provider Network. **Interpretation services** Interpretation services are available for members through multiple vendor and are provided at no cost to providers or members. • Refer to page 31 of the provider manual. CareOregon requires all contracted providers to make interpretation services available to members. • https://careoregon.org/docs/default-source/providers/manuals-and-	

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	formulary/careoregon-provider-manual-web.pdf?sfvrsn=2bdae56e_16 **Special Health Care Needs/ Mental Disabilities** Exceptional Needs Care Coordination (ENCC) team works closely with providers, APD caseworkers, members and community agencies in care planning for members receiving care coordination services. Care plans for members with special health care needs may be reviewed by Multi-disciplinary Teams and updated, as conditions or circumstances change. Multi-disciplinary teams comprised of CCO Exceptional Needs Care Coordinators (ENCC), APD caseworkers, physical health/behavioral health/dental care provider representatives, and members/caregivers are held for LTC and other members in each CCO. The ENCC Team has a central call line to accept referrals, provide information and offer support to providers, members and family members. ENCC staff members are available for referrals from members/caregivers/members' representatives, providers, other health care professionals, DHS/APD caseworkers, DHS Governor's Advocacy Office or Client Advisory Services Unit, community agency staff and the CCO work units and coordinate care across health plans and community care services, as appropriate. Health Resilience Specialists coordinate necessary care for high risk members, working across multiple disciplines and often accompanying members to mental health or dental appointments as	

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Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	needed. The Health Resilience Program employs two staff members who work with CCO members admitted to the Psychiatry Emergency Services such as Unity Hospital and an addiction specialist who assists the team with members who need support to connect with inpatient and outpatient treatment programs.	
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)*	Member Handbook (Page 13- 14) specifies: "Specialty care is care provided by a specialist provider, such as a cardiologist for heart problems, orthopedist for bone problems, or endocrinologist for hormone problems. If you need to see a specialist or other provider, your PCP will refer you. However, you can see specialists for some kinds of care without seeing your PCP first. This is called "direct access to a specialist." You can make your own appointment for the following services from a specialist who is a Jackson Care Connect provider: • "Routine women's health care and preventive women's health care services, which includes, but is not limited to, prenatal care, breast exams, mammograms and Pap tests" • Refer to CCO member handbook pages 13-14 http://jacksoncareconnect.org/docs/default-source/default-document-library/jcc-handbook_en-2014.pdf?sfvrsn=18	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
4. The CCO has a mechanism to allow members to obtain a second opinion from a network provider or arrange for the member to obtain one outside the network, at no cost to the member. *42 CFR §438.206(b)(3)* *Contract: Exhibit B Part 4 (2)(n)*	JCC Standard I, III, IV, Prior Authorization Policy pg. 2 CareOregon does not require prior authorization for consultations with specialists in or out of network. If an out of network provider accepts DMAP rates there is nothing for them or the member to do and can see the member. If the out of network provider does not accept DMAP rates and Single Case Agreement will be negotiated with Contracting to insure the provider/member needs are met. There is no cost to the member for these services.	☒ 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)*	JCC Standard I, III, IV, Prior Authorization Policy pg 2 There is no member financial liability without an OHA approved waiver. Non-contracted providers are paid at DMAP rates for services and any potential cost to the member would be no more for contracted providers.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
6. The CCO demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services: a. In accordance with 42 CFR §431.51(b)(2), members shall not be restricted in freedom of choice of providers of family planning services.	JCC Standard I, jcc-handbook_en-2014 (pg. 10) JCC Standard I, III, IV, Prior Authorization Policy pg 1 CareOregon does not restrict members in freedom of choice of providers of family planning services and able to self-refer for family planning services. Pg. 10 of the JCC Member handbook states, "As an OHP client, you will be…Free to get mental health and	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
b. Therefore, members are permitted to self-refer to any provider for the provision of family planning services, including those not in the CCO's network. *42 CFR §431.51(b)(2)* *42 CFR §438.206(b)(7)* *Contract: Exhibit B Part 2 (6)(b)*	family planning services without a referral." The Prior Authorization policy states members have direct access to specialists for funded services and may call the providers directly to make appointments.	
7. The CCO ensures its provider network observe the timely access to services provisions and complies with the following requirements: a. Meet and require its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. b. Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid Fee for Service (FFS), if the provider serves only Medicaid enrollees. c. Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary. d. Establish mechanisms to ensure compliance by network providers. e. Monitor network providers regularly to determine compliance. f. Take corrective action if there is a failure to comply by a network provider. *42 CFR §438.206(c)(1)* *Contract: Exhibit B Part 4 (2)(a)* *Contract: Exhibit B Part 4 (13)(b)(3), (4)*		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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 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.	The CCO has an "Access to Services Policy", attached, that will be updated by September 30, 2019 to include specific Behavioral Health expectations for access, both routine and for priority populations. Additionally, the CCO will develop a reporting and tracking system for monitoring of Behavioral Health network adequacy and capacity by December 31, 2019. This will be integrated into the CCO Network Adequacy Steering Committee, and the associated policy (attached) will be revised accordingly.	☐ Complete ☐ Progress Sufficient to Start Operations ☒ Incomplete ☐ NA

Standard I—Availability of Services

Requirement	Evidence as Submitted by the CCO	Score
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*		
HSAG Findings: The CCO's Accessibility of Services policy included timely access definitions for primary care provider (PCP) after-hours access, routine appointment access to PCPs, and customer service telephone access, but did not include timeliness requirements for priority populations.		
Required Actions: The CCO should update its policies and procedures to include the required timeliness expectations for specialty behavioral health providers as well as defined mechanisms to monitoring, tracking and reporting of specialty behavioral health providers to ensure its network is sufficient to provide timely access for priority populations.		
9. The CCO has written policies and procedures that ensure scheduling and rescheduling of member appointments are appropriate to the reasons for and urgency of the visit. The member shall be seen, treated, or referred within the following timeframes: a. *Well care:* Within four (4) weeks from the date of a patient's request. b. *Urgent care:* Within seventy-two (72) hours or as indicated in the initial screening for urgent care.	a-c. CareOregon's contract language, Provider Manual and policies outline requirements and expectations from our provider network regarding timely access to care. • Refer to the Accessibility of Services policy • Refer to an excerpt from our contract language in section 4.02(a) and 31.1 in exhibit B addresses access expectations.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	• Provider Manual pages 24 - 25 for Appointment Availability and Standard Scheduling Procedures – https://careoregon.org/docs/default-source/providers/manuals-and-formulary/careoregon-provider-manual-web.pdf?sfvrsn=2bdae56e_16 In addition, the Provider Services Department routinely monitors and surveys our PCP Network appropriate access exists for our members on a monthly basis. Data is collected and analyzed regarding wait times for new patient appointments to establish care, existing patients needing appointments, and urgent/emergent appointments to ensure timely access to services and resolve potential access issues. • Refer to JCC Standard I Accessibility of Services policy e-f. The CCO's delegated dental contracts include adherence to all applicable OARs including OAR 410-141-3220 and states, "Access to Care. Exhibit B, Part 4, Section 2 shall be delegated to DCO, as it applies to the provision of Dental Services that are Covered Services." Although maintaining and monitoring policies and procedures on accessibility of services has to-date been fully delegated to the dental plan partners and reviewed during Delegation Oversight, the CCO will include emergency, urgent	

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	and routine oral health appointment timeframes in their Accessibility of Services P&P and have it approved and implemented by March 30, 2020. g. The CCO outlines requirements and expectations from our provider network regarding timely access to care. • Refer to the Accessibility of Services policy • Providers are contacted on a routine basis to report accessibility • Further processes and procedures are in development for implementation in 2020	
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)*	JCC membership data shows that over 8% of members have limited English proficiency. Interpretation is being offered at a variety of levels across the provider network and there is room for improvement in following best practices. It is common for bilingual staff who have other duties and are not qualified or certified interpreters to get pulled in to interpret. It is also not uncommon for members to rely on family members for interpretation. Even in cases where providers are using qualified interpreters there is a need to train providers on best practices for meaningful interpretation to improve health outcomes as well as member experience. As noted in the TQS (excerpt attached), a central objective of the JCC Equity Action workplan is to work g with language service vendors to increase	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	awareness among providers on the importance of interpretation, resources available, and the best practices. JCC is making progress with this initiative in 2019. • JCC Standard 1 Question 10 TQS Language Services Excerpt The attached reports are reviewed monthly with Linguava, our vendor, and an action plan is developed to spread the penetration and reach out to new providers. • JCC Standard 1 Question 10 Linguava Services Report • JCC Standard 1 Question 10 JCC Implementation Stages-Linguava Data (members served) will be reviewed with our 4 major network partners at Leadership meetings to celebrate successes and identify barriers. BH providers have been connected to the vendor and our Behavioral Health Manager is checking in with them regularly to ensure staff are comfortable with accessing, and are using, the service. Contracting has been offered to non-network partners (e.g. Mercy Flights) where members served often have language barriers. For members served where there are no contracts in place, JCC staff can contact the account manager from Linguava directly to arrange for service.	

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	All of JCC staff will be participating in a 2 hour Equity Workshop on 8/29 which will explore how effective interpretation impacts the power, privilege and access to communication and information; and share and exchange interpreting tools and techniques to reduce interpreter error and improve access. The goal of the workshop is to empower all JCC team members to be effective champions of quality interpretation services in their external interactions. This same workshop will be offered to at least 2 network partners in 2019.	
11. The CCO ensures that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities. *42 CFR §438.206(c)(3)* *Contract: Exhibit B Part 4 (3)(a)(2)(e)*		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		

Standard I- Availability of Services	
	Total #
Complete	**8**
Progress Sufficient	**0**
Incomplete	**1**
Not Applicable (NA)	**2**

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. The CCO submits documentation to the State, in a format specified by the State, to demonstrate that it complies with the following requirements: a. Offers an appropriate range of preventive, primary care, specialty services, that is adequate for the anticipated number of enrollees for the service area. b. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area. *42 CFR §438.207(b)(1-2)* *Contract: Exhibit G*	a. The CCO submits the yearly DSN report to the State in the required format in addition to answering all narrative questions as to access and capacity. The last reports were submitted on 6/28/2019. • Refer to JCC Standard II 2019 Full DSN • Refer to JCC Standard II 2019 Full DSN Narrative b. The CCO utilizes geocoding Quest reports to ensure an adequate network based on time and distance standards and identify contracting opportunities. • Refer to JCC Standard II Network Adequacy Steering Committee policy • Refer to JCC Standard II Network policy	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
2. The CCO submits the documentation described above as specified by the State, but no less frequently than the following: a. At the time it enters into a contract with the State. b. On an annual basis. c. At any time there has been a significant change (as defined by the State) in the CCO's operations that would affect the adequacy of capacity and services, including: i. Changes in the CCO's services, benefits, geographic service area, composition of or payments to its provider network; or ii. Enrollment of a new population. *42 CFR §438.207(c)(1-3)*	The CCO submits the yearly DSN report to the State in the required format in addition to answering all narrative questions as to access and capacity. The last reports were submitted on 6/28/2019. • Refer to JCC Standard II 2019 Full DSN • Refer to JCC Standard II 2019 Full DSN Narrative c. The CCO has policies in place to notify the State of changes in network capacity along and/or any circumstance in which the CCO experiences a change in operations that is reasonably likely to affect our participating provider capacity or	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Contract: Exhibit G	reduce or expand the amount, scope or duration of Covered Services being provided to members. • Refer to JCC Standard II Contracted Provider Termination and Suspension policy	
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)*	a-b. The CCO applies the time/distance network adequacy standards when analyzing our provider network utilizing geocoding software (Quest). Access standards in the Quest reports are based on the values indicated in terms of travel time and distance to network providers/facilities. The time and distance metrics speak to the access requirements pertinent to the approximate locations of beneficiaries, relative to the locations of the network provider/facilities and members to ensure access to at least one provider/facility, for each specialty type, within established time and distance requirements for that county. • Refer to JCC Standard II Network Adequacy Report 2019 The CCO's delegated dental contracts include maintaining and monitoring delivery system capacity, including consideration of geographical location, distance and travel time. The CCO reviews adherence to these standards during Delegation Oversight. In addition, the CCO geomaps membership alongside each delegated dental plan's network providers to ensure adequate adequacy is	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	maintained and that time and distance standards are met. • Refer to JCC Standard II Dental Maps In the event access is an issue**,** the CCO supports Telemedicine to give members a wider access to quality care and eliminate distance barriers to improve access to services in conjunction to guidelines set by the Division of Medical Assistance Program (DMAP) and Centers of Medicare and Medicare Services (CMS). The CCO has expanded what types of provider to member interactions it will consider for reimbursement which includes new avenues of service include phone, video conference and e-mail consultations. See JCC Standard II Telemedicine - Videoconferencing Email and Telephonic Services - Training Guide and JCC Standard II Rubicon presentation. The CCO is piloting an E-Consult service (RubiconMD) that enables PCPs to quickly access clinical experts in over 150 specialties and sub-specialties. This program is designed to validate if a patient would benefit from seeing a specialist and provide PCPs with clinical unbiased opinions on care, thus reducing inappropriate referrals which contributes to better overall access to specialty services and patient care. Responses are received within a maximum of 12 business hours which includes the opportunity for the referring provider to ask follow-up questions.	

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: The CCO's Network Adequacy policy did not include relevant network capacity standards for CCO members. Instead, the documentation referenced CMS Medicare Advantage Network Adequacy criteria, which were incorrectly referenced and not in alignment with OHA network standards.		
Required Actions: HSAG recommends that the CCO revise its policies and procedures to define the time/distance standards for its adult and pediatric primary care, Patient-Centered Primary Care Home (PCPCH), obstetrician/gynecologist (OB/GYN), behavioral health, and oral health providers to align contract requirements.		
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)*	a-b. The CCO applies the time/distance network adequacy standards when analyzing our provider network utilizing geocoding software (Quest). Access standards in the Quest reports are based on the values indicated in terms of travel time and distance to network providers/facilities. The time and distance metrics speak to the access requirements pertinent to the approximate locations of beneficiaries, relative to the locations of the network provider/facilities and members to ensure access to at least one provider/facility, for each specialty type, within established time and distance requirements for that county. • Refer to JCC Standard II Network Adequacy Report 2019 Clinics commonly have multiple providers of the proper scope of service to treat pediatrics, adults and geriatric members. Additional specialties common to a PCP office include but are not limited to: • Family Medicine • Internal Medicine	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• Physician Assistant • Pediatricians • Geriatric Medicine • Osteopaths • Naturopaths Because of this multi-specialty availability to treat members under 18, adults, and members over 65 the ratio of providers to members becomes the majority of our network.	
HSAG Findings: The CCO's Network Adequacy policy did not include relevant network capacity standards for CCO members. Instead, the documentation referenced CMS Medicare Advantage Network Adequacy criteria, which were incorrectly referenced and not in alignment with OHA network standards.		
Required Actions: HSAG recommends that the CCO revise its policies and procedures to define the time/distance standards for its adult and pediatric specialty care providers.		
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)*	The CCO is contracted with every hospital in the CCO service area for inpatient and emergency services. In addition, the CCO is contracted with additional hospitals in the Metro area in case of inpatient transfers. • Refer to JCC Standard II Network Adequacy Report 2019	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

<table>
<tr><th colspan="3">Standard II—Assurance of Adequate Capacity and Services</th></tr>
<tr><th>Requirement</th><th>Evidence as Submitted by the CCO</th><th>Score</th></tr>
<tr><td colspan="3">HSAG Findings: The CCO’s Network Adequacy policy did not include relevant network capacity standards for CCO members. Instead, the documentation referenced CMS Medicare Advantage Network Adequacy criteria, which were incorrectly referenced and not in alignment with OHA network standards.</td></tr>
<tr><td colspan="3">Required Actions: HSAG recommends that the CCO revise its policies and procedures to define the time/distance standards for its hospital and emergency services.</td></tr>
<tr><td>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)</td><td>The CCOs delegated pharmacy vendor, OptumRx, maintains and monitors network adequacy with oversight from the CCOs Delegation Oversight Committee.
Monthly updates regarding changes to the Pharmacy Network are provided to the CCO on a monthly basis in addition to a yearly comprehensive adequacy report.
These monthly and yearly reports to the CCO ensure that network adequacy is maintained in relationship to membership geolocation & time and distance standards.
• Refer to JCC Standard II Pharmacy CORMCAID Geo by Account report</td><td>☒ Complete
☐ Progress Sufficient to Start Operations
☐ Incomplete
☐ NA</td></tr>
</table>

Standard II—Assurance of Adequate Capacity and Services	
	Total #
Complete	**3**
Progress Sufficient	**3**
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)*	**1(a)** CareOregon has specific processes in place to ensure that members are assigned and have access to a designated Primary Care Physician/Clinic (PCP). This includes a daily PCP auto assignment process and a weekly PCP auto re-assignment process. PCPs are essential to the care of our members which includes performing routine health screenings, treating illness, and coordinating patient care. • JCC Standard III, question 1, PCP-PDP Auto Assignment PP Care Coordination services also occur within CareOregon and are provided primarily through the Regional Care Team (RCT) model. All PCP Clinics have a designated Regional Care Team within CareOregon and thus, members do as well. Members are assigned to an RCT based upon the Primary Care Provider/Clinic they are assigned to, engaged with, or based on the location of their home address. The purpose of the RCT is to ensure that Members have a consistent care team who will collaborate across disciplines to develop and implement a member-centric care plan through telephonic, electronic, or community-based interventions to resolve identified needs and to promote healthy outcomes. RCTs are responsible for coordinating the provision of all covered services and some non-covered services, assisting members in navigating the health care delivery system, providing	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	adequate, timely and appropriate access to integrated health care services, and connecting members with providers and other appropriate care settings. Members have access to their RCT through their PCP or by calling CareOregon Customer Service. Care Coordination may be requested by the member, a member representative, the member's provider, or anyone else involved in the member's care. Once enrolled into care coordination services, direct contact information for the Regional Care Team and for the lead Care Coordinator assigned to the member is provided to the member and/or the member's treatment/care team. • JCC Standard III, RCT Care Coordination Policy 2019 • JCC Standard III, RCT Region System Phone List **1(b)** One of the essential functions of the RCT is to ensure effective and safe transitional support for members across the continuum of care. This accomplished by producing an integrated transition of care plan in consultation and collaboration with the current treatment team and appropriate providers. The goal is to facilitate transitions between settings and levels of care for the member into the most appropriate, independent, and integrated community-based settings and to ensure appropriate follow-up care. We utilize the Collective platform which is integrated into our care management platform to assist in real-time notification of admission and discharge. Identification	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	of all those working with the member in the Care Team section of the Collective Platform which we utilize to coordinate care • JCC Standard III, RCT Care Coordination Policy 2019 • JCC Standard III, GSI Collective Alerts Screen Shot • JCC Standard III, Collective Care Team Screen Shot Our Transitions process is focused on evidence-based interventions that are trauma-informed and that best meet the specific needs of individual members. Members receive targeted telephonic and in-person interventions in the home and community setting to create therapeutic relationships and foster members' engagement in their own care. The core components of our transition interventions include: • JCC Standard III, H5859 2019 MOC Submission and Appendices • JCC Standard III, Transitions Job Aid All Regional Care Team staff were trained on the above processes most recently on July 16th 2019. Staff are trained on the care coordination requirements, standards, and process within the first 90 days of their employment and at least annually thereafter. • JCC Standard III, Care Coordination Standards	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• JCC Standard III, Care Coordination Timeline of Activities. RCT supervisors were educated to the Analyses, Performance and Audits policy and file review process at the Care Management Leadership meeting on January 29, 2019. Follow-up audit process training with RCT supervisors took place on February 13th, March 12th and March 18th. Formal monthly file review audits by team began in May, 2019. • JCC Standard III, Analyses Performance and Audits Policy • JCC Standard III, Care Coordination Audit Tool • JCC Standard III, Audit Policy and File Process Supervisor Training	
2. The CCO coordinates the services it furnishes to the member: a. Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays; b. With the services the member receives from any other MCO, PIHP, or PAHP; c. With the services the member receives in FFS Medicaid; and d. With the services the member receives from community and social support providers. *42 CFR §438.208(b)(2)* *Contract: Exhibit B Part 4 (1)(c)*	2(a) All CareOregon members have access to care coordination services through our Regional Care Team model. An essential function of the RCT is to ensure effective and safe transitional support for members across the continuum of care. This accomplished by producing an integrated transition of care plan in consultation and collaboration with the current treatment team and appropriate providers. The goal is to facilitate transitions between settings and levels of care for the member into the most appropriate, independent, and integrated community-based settings and to ensure appropriate follow-up care. • JCC Standard III, RCT Care Coordination Policy 2019	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• JCC Standard III, Transitions Job Aid • JCC Standard III, GSI Collective Alerts Screen Shot • JCC Standard III, Collective Care Team Screen Shot 2(b-d) All care coordination activities are documented and maintained in a care management platform. Each member enrolled into care coordination services receives a comprehensive needs assessment called the Care Coordination Assessment (CCA) and an individualized care plan. Individualized care plans are developed and utilized to address the needs of the member and are to incorporate the supportive and therapeutic and cultural and linguistic health of each Member, particularly those with Intensive Care Coordination (ICC) health needs. • Developed with the member (when appropriate) • In consultation with any provider, community partner, or other individual involved in the member's care • Ensure they reflect member, family or caregiver preferences and goals to ensure engagement and satisfaction • ICPs are shared, as appropriate, with the member and any individual involved in the member's care, as well as State or other MCOs, PIHPs, and PAHPs, while protecting the member's privacy whenever possible and in accordance with the	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	privacy requirements in 45 CFR parts 160 and 164 subparts A and E to the extent that they are applicable. – JCC Standard III, Printing_Sharing Care Plan Job Aid – JCC Standard III, CCA Printable All Regional Care Team staff were trained on the above processes most recently on July 16th, 2019. Staff are trained on the care coordination requirements, standards, and process within the first 90 days of their employment and at least annually thereafter. • JCC Standard III, Care Coordination Standards • JCC Standard III, , Care Coordination Timeline of Activities.	
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)*	The CCO conducts health risk screenings for new members by mailing Health and Wellness questionnaires to new members. The Health and Wellness Questionnaire (HWQ) is a brief member-centric tool that asks about potential individual medical, functional, cognitive and psychosocial needs. The HWQ is mailed in Welcome Packets/EZ Guide mailings, and welcome telephone calls are made or reminder postcards are sent following that. These efforts will be tracked through vendor mail reports, Customer Services and Mailroom Call Tracking reports and GSI Health Risk Screening documentation. • JCC Standard III, Health Risk Screening Policy	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

<table>
<tr><th colspan="3">Standard III—Coordination and Continuity of Care</th></tr>
<tr><th>Requirement</th><th>Evidence as Submitted by the CCO</th><th>Score</th></tr>
<tr><td></td><td>• JCC Standard III, Health and Wellness Questionnaire
• JCC Standard III, HRS-Reminder-Mailer</td><td></td></tr>
<tr><td colspan="3">HSAG Findings: The Health Risk Screening policy stated that the CCO mails a Health and Wellness Questionnaire to each newly enrolled member as part of the welcome packet. During the remote interview session, staff members stated that they make a welcome call to each newly enrolled member explaining the survey and attempt to complete it telephonically, if possible. No other attempts are made to complete the survey. The CCO had different reports to track the survey mailing and welcome call, but there was not one comprehensive report or tracking mechanism for staff members to determine which members had completed the survey and which members required follow-up.</td></tr>
<tr><td colspan="3">Required Actions: HSAG recommends that the CCO revise its process for conducting an initial screening of all newly enrolled members to include subsequent outreach attempts if the initial attempt at survey completion was not successful. In addition, HSAG recommends that the CCO create or utilize a more centralized tracking mechanism so that staff members know which members completed the survey and which members require follow-up without having to look in multiple places to obtain that information.</td></tr>
<tr><td>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)</td><td>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</td><td>☐ Complete
☐ Progress Sufficient to Start Operations
☒ Incomplete
☐ NA</td></tr>
</table>

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	– JCC Standard III, Question 4, Careoregon-provider-manual-primary care sections pgs 22-25 – JCC Standard III, Question 4, Provider Base Agreement, Section 4.02(d) Referrals	
HSAG Findings: The Provider Base Agreement submitted as evidence did not include any of the required elements. The agreement stated that "When making a referral to another health care provider, a Provider shall furnish the other provider complete information on treatment procedures and diagnostic tests performed prior to such referral, which may include providing copies of the medical records." The submitted agreement did not specifically mention hospital admissions, hospital discharges, the processes for requesting hospital admission or specialty services, and did not address the coordinating role of patient-centered primary care. During the remote interview session, staff members stated that they will work with the legal department on updating the CCO's provider agreements.		
Required Action: The CCO should update its service agreements with hospital and specialty providers to include all provisions as required in the contract with OHA.		
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)*	5(a) The CCO has processes in place to ensure that hospitals and specialty service providers are accountable for achieving successful transitions of care. • - JCC Standard III, Question 5 Provider Base Agreement, Section 7.02(d) Transitions of Care 5(b) One of the essential functions of care coordination services provided through our Regional Care Team model is to ensure effective and safe transitional support for members across the continuum of care. This accomplished by producing an integrated transition of care plan in consultation and collaboration with the current treatment team and appropriate providers. The goal is to facilitate transitions between settings and levels of care for the member into the most	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	appropriate, independent, and integrated community-based settings and to ensure appropriate follow-up care. Our Transitions process is focused on evidence-based interventions that are trauma-informed and that best meet the specific needs of individual members. Members receive targeted telephonic and in-person interventions in the home and community setting to create therapeutic relationships and foster members' engagement in their own care. We utilize the Collective platform which is integrated into our care management platform to assist in real-time notification of admission and discharge. Identification of all those working with the member in the Care Team section of the Collective Platform which we utilize to coordinate care • JCC Standard III, Transitions Job Aid • JCC Standard III, GSI Collective Alerts Screen Shot • JCC Standard III, Collective Care Team Screen Shot All Regional Care Team staff are trained on the Transitions process within the first 90 days of their employment and at least annually thereafter. • JCC Standard III, RCT Care Coordination Policy 2019 JCC Standard III, H5859 2019 MOC Submission and Appendices	

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<tr><th>Requirement</th><th>Evidence as Submitted by the CCO</th><th>Score</th></tr>
<tr><td colspan="3">HSAG Findings: The CCO submitted a base provider agreement as evidence; however, it only referred to transition of care if the provider agreement was terminated or expired. When asked during the remote interview session, staff members had difficulty articulating any current processes that would ensure providers are accountable for achieving successful transitions of care. The CCO did have policies and processes in place to ensure that Regional Care Teams were assisting with member transitions into the most appropriate settings.</td></tr>
<tr><td colspan="3">Required Actions: HSAG recommends that the CCO develop and implement processes to ensure that hospitals and specialty service providers are accountable for achieving successful transitions of care.</td></tr>
<tr><td>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)</td><td>All care coordination activities are documented and maintained in a care management platform. Each member enrolled into care coordination services receives a comprehensive needs assessment and an individualized care plan. Individualized care plans are developed and utilized to address the needs of the member and are to incorporate the supportive and therapeutic and cultural and linguistic health of each Member, particularly those with Intensive Care Coordination (ICC) health needs. ICPs are:
• Developed with the member (when possible)
• In consultation with any provider, community partner, or other individual involved in the member's care
• Ensure they reflect member, family or caregiver preferences and goals to ensure engagement and satisfaction
• ICPs are shared, as appropriate, with the member and any individual involved in the member's care, as well as State or other MCOs, PIHPs, and</td><td>☒ Complete
☐ Progress Sufficient to Start Operations
☐ Incomplete
☐ NA</td></tr>
</table>

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	PAHPs, while protecting the member's privacy whenever. • This is currently a manual process, however, we have road mapped connecting to the provider and member portals directly from our care management platform so these care plans can be shared digitally. Care Coordination services shall not duplicate or replace the direct provision of health care services provided by the member's PCP, specialist and their office staff, or assistance provided by the member's State case worker. Care Coordination services are meant to complement, coordinate, and integrate these services, which may include education, support, and referral to an appropriate disease management program, or to a palliative care or hospice program, or to community resources, as appropriate. All Regional Care Team staff were trained on the above processes most recently on July 16th 2019. Staff are trained on the care coordination requirements, standards, and process within the first 90 days of their employment and at least annually thereafter. • JCC Standard III, RCT Care Coordination Policy 2019 • .JCC Standard III, Care Coordination Standards • JCC Standard III, Care Coordination Timeline of Activities. • JCC Standard III, Printing_Sharing Care Plan Job Aid	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
7. The CCO ensures that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards. *42 CFR §438.208(b)(5)* *Contract: Exhibit B Part 8 (1)(d-f)*		☐ 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)*	All care coordination staff complete training upon hiring and annually thereafter, regarding privacy and confidentiality in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E. - *For further information on companywide training Please refer to HSAG Standard VIII – Confidentiality of Health Information, questions 1 – 3.* Care Coordination staff also receive training around privacy standards as it relates to the sharing of care plans. Care Coordination staff were invited to attend a recent webinar, on July 12th, put on by the OHA on the topic of confidentiality and privacy. The *Confidentiality Toolkit* is available to all care coordination staff. • JCC Standard III, RCT Care Coordination Policy 2019 • JCC Standard III, Confidentiality Toolkit	☒ 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)*	The CCO conducts health risk screenings for new members by mailing Health and Wellness questionnaires to new members. The Health and Wellness Questionnaire (HWQ) is a brief member-centric tool that asks about potential individual medical, functional, cognitive and psychosocial needs. The HWQ is the first step in screening members for special healthcare needs and those who might be eligible for LTSS. The HWQ is mailed in Welcome Packets/EZ Guide mailings, and welcome telephone calls are made or reminder postcards are sent following that. These efforts will be tracked through vendor mail reports, Customer Services and Mailroom Call Tracking reports and GSI Health Risk Screening documentation. • JCC Standard III, Health Risk Screening Policy • JCC Standard III, Health and Wellness Questionnaire Once identified, CCO members with special health care needs and those eligible for LTSS complete a Care Coordination Assessment. In addition, these members will be periodically assessed and their care monitored by the PHP Regional Care Teams (RCTs), which are responsible for assigned panels of members seen at primary care providers, through the following means: • Lists generated from a population segmentation algorithm to identify members moving between four risk cohorts (Health, Low, Rising and High)	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• RCT reviews of members moving from Low Risk to Rising Risk to update care plans • Review of care plans based upon shifts between cohorts that may occur multiple times per year • JCC Standard III, Population Segmentation Standard Slide DeckV2 • JCC Standard III, CCA_Printable	
HSAG Findings: During the remote interview session, staff members stated that, once a member is identified as having special healthcare needs or needing long-term supports and services (LTSS), the CCO completes the Care Coordination Assessment. Assessment information is then entered into the care management system, GSI, which was demonstrated by staff members. The CCO did not provide a written policy, procedure, or process flow that described who is responsible for conducting the comprehensive assessment (registered nurses [RNs], social workers, etc.), the timelines for completion of the assessment, how the assessment is completed (face-to-face, telephonically), or how/where the assessment results are documented. The CCO staff members stated that they start the assessment within three days of member referral to care coordination but there was no specific time frame for completion.		
Required Actions: HSAG recommends that the CCO develop policies, procedures, and/or workflows to describe the processes and timelines used by the CCO to complete the comprehensive assessment on all members identified as needing LTSS or having special healthcare needs. In addition, HSAG recommends that the CCO document and implement processes to track and monitor the completion of assessments to ensure that expected timelines for completion are being met.		
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)*	Members with special healthcare needs are identified through the Health Risk Screening process and by the eligibility code received through the daily demographic file. The code displays as a tag in our care management platform. • JCC Standard III, Question 10, PERC Code Screen Shot Once identified, CCO members with special health care needs will be periodically assessed and their care	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	monitored by the PHP Regional Care Teams (RCTs), which are responsible for assigned panels of members seen at primary care providers, through the following means: • Lists generated from a population segmentation algorithm to identify members moving between four risk cohorts (Health, Low, Rising and High) • RCT reviews of members moving from Low Risk to Rising Risk to update care plans • Review of care plans based upon shifts between cohorts that may occur multiple times per year Individualized care plans are developed and utilized to address the needs of the member and are to incorporate the supportive and therapeutic and cultural and linguistic health of each Member, particularly those with Intensive Care Coordination (ICC) health needs. • JCC Standard III, Health Risk Screening Policy • JCC Standard III, RCT Care Coordination Policy 2019 • JCC Standard III, Analyses Performance and Audits Policy • JCC Standard III, Population Segmentation Standard Slide DeckV2	
HSAG Findings: The CCO had written policies and procedures for identifying members with special healthcare needs through the initial health risk screening process. The CCO also provided a care coordination policy that included general information about the care/treatment plan but with limited specificity. However, the CCO did not provide a policy that described the process for conducting a comprehensive assessment on all members identified as having a special healthcare need. While policies and procedures did not clearly identify that all members identified as having special healthcare needs		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
or in need of LTSS received a comprehensive assessment, staff responses during the remote interview session indicated understanding of this requirement and the establishment of processes to support it.		
Required Actions: HSAG recommends that the CCO develop and implement written policies and procedures for completing the comprehensive assessment for all members identified as having a healthcare need. In addition, HSAG recommends that the CCO revise its care coordination policies to include more specificity as to how the care plans are created, who is responsible for creating the initial care plan and any subsequent updates, the timelines for updating the care plan consistent with the CCO's contract with OHA, processes for ensuring member involvement in the care planning process, and documentation of sharing care plan information with providers involved in the member's care.		
11. The CCO responds to requests for Intensive Care Coordination services with an initial response by the next business day following the request. *Contract: Exhibit B Part 2 (8)(a)(4)*		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		
12. For members with physical and/or behavioral special health care needs determined to need a course of treatment or regular care monitoring, the member's Intensive Care Coordinator develops an Intensive Care Coordination Plan (ICCP) or treatment plan in consultation with any specialists caring for the member and with member participation. The ICCP or treatment plan must: a. Be approved by the CCO in a timely manner (if approval is required; b. Revised upon assessment of the members functional need or at the request of the member;		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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))*		
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		
13. For members with special health care needs determined through an assessment to need a course of treatment or regular care monitoring, the CCO must have policies or procedures in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs. *42 CFR §438.208(c)(4)* *Contract: Exhibit B Part 4 (2)(f)(2)*	CareOregon allows all members, including those with special health care needs, to have direct access to specialists for funded services. Members may access specialists by calling them directly to make appointments. The authorization amount is reviewed by CCO staff (including Medical Directors) and approved in amounts appropriate to the member's condition and identified needs. • JCC Standard I,III, IV Prior Authorization Policy Doc	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care	
	Total #
Complete	**5**
Progress Sufficient	**4**
Incomplete	**1**
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)*	JCC Standard IV, Prior Authorization Policy pg1. JCC Levels of Review-DME Team-Desktop Proc pg 8, 10, 18 and 19- shows the benefit application beyond FFS Medicaid. Pg 10 is an example of how the DME staff consult limits in effect for FFS members and able to approve at those limits. Pg 18-19 provides an example of the process for the RN to review and consult the prioritized list for coverage guidance. JCC OHP Authorization Guidelines (pg 1-2) is an online document for providers explaining which frequently requested service types require authorization or other directions providers need to streamline the process. On pg. 1, it demonstrates how the CCO refers providers to the prioritized list, on MMIS. The grid explains situations which are beyond the FFS requirements. On pg. 2, it shows that some services, day surgeries, do not require authorization which expands what may be offered on FFS. JCC DME No Authorization Required List pg 1. Shows DME items which may require authorization for FFS but CCO allows without authorization as long as within DMAP's quantity limits (which apply to FFS). JCC No Authorization Required CPT Code List pg 1. Shows that for OHP members the prioritized list is consulted and applied. Diagnostic procedures are allowed without applying prioritized list requirements (beyond FFS); #2 notes for treatment requests services	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	must pair above the line (same as FFS) in order to be no authorization. The prior authorization team that processes DME reviews requests according to the services included in the OHP benefit package, diagnosis that are above the funding line, within allowable limits and meet the coverage criteria determined by the Oregon Administrative Rules as outlined in their Levels of Review process guide. The prior authorization team that processes requests for services other than DME review requests according to the services covered in the OHP benefit package, pairing of diagnosis and CPT codes in MMIS, and that meet the coverage criteria determined by the Oregon Administrative Rules as outlined in their Levels of Review process guide. There are many items and services that not reviewed for authorization, beyond what is covered by DMAP, and will pay if billed, which can be found on the DME No Auth List, Authorization Guidelines by CPT Code, and CareOregon Medicaid and Medicare Authorization Guideline forms which are posted online.	
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;	JCC Standard I, III, IV, Prior Authorization Policy pg 1. The CCO authorized services are approved in a way to ensure the services are sufficient in amount, duration, or scope to achieve the purpose for which the services are furnished. ii. Services supporting individuals with on-going or chronic conditions or who require long-term services	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
ii. The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the member's ongoing need for such services and supports; and iii. Family planning services are provided in a manner that protects and enables the enrollee's freedom to choose 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*	and supports will be authorized in a manner reflecting the member's unique needs for services and supports. Today each request received is reviewed considering the member's individual circumstances and condition. In 2020, CCO will also include long-term services while coordinating and partnering with community and long-term service partners to provide seamless transition of these services. iii. Per the Member Handbook Rights section, members are "Free to get help with mental health and family planning services without a referral." Our authorization/claims system is configured to allow all consultations with specialists to approve without authorization regardless if provider is in network or out of network. Members are free to access the provider of their choice to meet their family planning needs.	
HSAG Findings: The documentation submitted by the CCO described utilization management policies; however, the policies did not specifically describe how prior authorization requests for individuals with chronic conditions or who require LTSS are authorized in a manner that reflects the member's ongoing need for such services and supports.		
Required Actions: HSAG recommends that the CCO revise the applicable policies and procedures to include information that specifically addresses the authorization process for members with chronic conditions or who require LTSS, and include the provision that services are authorized in a manner that reflects the member's ongoing need.		
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)*	Refer to NQTL Analysis document pages: 31, 52, 53, 79 and 90	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
4. The CCO has processes to ensure that any financial requirements or treatment limits to mental health or substance use disorder benefits in any classification are no more restrictive then the financial requirements or treatment limits to medical/surgical benefits in the same classification (whether or not the benefits are furnished by the CCO). *Contract: Exhibit E (22)*	Refer to NQTL Analysis document pages: 31, 52, 53, 79 and 90	☒ 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: 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)*	a. The CCO's Quality Management Committee will need to approve additional language to the JCC Standard IV, Medical Necessity Policy to include, "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 procedure." This Committee will adopt prior to 1/1/2020 b. JCC Standard IV, Medical Necessity Policy pg. 1-2 states the CCO will furnish medically necessary services addressing the prevention, diagnosis, and treatment of member's condition, and/or disorder resulting in impairments and/or disability; the ability for a member to achieve age appropriate growth and development; and to attain, maintain, or regain functional capacity.	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: The CCO did not submit a policy to illustrate compliance with the requirement that the CCO must furnish medically necessary services as defined in the Contract and in a manner that 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. Instead, it noted that its Quality Management Committee will revise the CCO's Medical Necessity policy as necessary prior to January 1, 2020.		

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Required Actions: HSAG recommends that the CCO adhere to its plan to revise its Medical Necessity policy to indicate that medically necessary services are provided in a manner that is "no more restrictive that 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 procedure…" In addition, the CCO should ensure that it operationalizes this element to ensure compliance.		
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)*	a) JCC Standard IV, Interrater Reliability Policy, pg 3-5 b) JCC Standard IV, Prior Authorization Policy pg 2 c) JCC Standard IV, Prior Authorization Policy pg 3 c) JCC Standard IV, Levels of Review-PA Team pg 18-OHP members -the processing guide for the prior authorization team outlies the processing of requests for the different levels of staff. Pg 18 shows the MDs review and make benefit determinations for services where medical necessity or coverage cannot be determined by RN or Prior (See JCC Standard IV, question 6 144-03 OHP Medication Prior authorization numbered pages 5, 6 and 10-highlighted) and JCC Standard IV, question 6 Authorization Assistant, PD Pharmacy Clinical Coordinator, JCC Standard IV, question 6, PD-Ambulatory Care Clinical Coordinator, JCC Standard IV, question 6, PD-Pharmacy Clinical Supervisor and JCC Standard IV, question 6, PD-Senior Pharmacy Clinical Coordinator). By 1/1/20 CareOregon will incorporate long-term care services and supports ensuring any decision to deny an authorization request in an amount, duration, or scope less than requested be made by an individual with appropriate expertise. We will develop	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	relationships and workflows with long-term care providers and community partners to meet the long-term care needs of our members.	
HSAG Findings: The documentation submitted by the CCO did not address the element in its entirety. Although the policies indicated that a medical director reviews denials, it did not indicate that a decision to authorize a service in an amount, duration, or scope that is less than requested be made by an individual who has the appropriate clinical expertise.		
Required Actions: HSAG recommends that the CCO update the applicable policies to indicate that authorization denials (any decision to authorize a service in an amount, duration, or scope that is less that requested) are made by an individual with the appropriate clinical expertise.		
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)*	Provider contract 4.03(h) states the CCO's policy that utilization management policies are not structured in a way to provide incentives to the provider network, employees or other utilization reviewers to inappropriately deny, limit, or discontinue medically appropriate services to any member.	☒ 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)*	The CCO's Pharmacy and Therapeutics Committee serves as the DUR Board and oversees the DUR program activities operated by the pharmacy department. (See JCC Standard IV, question 8, 144-04 PT Committee and Formulary Management numbered pages 9-10). DUR program activities are summarized and reported to OHA annually to comply with the requirements. (See JCC Standard IV, question 8, DUR Annual Report Executive Summary).	☒ 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	CCO's NOABD policy, pg 2-3 states the CCO "notifies the requesting provider, and gives the member written notice of any decision by the CCO to	☒ Complete

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested."	☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
10. The written notice of adverse benefit determination must be consistent with the provisions under 42 CFR 438.10(c) and must include: a. The date of the notice; b. CCO name, address, phone number; c. Name of the member's Primary Care Practitioner, Primary Care Dentist, or behavioral health practitioner, as applicable; d. Member's name, address, and ID number e. Service requested or previously provided and adverse benefit determination the CCO made or intends to make; 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	JCC Standard IV, NOABD Policy, page 4-5 JCC Standard, I, IV, Prior Authorization Policy, pg 5 J CC Standard, IV, NOABD_Audit_tool The CCO's NOABD template is approved by the state and contains the required elements under 42 CFR 438.10(c). Whenever possible, the letter is pulled without human entry to ensure consistency of required elements. A copy of a redacted NOABD is provided to show the presence of the required elements. Monthly audits by the Medical Benefits Supervisors of NOABDs are completed and reviewed for trends and to provide end-use feedback. JCC Standard IV, NOABD_Audit_tool shows how we audit the a sample.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
each reason and specific circumstances identified in the notice that include, but is not limited to: k. The right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. l. The member's right to request an appeal with the CCO within 60 days of the CCO's adverse benefit determination, including information on exhausting the CCO's one level of appeal described at §438.402(b) and the right to request a State fair hearing (contested case hearing) within 120 days after issuance of the CCO's Notice of Appeal Resolution or where the CCO failed to meet appeal timelines as outlin4ed 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)*		

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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 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)*	JCC Standard IV, NOABD Policy pg3 JCC Standard IV, 14 Day Extension Guide pg 1 explains the process for determining when a 14 day letter may be issued; the remainder of document explains the complete process.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
12. For cases in which a provider indicates, or the CCO determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the CCO must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service. a. The CCO may extend the 72-hour time period by up to 14 calendar days if the member requests an extension, or if the CCO justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest. *42 CFR §438.210(d)(2)(i-ii)* *Contract: Exhibit B Part 2 (3)(i)*	JCC Standard IV, Prior Authorization Policy pg 4 JCC Standard IV, 14 Day Extension Guide pg 1 explains the process for determining when a 14 day letter may be issued; the remainder of document explains the complete process.	☒ 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.	The CCO's pharmacy department reviews prior authorization requests 365 days per year to meet OHA turnaround time requirements. All requests for	☒ Complete ☐ Progress Sufficient to Start Operations

HSAG HEALTH SERVICES ADVISORY GROUP

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	outpatient drugs are to be responded within 24 hours of the request. Monthly internal compliance reporting demonstrates greater than 99% of the requests were responded within 24 hours. (See JCC Standard IV, question 13, Compliance dashboard and JCC Standard IV, question 13, coverage determination report). If during the review process a medical emergency justifies the immediate medical need of the drug, a 72-hour emergency supply will be supplied (See JCC Standard IV, question 13, 144-03 OHP Medication Prior Authorizations numbered pages 5-6)	☐ Incomplete ☐ NA
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.	JCC Standard IV, NOABD Policy pg 5 confirms the CCO's policy for exemptions to the 20 day notice prior to reducing, suspending, or terminating previously authorized services for OHP members.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
– The agency establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth. – A change in the level of medical care is prescribed by the member's physician. – The notice involves an adverse determination made with regard to the preadmission screening requirements. • If probable member fraud has been verified, the CCO gives notice five (5) calendar days before the date of action. *42CFR438.404(c), 42CFR431.211, 42CFR431.213(a)-(g), 42CFR431.214(a)* *Contract: Exhibit I (3)(c)*		
15. The CCO defines Emergency Services as covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish the services and needed to evaluate or stabilize an emergency medical condition. *42 CFR §438.114(a)* *Contract: Exhibit A (C)*	JCC, Standard IV, Emergency and Post-Stabilization Services, pg 1 defines Emergency Services.	☒ 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)*	JCC, Standard IV, Emergency and Post-Stabilization Services, pg 1 defines Post-stabilization Care Services	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
17. The CCO: a. Covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the CCO; and b. Does not deny payment for treatment obtained under either of the following circumstances: i. A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in paragraphs (a), (b), and (c) of the definition of emergency medical condition in paragraph (a) of this section. ii. A representative of the CCO instructs the member to seek emergency services. *42 CFR §438.114(c)(1)* *Contract: Exhibit B Part 2 (4)(a)(3,5&11)*	a) JCC, Standard IV, Emergency and Post-Stabilization Services, pg 2 b) JCC, Standard IV, Emergency and Post-Stabilization Services, pg 3. The claim system is configured to pay **all** emergency treatment claims which includes i,ii. The CCO covers emergency services for both contracted and non-contracted providers/facilities. Services do not have to be life and death to be considered an emergency. The claims system is configured in such a way that emergency room services codes pay without authorization. All claims for emergency services pay to providers able to submit to DMAP.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
18. The CCO does not: a. Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms; and b. Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, MCO, PIHP, PAHP or applicable State entity of the Member's screening and treatment within 10 calendar days of presentation for emergency services. *42 CFR §438.114(d)(1)* *Contract: Exhibit B Part 2 (4)(a)(1&10)*	a) JCC, Standard IV, Emergency and Post-Stabilization Services, pg 1 b) JCC, Standard IV, Emergency and Post-Stabilization Services, pg 3 There are no requirements by the CCO regarding limits of emergency medical condition to a list of codes/symptoms. There are no requirements that emergency room providers or fiscal agents notify the PCP or CCO within 10 calendar days of presentation for emergency services.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
19. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42 CFR §422.114(d)(2)* *Contract: Exhibit B Part 2 (4)(a)(9)*	JCC, Standard IV, Emergency and Post-Stabilization Services, pg 3 Per the Emergency and Post-Stabilization Services policy there is no liability for the member for the subsequent screening and treatment needed to diagnose the condition or stabilization of the member following emergency services.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
20. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in paragraph (b) of this section as responsible for coverage and payment. *42 CFR §422.114(d)(3)* *Contract: Exhibit B Part 2 (4)(a)(9)*	JCC, Standard IV, Emergency and Post-Stabilization Services, pg 4 states, "The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in paragraph (b) of this section as responsible for coverage and payment."	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
21. Poststabilization care services are covered and paid for in accordance with provisions set forth at 42 C.F.R. §422.113(c). a. The CCO is financially responsible (consistent with §422.214) for post-stabilization care services obtained within or outside the CCO's network that are pre-approved by a plan provider or other organization representative; b. The CCO is financially responsible for post-stabilization care services obtained within or outside the CCO's network that are not pre-approved by a plan provider or other organization representative, but administered to maintain the member's stabilized condition within 1 hour of a request to the CCO for pre-approval of further post-stabilization care services;	a-c. JCC, Standard IV, Emergency and Post-Stabilization Services, pg 2 OHP member are not held financially liable for any emergency and post-stabilization services.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
c. The CCO is financially responsible for post-stabilization care services obtained within or outside the CCO's network that are not pre-approved by a plan provider or other organization representative, but administered to maintain, improve, or resolve the member's stabilized condition if: i. The CCO does not respond to a request for pre-approval within 1 hour; ii. The CCO cannot be contacted; or iii. The CCO's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the CCO must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in §422.113(c)(3) is met. d. Must limit charges to members for post-stabilization care services to an amount no greater than what the organization would charge the member if he or she had obtained the services through the CCO's network. For purposes of cost sharing, post-stabilization care services begin upon inpatient admission. *42 CFR §438.114(e)* *42 CFR §422.113(c)(2)(i-iv)* *Contract: Exhibit B Part 2 (4)(a)(6&8)*		
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;	a-c. JCC, Standard IV, Emergency and Post-Stabilization Services, pg 4 outlines when the CCO's financial responsibility for post-stabilization care services it has not pre-approved ends.	☒ Complete ☐ Progress Sufficient to Start Operations

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
b. A plan physician assumes responsibility for the member's care through transfer; c. A CCO representative and the treating physician reach an agreement concerning the member's care; or d. The member is discharged. *42 CFR §438.114(e)* *42 CFR §422.113(c)(3)(i-iv)* *Contract: Exhibit B Part 2 (4)(a)(7)*		☐ Incomplete ☐ NA
23. The CCO has written policies and procedures that describe the process for receiving member requests, approving non-emergent medical transportation (NEMT) services, and scheduling, assigning, and dispatching providers. *Contract: Exhibit B Part 2 (4)(b)*	NEMT new employee orientation training slide deck – attached above CCO Customer/Member Service Call Center call processing guide - attached above The CCO has practices and processes for receiving member requests, approving non-emergent medical transportation (NEMT) services, and scheduling, assigning, and dispatching providers, and will need to formalize these practices and processes beyond current activities, into 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 by January 1, 2020	☐ Complete ☐ Progress Sufficient to Start Operations ☒ Incomplete ☐ NA
HSAG Findings: The CCO did not provide written policies and procedures regarding non-emergent medical transportation (NEMT) services. In addition, the documentation that was provided did not describe specific NEMT processes of the CCO or of its NEMT providers.		
Required Actions: The CCO should develop written policies and procedures regarding NEMT services that describe the process for receiving member requests, approving NEMT transportation, and scheduling, assigning, and dispatching providers.		

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)*	The CCO has 24 X 7 after hour vendors with live operators after hours. The CCO will assure a welcome message is instituted with English and Spanish options by Jan 1, 2020 http://jacksoncareconnect.org/for-members/transportation	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: The documentation provided by the CCO indicated that the NEMT Call Center operating hours are Monday through Friday from 9:00 a.m. to 5:00 p.m. In the "Evidence as Submitted by the CCO" column, the CCO stated that it has live operators 24 hours a day, 7 days a week. However, the documentation provided did not support this comment. The documentation provided instructed the member to leave a message and that "… someone will call you back to get your information."		
Required Actions: HSAG recommends that the CCO ensure it provides an after-hours message in English and Spanish instructing members how to access after-hours NEMT services.		
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)*	The CCO's Policy and Procedure: "Emergency and Post Stabilization Services" describes our policy, procedure and monitoring process. Please refer to highlighted areas on pages 2, 3 and 4.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
26. The CCO has written policies and procedures and monitoring systems for an emergency response system that provides immediate, initial or limited duration response for emergency behavioral health situations. *Contract: Exhibit M (2)(g)*	The contract has been updated since this template was created. The new contract reference and language are found in Exhibit M, (10) (a). This response will be reflective of the updated contract language. This is accomplished through contracts with behavioral health providers as stated in the attached policy, Emergency and Post Stabilization Services.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	This is also achieved through direct funding and contracts with the local CMHPs that provide crisis and safety net services in each county of the region served. An example of that contract language is attached (please see Exhibit I-1, pages 9-10).	
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)*	Jackson Care Connect has a strong relationship with Jackson County Mental Health, the Local Mental Health Authority and safety net services provider. The CCO contributes significant Medicaid funding to support the continuum of crisis services, including mobile crisis response and crisis clinicians embedded with the Sheriff's office. The contract is attached – please refer to page 16. The updated amendment is also attached, please refer to pages 9-10.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services	
	Total #
Complete	**22**
Progress Sufficient	**4**
Incomplete	**1**
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)*	• Delegation Oversight Policy – pg. 2-3 • Dental Care Organization Delegation Agreement template universal redline pg. 24 (3), 1, 3 [Please note that the page citations to the Delegation Agreement refer to the contract page numbers, not to the PDF page numbers. The DCO delegation agreement provided as a sample is representative of any other delegate agreement the CCO would execute.]	☒ 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.	We plan to submit all notices and reports required in the finalized CCO contract. • Delegation Oversight Policy—pg. 2-3. • Non-provider Subcontractor Contracting Policy pg. 2 We update our delegations every year with any new required terms from the CCO Contract. We will do so this year again with any changes in the 2020 contract. The DCO delegation agreement provided as a sample is representative of any other delegate agreement the CCO would execute. • Dental Care Organization Delegation Agreement template universal redline: – Pg. 2, 6, 12, 14, 15, 16, 17, 18, 19, 23, 30, 37-38, 41 all of Ex G (41) and L (48-53), The delegated activities or obligations, and related reporting responsibilities. Contractor shall not	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• The requirements for written agreements as outlined in the CCO's contract with OHA, including fully integrated service delivery and funding (as defined in ORS 414.025). *42 CFR §438.230(c)(1-3)* *Contract: Exhibit B Part 4 (12), (13)(a)(1) and (13)(b)(1)(a-j), Exhibit M(1)*	fully subcontract the provision of Behavioral Health services and Care Coordination to another entity. – Pg. 1 (D) The subcontractor agreement to perform the delegated activities and reporting responsibilities specified in compliance with the CCO's obligations. – Pg. 26-29, 38 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. – Pg. 14, 31, 33-34, 39 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).	

HSAG Findings: The policies and procedures submitted included all provisions in this element. Additionally, the CCO provided a 2019 template subcontractor agreement for a dental care organization and indicated that the template is representative of any subcontractor agreement. The template included all OHA-required provisions except the subcontractor's requirement to meet the standards for timely access to care and services and a statement that, if the CCO is not paid or not eligible for payment by OHA for services provided, the subcontractor will not be paid or be eligible for payment either. In addition, some citations referencing the CCO contract in the subcontract template did not align with the current CCO contract. During the remote interview session, CCO staff members stated that they planned on completing updates to the subcontractor template once the final CCO contract is received. While the CCO subsequently provided a screen capture of a page from a 2018 DCO contract that included the requirement for timely access to care and services, this information was not found in the 2019 DCO template subcontractor agreement provided by the CCO.

HSAG HEALTH SERVICES ADVISORY GROUP

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Required Actions: HSAG recommends that the CCO update the template subcontractor agreement to include all requirements for written agreements and ensure any citations to the CCO contract are accurate.		
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)*	Pre-delegation Activities • Delegation Oversight Policy—pg. 5 Notices and Reports to OHA • Delegation Oversight Policy—pg. 2-3	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
4. The CCO has a process to monitor the subcontractor's performance on an ongoing basis. • Formal reviews shall be conducted by the CCO at least annually. *Contract: Exhibit B Part 4(13)(a)(12-14)*	The CCO has a robust program for monitoring subcontractors that includes a Delegation Oversight Team (DOT), direct oversight of DOT activities by the Director of Legal Affairs and the Delegation Oversight Committee (DOC), and an escalation path to the Chief Legal Officer. The DOT consists of 3 FTE Delegation Oversight Specialists (currently one vacancy but the position is posted), 1 FTE Regulatory Manager, and 1 .5FTE Regulatory Coordinator. • Delegation Oversight Policy – entire document • Sample DOT Report – 2018 Advantage Dental • Sample DOC Meeting Agenda – July 2019 • DOT Org Chart In addition to the DOT and its formal annual reviews, Business Owners at the CCO are responsible for monitoring the day-to-day activities of subcontractors. • Business Owner Subcontractor Monitoring Training	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

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

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

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

Standard IX—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. In compliance with 42 C.F.R. §438.3(d), the CCO: a. Shall accept individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by CMS), up to the limits set under the Contract. b. Shall not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll. c. Shall not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability. *42 CFR §438.3(d)(1-4)* *Contract: Exhibit B Part 3 (6)(a)(2-3)*	CareOregon's Enrollment department accepts eligibility files from the State and processes in compliance with 42 C.F.R. §438.3(d): • The Enrollment Department follows State and Federal guidelines and the Medicaid Enrollment Policy. Please reference Medicaid Enrollment Policy paragraph 1 & Enrollment Production Quality Assurance PP overview and page 2. • Staff must attend an annual mandatory training and is expected to act with CareOregon's Code of Conduct in mind. • Our internal systems are also set up with permissions based on roles, access and training for the specific functions of enrolling or disenrolling members. • We have a Quality Assurance program in which work is randomly selected for accuracy and protocol in compliance with 42 C.F.R. §438.3(d). • Additionally, to further promote anti-discrimination efforts broadly in the organization on January 2018 our parent company, CareOregon, through its Board of Directors (which oversees the CCO as the sole member of the wholly owned LLC CCO) adopted this Equity, Diversity and Inclusion (EDI) Vision Statement:	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IX—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	"The pursuit of the highest possible standard of health for all people is the heart of CareOregon's values and mission. We recognize the process of achieving health equity and the creation of an inclusive and diverse work environment includes the intentional deployment of resources to identify disparities and redress them when found. It also requires giving special attention to the needs of those at greatest risk of poor health, based on social conditions and socially defined constructs, such as racial categories and poverty. *"To more fully accomplish our mission and live our values, the Board of Directors champions and supports a steadfast commitment to equity, and diversity and inclusion. This commitment will be reflected in our goals and vision. It will be evident in our organizational structure, policies, deployment of resources, and the composition of the staff and board of directors. We welcome individuals of all backgrounds and actively seek to foster an organizational culture of humility, respect, integrity, authenticity and learning while creating value informed by our members, staff and the communities in which we serve."* • We will update our mandatory staff training by 11/2019 and implemented for 2020 to ensure that all impacted departments are aware of Enrollment & Disenrollment guidelines. The enrollment team will partner with all other appropriate teams to	

Standard IX—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	coordinate this effort and ensure its distribution across our enterprise.	
HSAG Findings: The Medicaid Enrollment and Enrollment Production Quality Assurance policies and procedures did not include or specify that the CCO would not, on the basis of health status or need for healthcare services, discriminate against individuals eligible to enroll. Although policy, 1557 Nondiscrimination Communication Requirements, identified that the CCO will not discriminate on the basis of race, color, national origin, sex, age, or disability, it did not include that the CCO will not discriminate against individuals eligible to enroll on the basis of sexual orientation or gender identity. The policies also did not specify that the CCO 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.		
Required Actions: HSAG recommends that the CCO revise its policies to include all requirements identified in the federal regulations and in contract.		
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)*	When the Enrollment team receives a request for disenrollment, we first refer to the OAR's in compliance with Medicaid Enrollment Policy – "The Policy Paragraph on Page 1 and 42 C.F.R. §438.56(b) before staff will submit any disenrollment request to the State. The only requests that CareOregon Enrollment team submits to the State for disenrollment are: • Incarceration • Inpatient status at the time of enrollment • Deceased member We also have a Quality Assurance program in which work is randomly selected for accuracy and protocol Training will be updated by 11/2019 and implemented for 2020 to ensure that all impacted departments are aware of Enrollment & Disenrollment guidelines. The enrollment team will partner with all other appropriate teams to coordinate	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IX—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	this effort and ensure its distribution across our enterprise.	
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)*	Requests for disenrollment are made using the Member Disenrollment Request Criteria Form which requires that the request is made in compliance with regulations and requires the approval of the Chief Legal Officer prior to submission to OHA (form attached in evidence). When the Enrollment team receives a request for disenrollment, we first refer to the OAR's in compliance with Medicaid Enrollment Policy – "The Policy Paragraph on Page 1 and 42 C.F.R. §438.56(b) before staff will submit any disenrollment request to the State. The only requests that CareOregon Enrollment team submits to the State for disenrollment are: • Incarceration • Inpatient status at the time of enrollment • Deceased member We also have a Quality Assurance program in which work is randomly selected for accuracy and protocol Training will be updated by 11/2019 and implemented for 2020 to ensure that all impacted departments are aware of Enrollment & Disenrollment guidelines. The enrollment team will partner with all other appropriate teams to coordinate	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IX—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	this effort and ensure its distribution across our enterprise.	
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 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)*	Medicaid Enrollment Policy – "The Policy Paragraph on Page 1. In compliance with 42 C.F.R. §438.3(d). Application Processing PG page #2 speaks to loss of Medicaid verification. Disenrollments are completed by the State therefore if the Enrollment team receives a request from a member, they would be referred to contact the State directly as per the Enrollment's Medicaid Enrollment Policy. Training will be updated by 11/2019 and implemented for 2020 to ensure that all impacted departments are aware of Enrollment & Disenrollment guidelines. The enrollment team will partner with all other appropriate teams to coordinate this effort and ensure its distribution across our enterprise.	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: The Medicaid Enrollment Policy and Procedure did not specify when the CCO allows a member to request disenrollment according to federal or contract requirements. Also, the member handbook did not specify that the CCO allows a member to request disenrollment for cause, at any time, only that a Medicare member can change or leave the CCO at any time. Although "without cause" situations for disenrollment were identified in the member handbook for some of sub-element 4.b.i – 4.b.iii; sub-element 4.b.iv was not included in the documentation.		
Required Actions: HSAG recommends that the CCO update its policies and procedures and/or member handbook to include a description of the "for cause" and "without cause" reasons that members may request disenrollment to ensure CCO documentation is consistent with federal requirements.		

Standard IX—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	Medicaid Enrollment Policy – "The Procedure on Page 2. In compliance with 42 C.F.R. §438.3(d) Disenrollments are completed by the State therefore if the Enrollment team receives a request from a member, they would be referred to contact the State directly as per the Enrollment's Medicaid Enrollment Policy. Training will be updated by 11/2019 and implemented for 2020 to ensure that all impacted departments are aware of Enrollment & Disenrollment guidelines. The enrollment team will partner with all other appropriate teams to coordinate this effort and ensure its distribution across our enterprise.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
6. The following are cause for disenrollment: a. The member moves out of the CCO's service area. b. The CCO does not, because of moral or religious objections, cover the service the member seeks. c. The member needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the provider network; and the member's primary care provider or 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	Medicaid Enrollment Policy – "The Policy Paragraph on Page 1. In compliance with 42 C.F.R. §438.56(d)(2) Disenrollments are completed by the State therefore if the Enrollment team receives a request from a member, they would be referred to contact the State directly as per the Enrollment's Medicaid Enrollment Policy. Training will be updated by 11/2019 and implemented for 2020 to ensure that all impacted departments are aware of Enrollment & Disenrollment guidelines. The enrollment team will partner with all other appropriate teams to coordinate this effort and ensure its distribution across our enterprise.	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IX—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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 and procedure, Medicaid Enrollment, did not address any of the reasons listed for "cause" for disenrollment in sub-element 6. Additionally, the member handbook, however, included some of the reasons for "cause" for disenrollment except for sub-element 6.d.		
Required Actions: HSAG recommends that the CCO update its policies and procedures and other member information materials to include all required "cause" for disenrollment reasons.		

Standard IX—Enrollment and Disenrollment	
	Total #
Complete	**3**
Progress Sufficient	**3**
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*	PP 140 Notice of Adverse Benefit Determination CCO notifies member in timely manner of notice of action Pg. 3 PP 145 OHP Medicaid Grievance/Complaints CCO has Grievance System in place Pg. 1 A PP 145 Pre-Service/Post Service Appeals Processing CCO has Grievance System in place that includes appeals and State fair hearing Pg. 1 (1,2,3), Pg. 3 (1,2), Pg. 4 #11 (a-f) Pg. 20 A Member Handbook Pg. 11. JCC pg. 43-45 Website-Member Handbook http://www.jacksoncareconnect.org/for-members/member-handbook Provider Manual Pg. 5, 6, 7, 10 Website- Provider Manual https://careoregon.org/providers/support/provider-manual	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
2. The CCO has internal grievance procedures under which Medicaid members may challenge the denial of coverage of, or payment for medical assistance (adverse benefit determination). • The CCO may have only one level of appeal for members. • A member may request a State fair hearing (contested care hearing) after receiving an appeal resolution notice from the CCO that the adverse benefit determination has been upheld. • If the CCO fails to adhere to required timeframes for processing appeals, the member is deemed to have	PP 145 OHP Medicaid Grievance/Complaints CCO has grievance procedures that all members to challenge a denial Pg. 10 PP 145 Pre-Service/Post Service Appeals Processing CCO only has one level of appeal Pg. 4 #9, Pg. 8 #14 CCO has system in place for State fair hearing, Pg. 20 A If CCO fails to adhere to timeframe, member may request a State fair hearing Pg. 6 #8 (A), Pg. 20 (C) Member Handbook Pg. 11. JCC pg. 43-45,	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

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Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	Provider Manual Provider Manual Pg. 5, 6, 7, 10 Website-Member Handbook http://www.jacksoncareconnect.org/for-members/member-handbook Website-Provider Manual https://careoregon.org/providers/support/provider-manual	
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,	PP 140 Notice of Adverse Benefit Determination CCO defines Adverse Benefit Determination Pg. 1, 2 Member Handbook Pg. 11. JCC pg. 43-45, http://www.jacksoncareconnect.org/for-members/member-handbook Provider Manual Pg. 5, 6, 7, 10 https://careoregon.org/providers/support/provider-manual	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
deductibles, coinsurance, and other member financial liabilities. *42 CFR §438.400(b)* *42 CFR §438.52(b)(2)(ii)* *RFA: Appendix A (C)*		
4. The CCO defines Appeal as a review by the CCO of an Adverse Benefit Determination. *42 CFR §438.400(b)* *RFA: Appendix A (H)(11)*	PP 145 Pre-Service/Post Service Appeals Processing CCO defines appeal Pg.2	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
5. The CCO defines Grievance as an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. • Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievances include the member's right to dispute an extension proposed by the CCO to make an authorization decision. *42 CFR §438.400(b)* *RFA: Appendix A (H)(57)*	PP 145 OHP Medicaid Grievance/Complaints CCO defines grievance Pg. 6, Quality of Care Pg. 13 PP 145 Pre-Service/Post Service Appeals Processing CCO- allow member to dispute an extension Pg. 7 #10 (A, B)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
6. A member may file a grievance with the CCO at any time, either orally or in writing. Grievances can be submitted to the State or the CCO. *42 CFR §438.402(c)(2)(i), (c)(3)(i)* *Contract: Exhibit I (2)(a)*	PP 145 OHP Medicaid Grievance/Complaints CCO allows member to submit grievances at any time Pg. 1 (A, B)	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: The OHP Medicaid Grievance/Complaints policy noted that a member may file a grievance with the CCO at any time, either orally or in writing. However, it did not specify that a member may file a grievance with the State.		
Required Actions: HSAG recommends that the CCO update its OHP Medicaid Grievance/Complaints policy to indicate that a member may file a grievance with the State.		
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)*	PP 145 Pre-Service/Post Service Appeals Processing CCO allows member to file an appeal within 60 days Pg. 5, #2 CCO allows member to file appeal either orally or in writing Pg. 5 #1 (g) CCO notifies member via writing of appeal resolution Pg. 17, 18	☒ 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)*	PP 145 OHP Medicaid Grievance/Complaints CCO acknowledges each grievance either verbally at time of call or within 5 days written notice is sent Pg. 3 (A) CSR Grievance Call Processing Guide Pg. 1 PP 145 Pre-Service/Post Service Appeals Processing CCO acknowledges each appeal Pg. 5 #4	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
9. A member may file an appeal within 60 calendar days from date on the notice of adverse benefit determination. • The member may request an appeal either orally or in writing. Unless the member requests an expedited resolution, an oral appeal must be followed by a written, signed appeal. *42 CFR §438.402(c)(2)(ii), (c)(3)(ii)* *Contract: Exhibit I (1)(b)(2), (1)(c)(2-3)*		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: This element was a 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)*	PP 145 OHP Medicaid Grievance/Complaints CCO will resolve each grievance in writing and provide notice as expeditiously as the member's health condition requires Pg. 12. Current policy allows for verbal resolution. Policy will be updated to reflect contract language change to resolve each grievance in writing by 1/1/2020 For a., b., c., CCO notifies member, acknowledges receipt and notice is provided in manner easily understood Pg. 3 (D), 5, 6, 11	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: The CCO's OHP Medicaid Grievance/Complaints policy accurately documented the process and timeline for the grievance resolution process. However, as noted in the CCO's comment, not all grievances are resolved in writing.		
Required Actions: HSAG recommends that the CCO, as indicated in its comment, revise its Medicaid Grievance/Complaints policy to reflect that all grievances must be resolved in writing, effective January 1, 2020.		
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-	PP 145 OHP Medicaid Grievance/Complaints CCO will assist members in handling of grievances Pg.1 (c, d) PP 145 Pre-Service/Post Service Appeals Processing CCO will assist members in handling of appeals Pg.4, #3 (a)	☒ 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)*	PP 145 OHP Medicaid Grievance/Complaints CCO utilizes licensed staff for clinical review related to grievances Pg. 14 CCO considers all relevant information Pg. 2 (I) PP 145 Pre-Service/Post Service Appeals Processing CCO ensures appeal decision is not made by the original reviewer and that has expertise in treating member. CCO ensures clinical expertise in denial based on lack of medical necessity and denying an expedited resolution Pg. 3, 6 #3 and #6 CCO considers all relevant information Pg. 8# 17, 18	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
13. The CCO's appeal process must provide: a. That oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest	CCO staff are trained to offer an appeal when member is inquiring about an adverse benefit determination	☒ Complete ☐ Progress Sufficient to Start Operations

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
possible filing date for the appeal) and must be confirmed in writing, unless the member or the provider requests expedited resolution. b. The member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The CCO must inform the member of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in §438.408(b) and (c) in the case of expedited resolution. c. The member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the CCO (or at the direction of the CCO) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals. d. That included, as parties to the appeal, are: i. The member and his or her representative, or ii. The legal representative of a deceased member's estate. *42 CFR §438.406(b)(3-6)* *Contract: Exhibit I (4)(b)*	CSR Inquiry Call Processing Guide Pg. 1 PP 145 Pre-Service/Post Service Appeals Processing CCO informs member of right to present evidence and testimony Pg. 10 #2 (a) CCO allows member or representative to have all documents used to make a determination Pg. 9 #19 CCO defines parties included in appeal Pg. 2	☐ Incomplete ☐ NA
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.	PP 145 Pre-Service/Post Service Appeals Processing CCO resolves appeal within time frame Pg. 5 #5, Pg. 6 #8 CCO process expedited appeal within 72 hours Pg. 10, 11 #'s 1-6	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• 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)*	CCO provides notice in manner easily understood by member Pg. 7 #11 (f, g)	☐ NA
15. The CCO may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if: • The member requests the extension; or • The CCO shows (to the satisfaction of the State, upon request) that there is need for additional information and how the delay is in the member's interest. • If the CCO extends the timeframes, it must—for any extension not requested by the member: – Make reasonable efforts to give the member prompt oral notice of the delay. – 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.	PP 145 OHP Medicaid Grievance/Complaints CCO extends time frame Pg. 3 A PP 145 Pre-Service/Post Service Appeals Processing CCO may extend time frames Pg. 7 #'s 9, 10 When CCO extends time frame not requested by member CCO makes prompt effort to notify member Pg. 7 #'s 10, 11 If CCO fails to adhere to timeframe, member may request a State fair hearing Pg. 6 #8 (A), Pg. 20 (C)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• If the CCO fails to adhere to the notice and timing requirements for extension of the appeal resolution timeframe, the member may initiate a State fair hearing (contested case hearing). *42 CFR §438.408(c)* *Contract: Exhibit I (4)(c)(1)(c), (4)(c)(2)*		
16. The written notice of appeal resolution must include: The results of the resolution process and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing (contested case hearing), and how to do so. – The right to request that benefits/services continue while the hearing is pending, and how to make the request. – That the member may be held liable for the cost of these benefits if the hearing decision upholds the CCO's adverse benefit determination. *42 CFR §438.408(e)* *Contract: Exhibit I (4)(c)(4)*	PP 145 Pre-Service/Post Service Appeals Processing CCO written notice of appeal Pg. 11 #'s 1-4	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
17. The member may request a State fair hearing (contested case hearing) after receiving notice that the CCO is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of resolution. • The parties to the State fair hearing (contested case hearing) include the CCO, as well as the member and his or	PP 145 Pre-Service/Post Service Appeals Processing CCO maintains process for State fair hearing Pg. 20 (A,B,C)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
her representative or the representative of a deceased member's estate. *42 CFR §438.408(f)* *Contract: Exhibit I (5)*		
18. The CCO maintains an expedited review process for appeals, when the CCO determines, or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. The CCO's expedited review process includes: • The CCO ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. • If the CCO denies a request for expedited resolution of an appeal, it must: – Transfer the appeal to the time frame for standard resolution. – Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and follow-up within two calendar days with a written notice. *42 CFR §438.410* *Contract: Exhibit I (4)(c)(3)(e)*	PP 145 Pre-Service/Post Service Appeals Processing CCO maintains an expedited review process Pg. 10, 11 #'s 1-7	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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:	PP 145 Pre-Service/Post Service Appeals Processing CCO maintains process for continuation of benefits Pg. 5, 6 #1 (a) Pg. 7 11 (d), Pg. 9 #4, Pg. 11 #3 (d), Pg. 21 K (a, b, c)	☒ Complete ☐ Progress Sufficient to Start Operations

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• 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)*		☐ 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: • The member withdraws the appeal or request for State fair hearing.	PP 145 Pre-Service/Post Service Appeals Processing CCO maintains process for continuation of benefits Pg. 5, 6 #1 (a) Pg. 7 11 (d), Pg. 9 #4, Pg. 11 #3 (c,d), Pg. 21 K (a, b, c)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• 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)*		
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)*	PP 145 Pre-Service/Post Service Appeals Processing CCO may recover cost of services Pg. 7 11 (d i), 21 (c)	☒ 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. • 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	PP 145 Pre-Service/Post Service Appeals Processing CCO must effectuate within 72 hours and pay for services Pg. 9 #5 (a)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

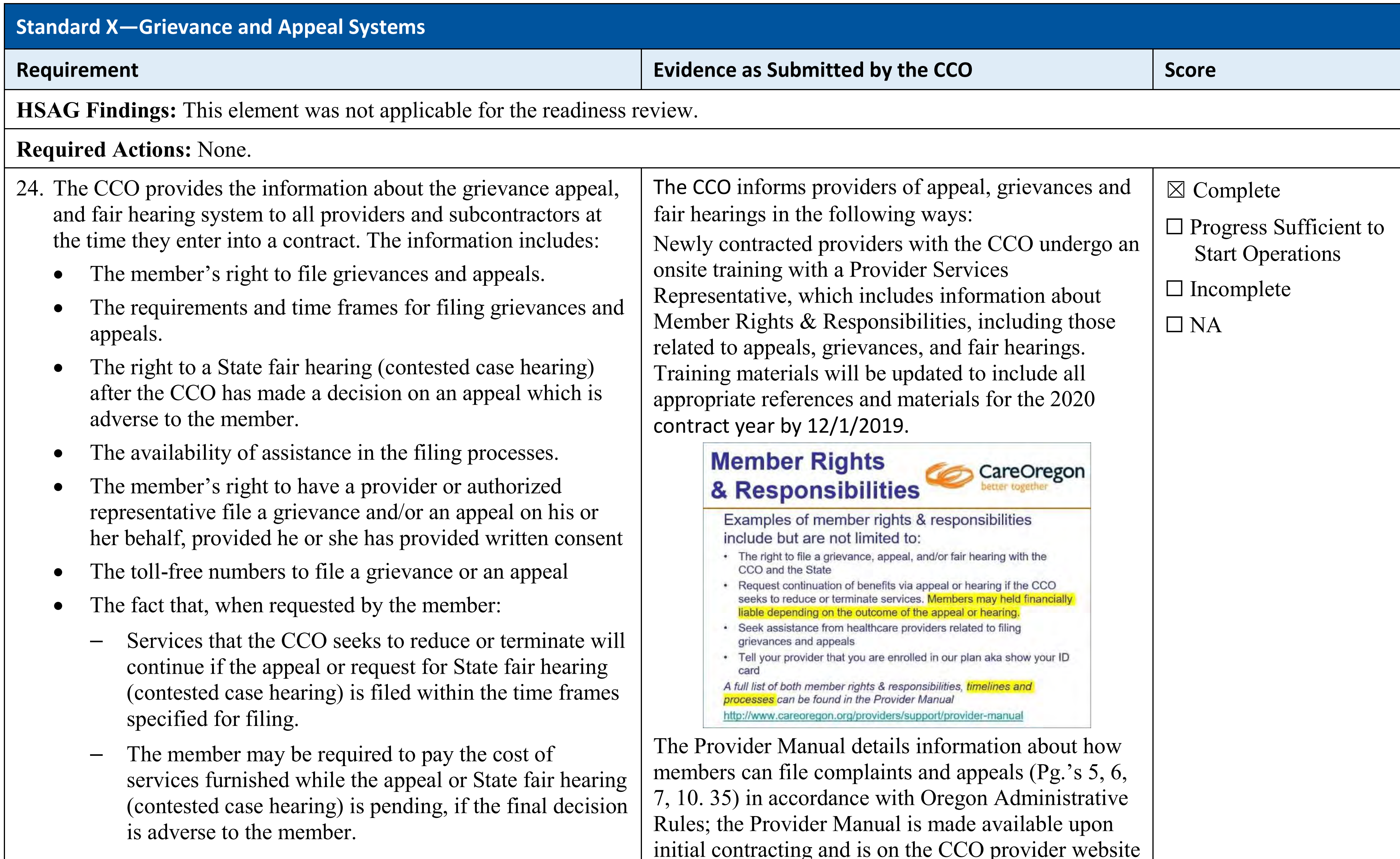
Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
while the appeal was pending, the CCO or the State must pay for those services, in accordance with State policy and regulations. *42 CFR §438.424* *Contract: Exhibit I (7)*		
23. The CCO maintain records of all member grievances and appeals. The record must be accurately maintained in a manner accessible to the State and available upon request to CMS. The record of each member grievance or appeal must contain, at a minimum, all of the following information: • A general description of the reason for the appeal or grievance; • The date received; • The date of each review or, if applicable, review meeting; • Resolution at each level of the appeal or grievance, if applicable; • Date of resolution at each level, if applicable; • Name of the covered person for whom the appeal or grievance was filed, member ID number, and date the member filed the grievance or appeal; • 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)*		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA

HSAG HEALTH SERVICES ADVISORY GROUP

<table>
<tr><th colspan="3">Standard X—Grievance and Appeal Systems</th></tr>
<tr><th>Requirement</th><th>Evidence as Submitted by the CCO</th><th>Score</th></tr>
<tr><td colspan="3">HSAG Findings: This element was not applicable for the readiness review.</td></tr>
<tr><td colspan="3">Required Actions: None.</td></tr>
<tr>
<td>24. The CCO provides the information about the grievance appeal, and fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes:

The member’s right to file grievances and appeals.
The requirements and time frames for filing grievances and appeals.
The right to a State fair hearing (contested case hearing) after the CCO has made a decision on an appeal which is adverse to the member.
The availability of assistance in the filing processes.
The member’s right to have a provider or authorized representative file a grievance and/or an appeal on his or her behalf, provided he or she has provided written consent
The toll-free numbers to file a grievance or an appeal
The fact that, when requested by the member:

Services that the CCO seeks to reduce or terminate will continue if the appeal or request for State fair hearing (contested case hearing) is filed within the time frames specified for filing.
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.

</td>
<td>The CCO informs providers of appeal, grievances and fair hearings in the following ways:
Newly contracted providers with the CCO undergo an onsite training with a Provider Services Representative, which includes information about Member Rights & Responsibilities, including those related to appeals, grievances, and fair hearings. Training materials will be updated to include all appropriate references and materials for the 2020 contract year by 12/1/2019.


The Provider Manual details information about how members can file complaints and appeals (Pg.’s 5, 6, 7, 10. 35) in accordance with Oregon Administrative Rules; the Provider Manual is made available upon initial contracting and is on the CCO provider website</td>
<td>☒ Complete
☐ Progress Sufficient to Start Operations
☐ Incomplete
☐ NA</td>
</tr>
</table>

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
42 CFR §438.414 *42 CFR §438.10(g)(xi)* *Contract: Exhibit B Part 3 (5)(b)*	for reference. The Brand, Marketing, & Communications department produces the Provider Manual and updates the manual appropriately with new information and as new OARs are implemented. The Provider Manual will be updated with the appropriate references for the 2020 contract year by 12/1/2019. Provider Manual Pg.'s 5, 6, 7, 10. 35 Website-Provider Manual https://careoregon.org/providers/support/provider-manual	

Standard X- Grievance and Appeal Systems	
	Total #
Complete	**20**
Progress Sufficient	**2**
Incomplete	**0**
Not Applicable (NA)	**2**

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
9. 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)*	a. CareOregon licenses the Cognizant TriZetto QNXT healthcare administration software for payers. The QNXT application automates critical functions including claims processing, member enrollment, authorizations, provider data and customer service. QNXT Connect provides exchange of HIPAA standard transactions with trading partners. HIPAA 834 Enrollment data files received from OHA are imported in to QNXT daily. The race or ethnicity (834 has a single field), preferred language, address, phone number and other data from the 834 file are imported and stored in QNXT. Each new member is assigned a Primary Care Provider programmatically based on an algorithm that takes in to account the characteristics of the member and provider. That date sensitive assignment is stored on each member's Member PCP table in the system. The provider table holds all of the demographics of a provider. See attached data dictionary of a few of the 62 member-related tables that hold these data elements (Standard XIII, question 1 d, Member File layout.docx). See attached Medicaid member enrollment policy (Standard XIII, question 1, Medicaid member enrollment policy.docx). HIPAA 837 dental, professional and institutional claims files are imported in to QNXT. There are over 75 claim related table to support the adjudication and storage of claims data, the layout of a few of the core	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	tables are attached (Standard XIII, question 1 a, Claim File layout.docx). CareOregon has built and Enterprise Data Warehouse (EDW) for internal analytics. The warehouse is built using the Kimball Dimensional Model, converting raw data into star schemas for efficient and accurate ingestion and storage, and subsequently modeled into flatter analytical tables for analyst consumption. The process of bringing a new data domain into the EDW begins with analysis of the dataset, from which a conceptual model is built. Through the modeling process the logical and physical models are then built. CareOregon builds the physical models the Erwin modeling tool. Mapping documents are also created and maintained which describe the data flow from source to target, and any transformations and business rules applied to the dataset. The requirements are then handed off to a developer who will build the process to load and update the data domain. Once developers have built and unit-tested the process, it is handed off to a Business Analysis for review and a Data Analyst (or requestor) for user acceptance testing. When all testing has passed the process is promoted to production. In addition, CareOregon creates user guides for each domain, which consists of an Executive Summary, a diagram and description of the logical model, and a field by field explanation of each data element in the domain Domains currently in production in CareOregon's EDW are: authorizations, enrollments, claims,	

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	member PCP Assignments, member demographics, provider demographics, and pharmacy claims. Several of these domains have subset or aggregate data marts built from them. Attached is the data warehouse Claim Line Fact User Guide (Standard XIII, question 1, Claim Line Fact User Guide.docx) and related mapping documents (Standard XIII, question 1, edw.dbo.claimLineFactMapping.xlsx and Standard XIII, question 1, edw.analysis.claimLineAll.xlsx) b. CCO maintains all records related to appeals, grievances and hearings in an internal Sharepoint document management system as well in an electronic health record e. MOTS – see Base Agreement highlighted page 30 f. Care Coordination activity, including member interactions, assessments, individualized care plans, and external documents are maintained within our Care Management Platform, GSI. External documents, including long term care referrals, are saved and uploaded to the member's Coordinated Care Plan within the Data Manager function of GSI, as referenced in the Uploading External Documents Job Aid.	
10. 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.	CareOregon systems are designed to automate claims processing as much as possible to ensure efficiencies, timeliness and accuracy. CareOregon accepts electronic claims (837D/I/P) from several clearinghouses, NEMT brokers and	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
42 CFR §438.242(b)(1)	CMS Benefits Coordination and Recovery Center (BCRC). Claims that are submitted on paper are sent to a clearinghouse vender for conversion to an 837 format. A monthly report of providers that submit paper claims is monitored so that Provider Relations Representative can contact providers to work with them to eliminate paper claim submissions. Claims are imported in to our claims processing system, QNXT, each weekday morning. Automated mass adjudication is run every night, Sunday through Thursday. Claims that do not require manual intervention will be set to a pay or deny status for finalization in the payment process that is run every Friday night. QNXT is a rules-based claims administration system. We require comprehensive claim information to make an accurate benefit determination. Rules are configured to identify when information is missing that prevents determining the benefits and denies the claim with a claim adjustment reason code to the provider. Further detail regarding the validation of claim content is included in 4. Below. Attached is a diagram showing the claim process (Standard XIII, question 2, Life of a Claim 2019.vsd). Attached is a report that is used to monitor the auto adjudication rate (Standard XIII, question 2, auto adjudication report row 98.xlsx).	☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
11. 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)*	Member enrollment data is explained in 1. above. The CCO collects the provider data elements as required in Exhibit G of the CCO contract and stores the elements in QNXT with a unique ID. Among the elements collected are: provider name, NPI, type, specialty, credential status with effective and termination date, OHA Medicaid ID, license number (with effective and termination date), Tax Identification Number, Organizational NPI, physical address, mailing address, billing address, PCPCH status, member assignment count and details, and accepting new patient status. The CCO collects additional practitioner and location-specific details in support of claims processing and the provider directory. Attached is a layout of some of the core provider tables (Standard XIII, question 3, Provider File layout.docx). CareOregon submits all Professional, Dental, and Institutional claims to OHA via MMIS within 45 calendar days of the claim's date of adjudication. Pharmacy claims are submitted to OHA via MMIS within 45 calendar days of service. All claim file submissions are certified to OHA within 24 hours of transmission. Attached is the Encounter Data submission policy (Standard XIII, question 3, JCC Encounter Submission PP.docx)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
12. 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. *42 CFR §438.242(b)(3)(i-iii)* *Contract: Exhibit J(3)*	QNXT is a rules-based claims administration system. We require comprehensive claim information to make an accurate benefit determination. Rules are configured to identify when information is missing that prevents determining the benefits and denies the claim with a claim adjustment reason code is communicated to the provider on their remittance advice. The rules validate that all information is present and identifies errors, omissions and questionable coding according to industry sourced coding policies. Attached is a list of QNXT rules (Standard XIII, question 4, QNXT Rules.xlsx). There may be times where a rule is not specific enough to identify certain situations, therefore, a custom script will pend the claim for manual review. For example, the claim submission window rule is set to deny claims submitted more than 120 days after the date of service. There are exceptions to this rule such as an external primary plan, maternity related services or a provider may submit documentation regarding timely filing. If the claim meets exception criterion, the script will pend the claim for review. Attached are policies on timely filing and timely payment (Standard XIII, question 4, Timely filing policy.docx and Standard XIII, question 4, Timely payment policy.docx). We use a fully integrated products to calculate inpatient prospective payment system (PPS), outpatient PPS and ambulatory surgical center	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	payment system. The software products also perform editing to determine correct grouping (i.e., DRG, APC) and pricing. For example, the CMS inpatient PPS validates diagnosis, procedure, age, sex, length of stay, etc. for grouping and pricing. CareOregon requires HIPAA compliant coding for claims processing (e.g., CPT, CDT, HCPCS, NDC, revenue, ICD-10, HIPPS/RUGS). Services that require a prior authorization are configured in QNXT as a plan benefit requirement or provider contract requirement. Authorizations are entered in to the QNXT Utilization Management module. The authorizations are either entered programmatically from a provider's request through our web portal or manually by our staff from a faxed request. Adjudication of a claim with services requiring authorization approval will look for a matching authorization and take actions based on the data and status (approved/denied). Claims are processed using the member's enrollment information in QNXT as provided by OHA in the daily 834 enrollment files. The claim record uses the enrollment in effect for the dates of service on the claim. The enrollment reflects the benefits (CCOA, CCOB, CCOG, CCOE) with an effective and termination date, including the primary or secondary plan status. If a secondary enrollment is applicable for a date of service, the claim will require primary benefit data to make a benefit determination	

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	c. Medicaid Enrollment Policy – "The Policy Paragraph on Page 1 Medicare Enrollment Policy paragraph on Page 1 & Application Processing Guide Page 2 CareOregon maintains provider data in QNXT. Claims submission requires individual and organizational NPIs as well as the billing provider Tax ID number. Providers must have an active DMAP provider ID before processing their claims for payment. A nightly process validates against the most recent OHA provider file that there is an active DMAP ID for all unfinalized claims. Claims whose rendering, attending or billing provider does not have a valid ID at the time are denied and CareOregon mails a letter requesting a completed Medicaid ID application and OHA provider disclosure form which are required for enrollment. Upon successful issuance of a DMAP ID, claims are adjusted for benefit adjudication. d. The CCO collects data from providers in standardized formats to the extent possible for use in quality improvement efforts, including value-based payment (VBP) administration and as a part of the OHA's CCO quality pool program. The CCO collects provider data for VBP payment programs as described by narrative and evidence included in Readiness Review ISCAT Section IV. Provider data collection also occurs as described in the CCO's Six Year Data Proposal (**JCC standard XIII, question**	

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	4d, JCC YearSixDataProposalTemplate 2018 5.09.19); and includes data received directly from individual clinics as well as OCHIN. Examples of data received in standard formats from these sources are included in the following files: (**OCHIN_IMeasures_20190125000000_NOHD_FINAL; CCO Diabetes A1c Primary Report 1_1 to 12_31_18; JCC standard XIII, question 4d, Metric Request**). Moving forward, the CCO would like to leverage data available through the OHA's Clinical Quality Metrics Registry to the extent feasible for both VBP program administration and quality pool program participation.	
13. 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)*	Std XIII Q5 Medicare claims extract_headers.xlsx Std XIII Q5 APAC_Mapping_2017.xlsx Std XIII HIS 15a- DW Arch Log.pdf: The CCO regularly submit collected data to OHA and CMS. Files "Std XIII Q5 Medicare claims extract_headers.xlsx" and "Std XIII Q5 APAC_Mapping_2017.xlsx" provides examples of data elements that are submitted on regular basis. We capture incoming enrollment, provider, claims data in an enterprise data warehouse, refer file "Std XIII HIS 15a- DW Arch Log.pdf: for architecture, which allows us to extract and deliver data to requestor.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
14. 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.		
15. 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

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		
16. The CCO shall: a. Collect and maintain sufficient member encounter data to identify the provider who delivers any item(s) or service(s) to members. b. Submit member encounter data to OHA at a frequency and level of detail to be specified by CMS and OHA, based on program administration, oversight, and program integrity needs. c. Submit all member encounter data that the State is required to report to CMS under §438.818. d. Specifications for submitting encounter data to the Agency in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate. *42 CFR §438.242(c)(1-4)*		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		
17. 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	The CCO backs up all data on a regular basis as per the policy “Standard XIII, Question 9 - Backup and Recovery Policy.docx”. This is a draft of the policy the CCO will approve and implement by 8/30/2019. The following docs provide supporting evidence of this policy:	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
d. Application and data criticality analysis and testing; and revisions procedures shall also be addressed within the required contingency plans. *45 CFR §164.308*	• Standard XIII, Question 9 - Backup Retention.JPG: Image of currently configured backup retention settings • Standard XIII, Question 9 - Backup Schedule.JPG: Image of currently configured backup schedule of the backup job • Standard XIII, Question 9 - Tape Backup Retention.JPG: Image of tape backup retention with our offsite vendor • Standard XIII, Question 9 - Veeam Restore Instructions.docx: Process for restoring data out of backups • Standard XIII, Question 9 - Recent Veeam Restores.docx: Example backup restore test Due to significant changes in the CCO's technology infrastructure in the past two years, the IS Disaster Recovery plan is currently being written to reflect current state. The new plan will be reviewed and approved by Executive leadership by 12/31/2019 and tested/exercised in Q1 2020. The draft plan is in the file "Standard XIII, Question 9 - IS Recovery Plan - Brookwood Datacenter (Draft).docx". The CCO has an organization-wide Disaster Plan (see doc "Standard XIII, Question 9 - CareOregon Disaster Plan - V 1.3.pdf") that defines the operational mode during a major business impacting event. CareOregon followed NFPA 1600 in the development of this plan. Incident Management	

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	activity is conducted consistent with National Incident Management System (NIMS) Incident Command System (ICS) principles and practices. The CCO uses Homeland Security Exercise and Evaluation Program (HSEEP) methodology to set training priorities, and design and deliver exercise and evaluation programs which help keep the plan relevant and on-track. An example of the results of an exercise is in the file "Standard XIII, Question 9 - 2019 CareOregon PACE AAR Final.pdf". The plan is reviewed and updated annually.	
HSAG Findings: The CCO submitted a comprehensive Disaster Response Plan for CareOregon that was last updated in August 2018. The document included policies, procedures, and operational guidelines for the CCO's contingency plans addressing objectives, organizational structure, and maintenance/testing protocols associated with disaster recovery, emergency modes of operations, and regular evaluations of data criticality. However, in its RR responses, the CCO indicated that, due to significant changes in the CCO's technology infrastructure, the IS Disaster Recovery Plan was currently being updated to reflect the current IS state, including execution of a business continuity/disaster recovery (BC/DR) plan for its secondary data center in Brookwood. The CCO anticipates that the new plan will be reviewed and approved by executive leadership by December 31, 2019, and tested/exercised in Q1 2020. The updated plan will include desk-level procedures necessary support the restoration of individual systems. Additionally, while the CCO submitted a backup retention policy, it was still in draft form. The draft document provides a general overview of backup procedures including general types of backups (i.e., systems, communications) and timing, media and physical storage, and testing procedures. Information System Capabilities Assessment Tool responses and evidence of completed backup and recovery tests delineated incremental, daily, and monthly backups, which were stored locally, in Microsoft (MS) Azure cloud services, and off-site tapes.		
Required Actions: HSAG recommends that the CCO's BC/DR plans and backup policies be finalized, tested, and submitted for review to confirm compliance with this standard and element.		
18. 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

<table>
<tr><th colspan="3">Standard XIII—Health Information Systems</th></tr>
<tr><th>Requirement</th><th>Evidence as Submitted by the CCO</th><th>Score</th></tr>
<tr><td>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)</td><td></td><td>☒ NA</td></tr>
<tr><td colspan="3">HSAG Findings: This element will be reviewed by the OHA HIT for the readiness review.</td></tr>
<tr><td colspan="3">Required Actions: None.</td></tr>
<tr><td>19. 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</td><td></td><td>☐ Complete
☐ Progress Sufficient to Start Operations
☐ Incomplete
☒ NA</td></tr>
</table>

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.		
20. 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	RFA4690-JCC-Att9-Health Information Technology Questionnaire. Per section 9.A.1.a - Amit Shah (CMO) and Nate Corley (VP IS and Analytics) will participate as a member in good standing, maintain and adhere to an active MOU, pay the annual assessments, and if elected serve on any governance or committees.	☐ 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.		
21. 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.		
22. 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	a. Patient Rosters are available online through our Provider Portal, CareOregon Connect. Roster information is refreshed daily. Providers may pull their clinic rosters at their convenience 24/7. There is no limitation as to how many times rosters may be pulled. Providers can export their patient rosters to for further review. Roster details include the data below: • Member Name • Member ID • Member Address (street address, city, zipcode)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Contract: Exhibit J (2)(k)(7)	• Home Phone number • Birthdate • Gender • Member's primary language • Start date • End date • Plan Information • Auto Assigned Date – date assigned to your clinic • Expected Date of Delivery (if applicable) In addition, the CCO uses Tableau and a Tableau server to maintain an externally available quality dashboard for network clinics. The dashboard includes information on member attribution, member characteristics, aggregate performance on measures included in VBPs and member level gaps in care. This dashboard is available to any provider involved in a primary care VBP with the CCO. A sample of the data provided to clinics through this dashboard is available in S**tandard XIII, question 14, COBI screenshots**. This data is available 24/7 to providers and is refreshed weekly. b. Patient Rosters are available online through our Provider Portal, CareOregon Connect. Roster information is refreshed daily. Providers may pull their clinic rosters at their convenience 24/7.	

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	There is no limitation as to how many times rosters may be pulled. Providers can export their patient rosters to for further review. Roster details include the data below: • Member Name • Member ID • Member Address (street address, city, zipcode) • Home Phone number • Birthdate • Gender • Member's primary language • Start date • End date • Plan Information • Auto Assigned Date – date assigned to your clinic • Expected Date of Delivery (if applicable) c. The CCO uses Tableau and a Tableau server to maintain an externally available quality dashboard for network clinics. The dashboard includes information on member attribution, member characteristics, and member level gaps in care. Clinics can search for individual members on the dashboard or export a full list of members who require intervention. This	

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	dashboard is available to any provider involved in a primary care VBP with the CCO. A sample of the data provided to clinics through this dashboard is available in S**tandard XIII, question 14, COBI screenshots, page 2.** This data is available 24/7 to providers and is refreshed weekly. d. The CCO uses Tableau and a Tableau server to maintain an externally available quality dashboard for network clinics. The dashboard includes information on member attribution, member characteristics, and member level gaps in care. Downloadable member lists include many demographics. See S**tandard XII, question 14, COBI downloadable member list** for included fields. The dashboard also includes a page that allows the CCO and clinics to look at performance on quality measures by demographics: age, gender, race, and language: S**tandard XIII, question 14, COBI screenshots**, page 3. This dashboard is available to any provider involved in a primary care VBP with the CCO. This data is available 24/7 to providers and is refreshed weekly. e. Tableau is used a tool to provide information for clinics on performance on VBP measures and for actionable information that can be used to identify patients requiring intervention. See **Standard XIII, question 14, COBI screenshots; Standard XII, question 14, COBI**	

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	downloadable member list. Providers participating in Primary Care Payment Model Track 1 submit their data through the CCOs VBP software PIPS: **Standard XIII, question 14, PIPS Provider Guide.**	
23. 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. The CCO utilizes a data warehouse encompassing member demographics, clinical, care coordination information and services (claim/encounter/event) information. There are multiple connected reporting and analytics tools that can be discussed in more detail and/or demonstrated in the upcoming interview. A high-level diagram of the current architecture is attached to this section (**Standard XIII, question 15a – DW Arch Log.pdf**). b. The CCO's data warehouse is paired with multiple risk scoring methodologies and a machine-learning-based population segmentation model to identify risk cohorts. A detailed presentation on this methodology and supporting technology was delivered at the Oregon HIMSS conference in the Spring of 2019. It is attached for reference in **Standard XIII, question 15b – Risk Strt Preso.pptx** (see slides 10-16, 20, 21). An example of the analysis these systems enable (member-identifiable data omitted) is also attached. See **Standard XIII, question 15b – Risk Strt example.xlsx**. It shows risk cohorts,	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	key conditions, and member engagement with provider clinic assignments. The CCO uses Tableau and a Tableau server to maintain an externally available quality dashboard for network clinics. The dashboard includes information on member attribution, member characteristics, and member level gaps in care. Downloadable member lists include many demographics. See S**tandard XII, question 14, COBI downloadable member list** for included fields. The dashboard also includes a page that allows the CCO and clinics to look at performance on quality measures by demographics: age, gender, race, and language: **Standard XIII, question 14, COBI screenshots, page 3.** This dashboard is available to any provider involved in a primary care VBP with the CCO. This data is available 24/7 to providers and is refreshed weekly.	

Standard XIII—Health Information Systems	
	Total #
Complete	**7**
Progress Sufficient	**1**
Incomplete	**0**
Not Applicable (NA)	**7**

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

Table B-1—JCC 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	0.0	
Address #1	100.0		
Provider's Capacity	5.1	100.0	
City	100.0		
Status of Medicaid Contract	100.0	98.6	
County	100.0		
Credentialing Date	99.8	100.0	99.0
DMAP (Medicaid ID)	100.0	100.0	
Provider First Name	100.0		

DSN Data Field	DSN Quality Metrics		
	% Present	% Valid Format	% Valid Values
Group/Clinic Name	100.0		
Non-English Language 1	7.8		
Non-English Language 2			
Non-English Language 3			
Provider Last Name	100.0		
Provider Network Status	100.0	99.8	
Provider NPI	100.0	100.0	100.0
Number of Members Assigned to PCPs	1.8	100.0	
PCP Indicator	100.0	0.0	
PCPCH Tier	26.6	0.0	
Phone Number	100.0		
Provider Category	100.0	100.0	100.0
Provider Service Category	100.0	100.0	100.0
Provider TIN	8.6	100.0	
Provider Taxonomy	100.0	99.7	99.7
Zip Code	100.0		

In general, key DSN data fields in the individual practitioner capacity report were populated although one data field, Provider TIN was populated for only 8.6 percent of the records. Additionally, while most of the populated fields contained valid formats, zero percent of the records with a PCP Indicator and PCPCH Tier fields were reported in the correct format. The overall average completeness was 80.4 percent across both required and conditional[B-1] fields and jumped to 94.9 percent when excluding conditional fields. Of note, only 7.8 percent of providers were associated with a non-English language.

Table B-2—JCC 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	99.8	
County	100.0		
DMAP (Medicaid ID)	100.0	99.9	
Facility NPI	100.0	100.0	100.0
Phone Number	100.0		
Provider Category	100.0	100.0	100.0
Provider Service Category	99.9	100.0	100.0
Facility TIN	100.0	100.0	
Facility or Business Taxonomy	100.0	99.8	99.8
Zip Code	100.0		

Overall, key DSN data fields in the facility and service provider capacity report were present and populated with valid values with an overall average completeness of 100.0 percent across all data fields.

Provider Network Capacity

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

Table B-3—JCC 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	2,463	38.8	2,457	99.8	6	0.2
Specialty Provider	3,561	56.1	3,551	99.7	10	0.3
Dental Service Provider	137	2.2	137	100.0	0	0.0
Mental Health Provider	176	2.8	176	100.0	0	0.0
SUD Provider	3	0.0	3	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	0	0.0	0	0.0	0	0.0
Alcohol/Drug	0	0.0	0	0.0	0	0.0
Health Education, Health Promotion, Health Literacy	0	0.0	0	0.0	0	0.0
Palliative Care	7	0.1	7	100.0	0	0.0
Facility/Service Practitioners						
Hospital, Acute Psychiatric Care	9	2.0	9	100.0	0	0.0
Ambulance and Emergency Medical Transportation	3	0.7	0	0.0	0	0.0
Federally Qualified Health Centers	86	18.7	86	100.0	0	0.0
Home Health	21	4.6	21	100.0	0	0.0
Hospice	0	0.0	0	0.0	0	0.0
Hospital	45	9.8	45	100.0	0	0.0
Imaging	0	0.0	0	0.0	0	0.0
Indian Health Service and Tribal Health Services	3	0.7	3	100.0	0	0.0
Mental Health Crisis Services	2	0.4	2	100.0	0	0.0
Community Prevention Services	9	2.0	9	100.0	0	0.0
Non-Emergent Medical Transportation	1	0.2	1	100.0	0	0.0
Pharmacies	49	10.7	49	100.0	0	0.0
Durable Medical Providers	119	25.9	119	100.0	0	0.0
Post-Hospital Skilled Nursing Facility	66	14.3	66	100.0	0	0.0
Rural Health Centers	18	3.9	18	100.0	0	0.0
School-Based Health Centers	0	0.0	0	0.0	0	0.0
Urgent Care Center	29	6.3	29	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.

HSAG HEALTH SERVICES ADVISORY GROUP

In general, JCC'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; traditional health workers; alcohol/drug providers; or health education, health promotion, health literacy providers. Additionally, of the 17 required facilities and services, three provider service categories had a count of zero—i.e., hospice, imaging services, and school-based health centers. Additionally, while JCC reported three ambulance and emergency medical transportation providers, none were identified as being contracted or having a contract pending.

Provider Accessibility

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

Table B-4—JCC 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	2,463	1,145	46.5	195	7.9
Specialty Provider	3,561	1,872	52.6	243	6.8
Dental Service Provider	137	122	89.1	41	29.9
Mental Health Provider	176	69	39.2	4	2.3
SUD Provider	3	3	100.0	0	0.0
Certified or Qualified Health Care Interpreters	0	0	0.0	0	0.0
Traditional Health Workers	0	0	0.0	0	0.0
Alcohol/Drug	0	0	0.0	0	0.0
Health Education, Health Promotion, Health Literacy	0	0	0.0	0	0.0
Palliative Care	7	0	0.0	0	0.0
TOTAL	**6,347**	**3,211**	**50.6**	**483**	**7.6**

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

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

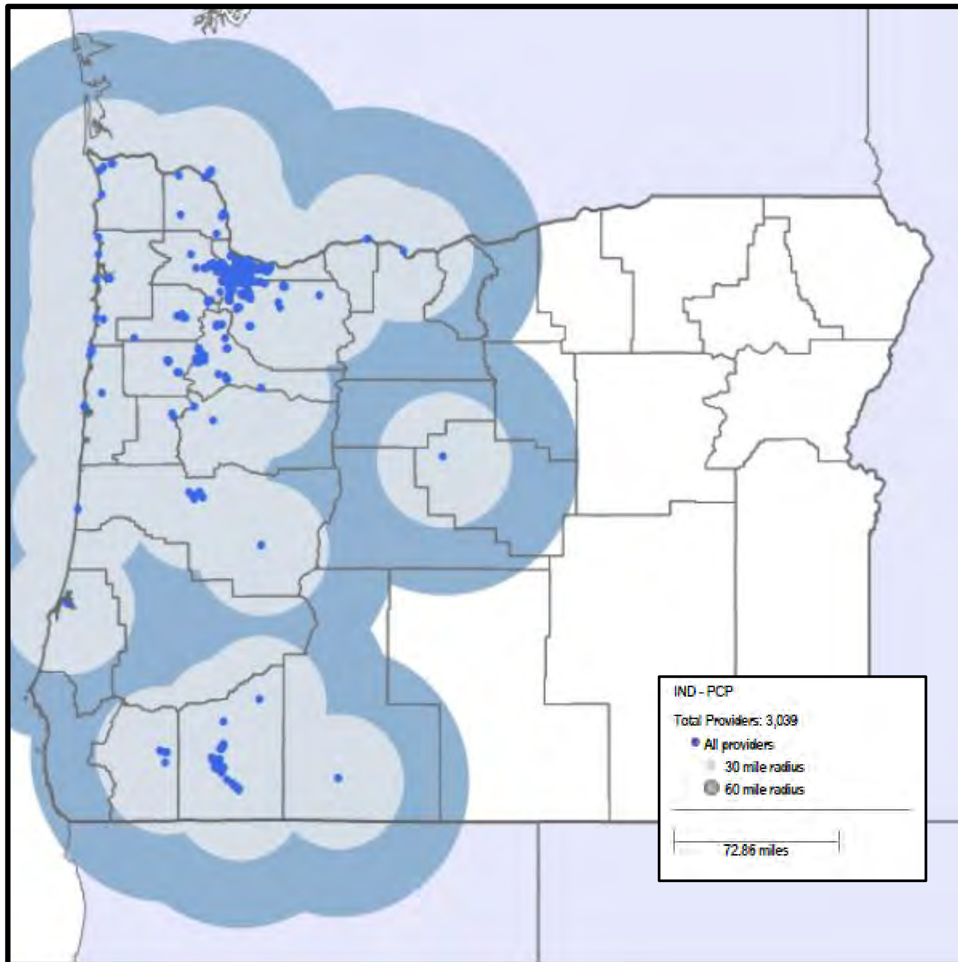
[2] Specialty Category designations specifying *adult* and *pediatric* providers were combined and deduplicated by NPI to preventing counting providers within a specialty category more than once.

Overall, only 50.6 percent of JCC’s provider network was accepting new patients across all provider specialty categories, including core specialties. Of particular interest, two core specialty categories indicated that 50 percent or fewer providers were accepting new patients (i.e., PCPs and mental health providers) with only 52.9 percent of specialty providers accepting new patients. Of its individual practitioners, only 7.6 percent noted speaking a language other than English with primary care providers, specialty providers, and mental health service providers reporting 7.9 percent, 6.8 percent, and 2.3 percent, respectively, speaking a non-English language. Dental service providers were noted with the highest percentage of records indicating they accepted new patients and spoke a non-English language (89.1 percent and 29.9 percent, respectively).

Geographic Distribution

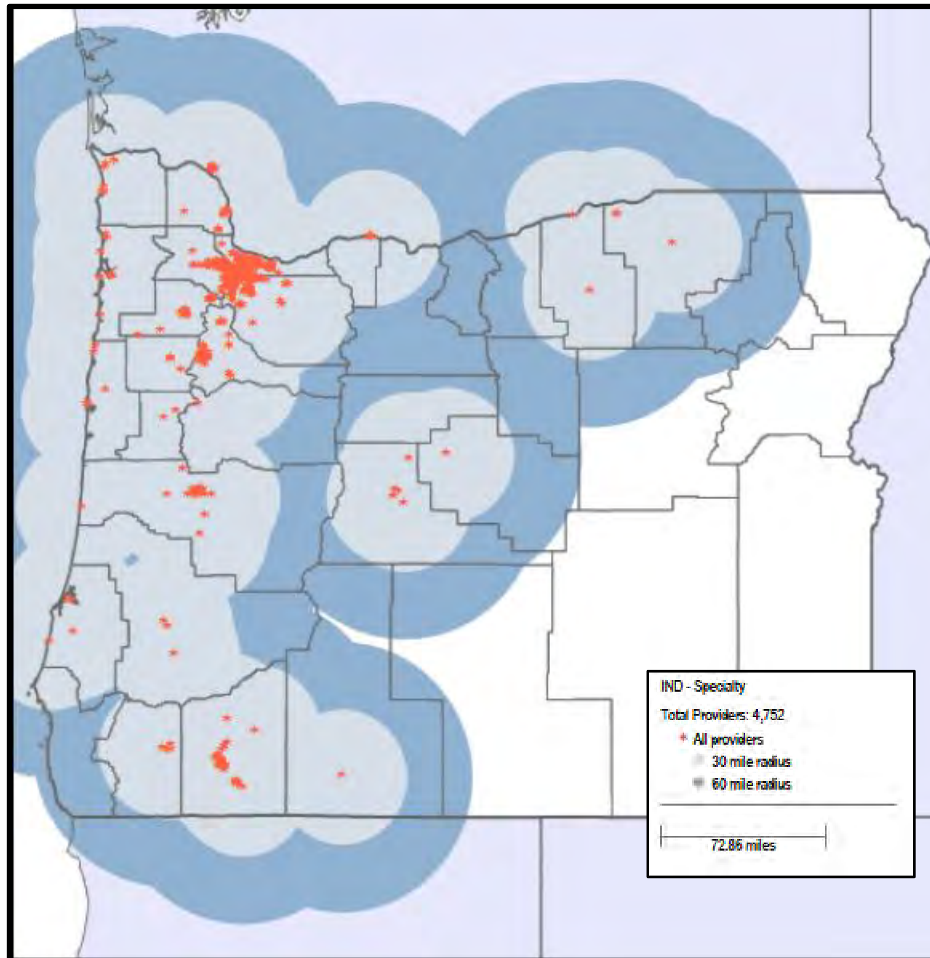
The geographic distribution of providers relative to member populations assessed whether or not the practitioner and facility locations were spread proportionately across the beneficiary population. Since beneficiary data was not available at the time of this analysis, the geospatial maps display the 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. Most of the zip codes within JCC's service area (i.e., Jackson County) are classified as rural except for areas associated with Medford and Phoenix/Talent, Oregon.

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



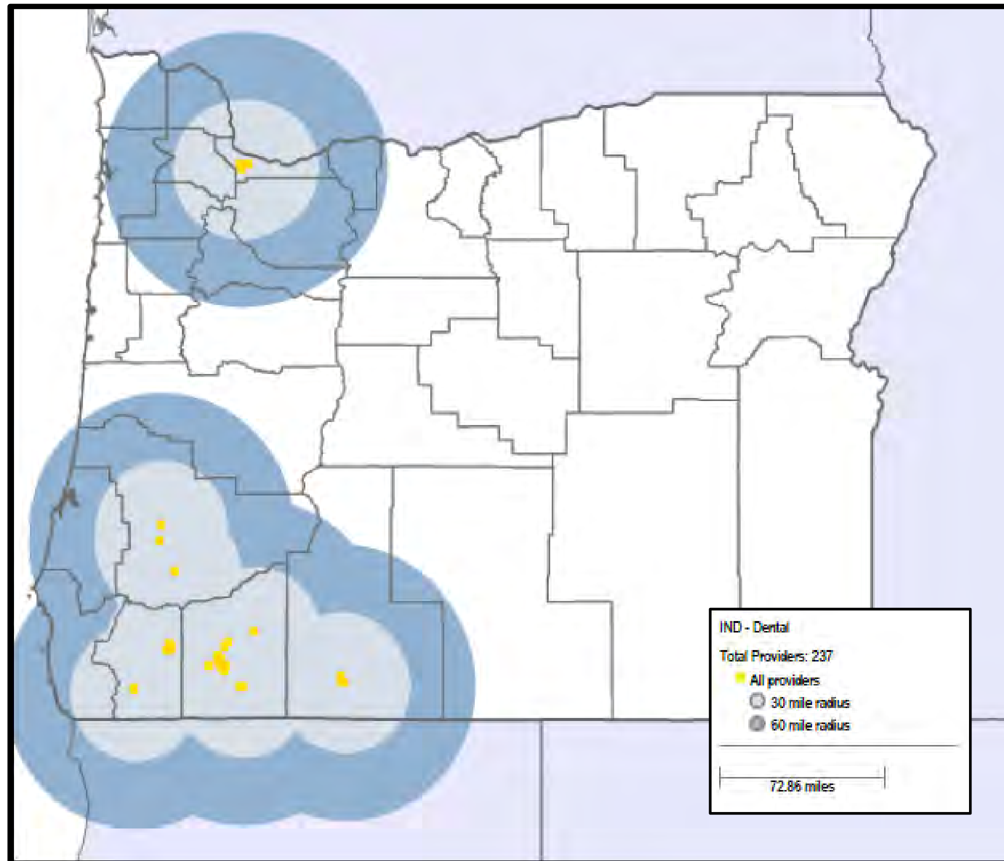
As shown in Figure B-1, the distribution of JCC's network of PCPs is sufficient to cover the CCO's service area. All regions of the service area are within 30 miles of a primary care provider.

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



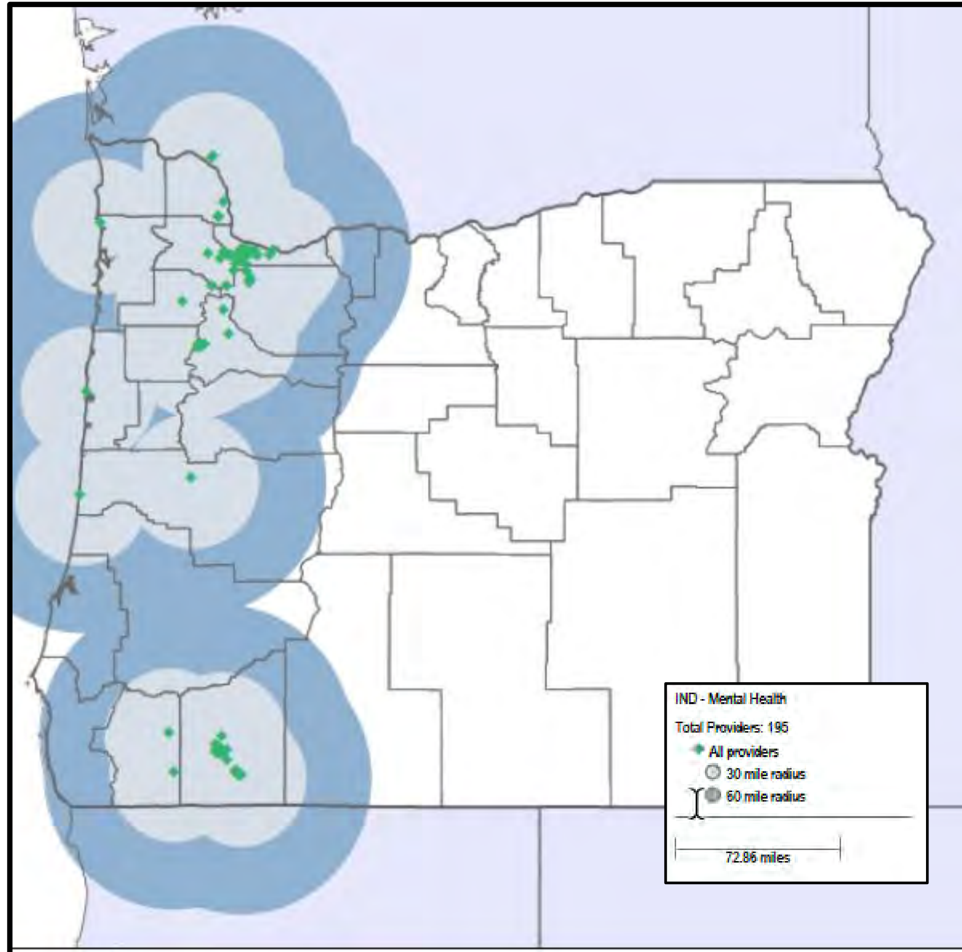
As shown in Figure B-2, the distribution of JCC's specialty providers is sufficient to cover the CCO's service area. Most of the regions within its service area are within 30 miles of a specialty provider with the exception of some rural areas which are within 60 miles of the nearest specialty provider.

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



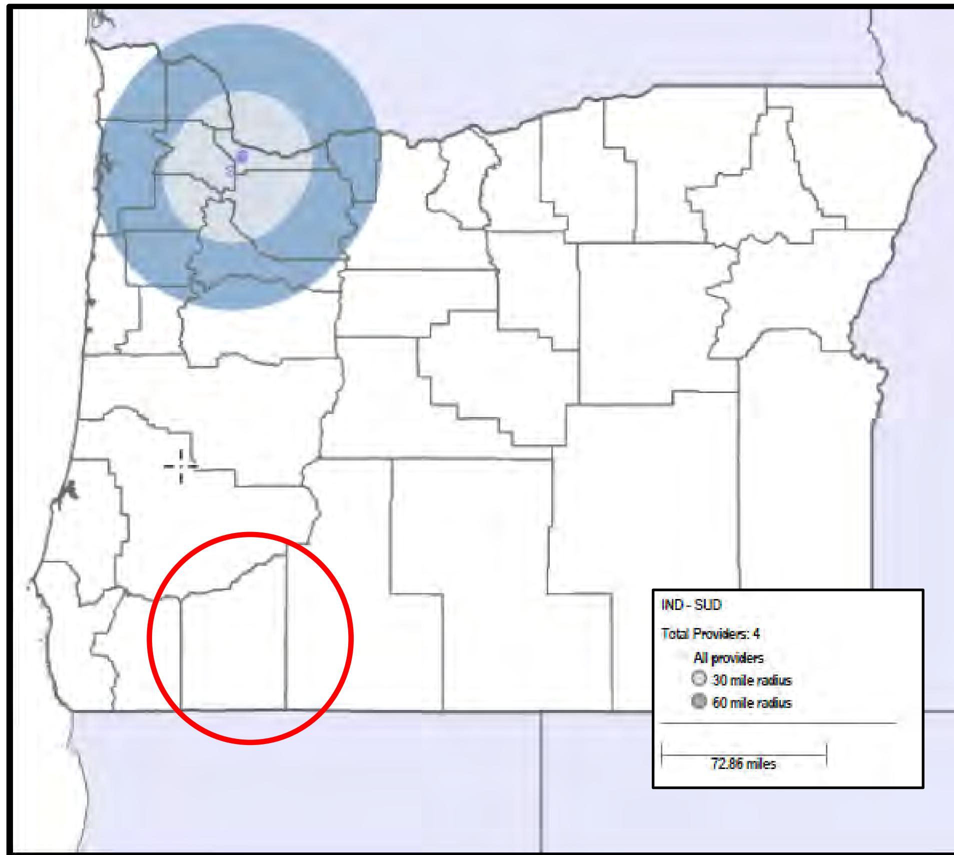
As shown in Figure B-3, the distribution of JCC's dental service providers is sufficient to cover the CCO's service area. Most of the regions within its service area are within 30 miles of a dental provider with the exception of some rural areas which are within 60 miles of the nearest dental provider.

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



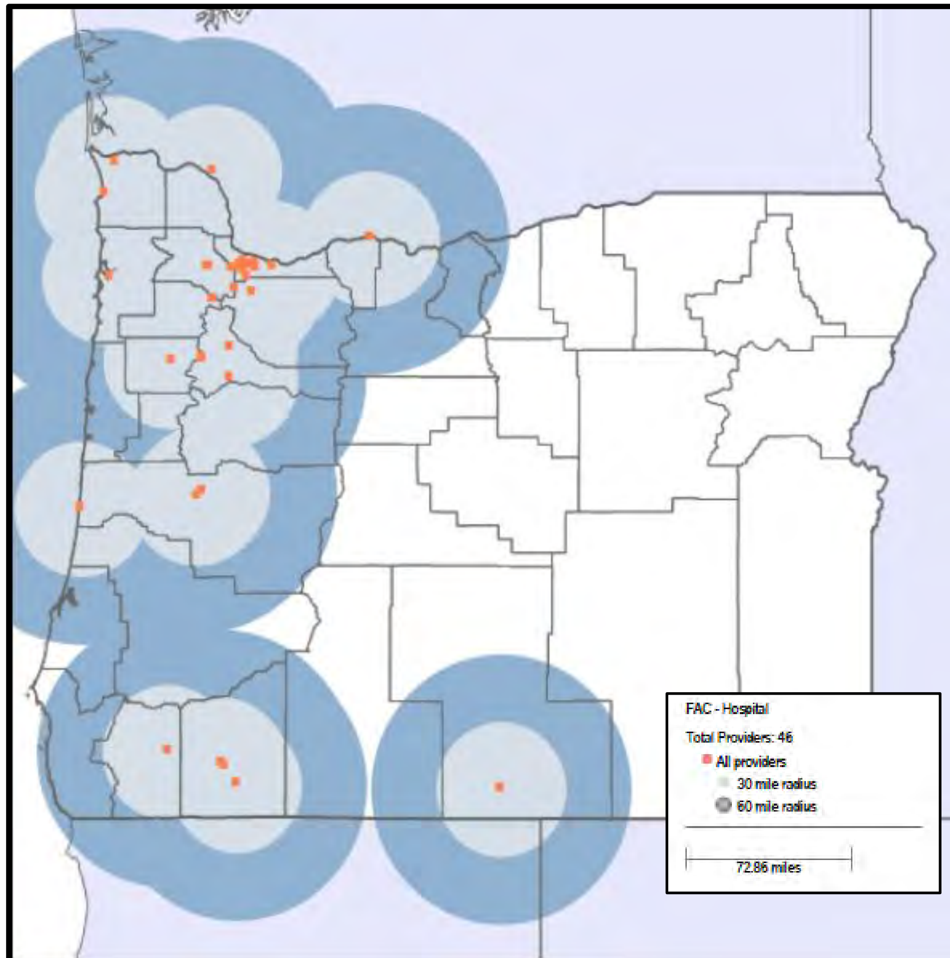
As shown in Figure B-4, the distribution of JCC's mental health providers is sufficient to cover the CCO's service area. Most of the regions within its service area are within 30 miles of a mental health provider with the exception of some rural areas which are within 60 miles of the nearest mental health provider.

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



As shown in Figure B-5, the distribution of JCC's contracted SUD providers are not located within the CCO's service area. As such, none of JCC's members are within 30 or 60 miles of the nearest SUD provider.

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



As shown in Figure B-6, the distribution of JCC's hospital facilities is sufficient to cover the CCO's service area. Most of the regions within its service area are within 30 miles of a hospital with the exception of some rural areas which are within 60 miles of the nearest hospital.

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

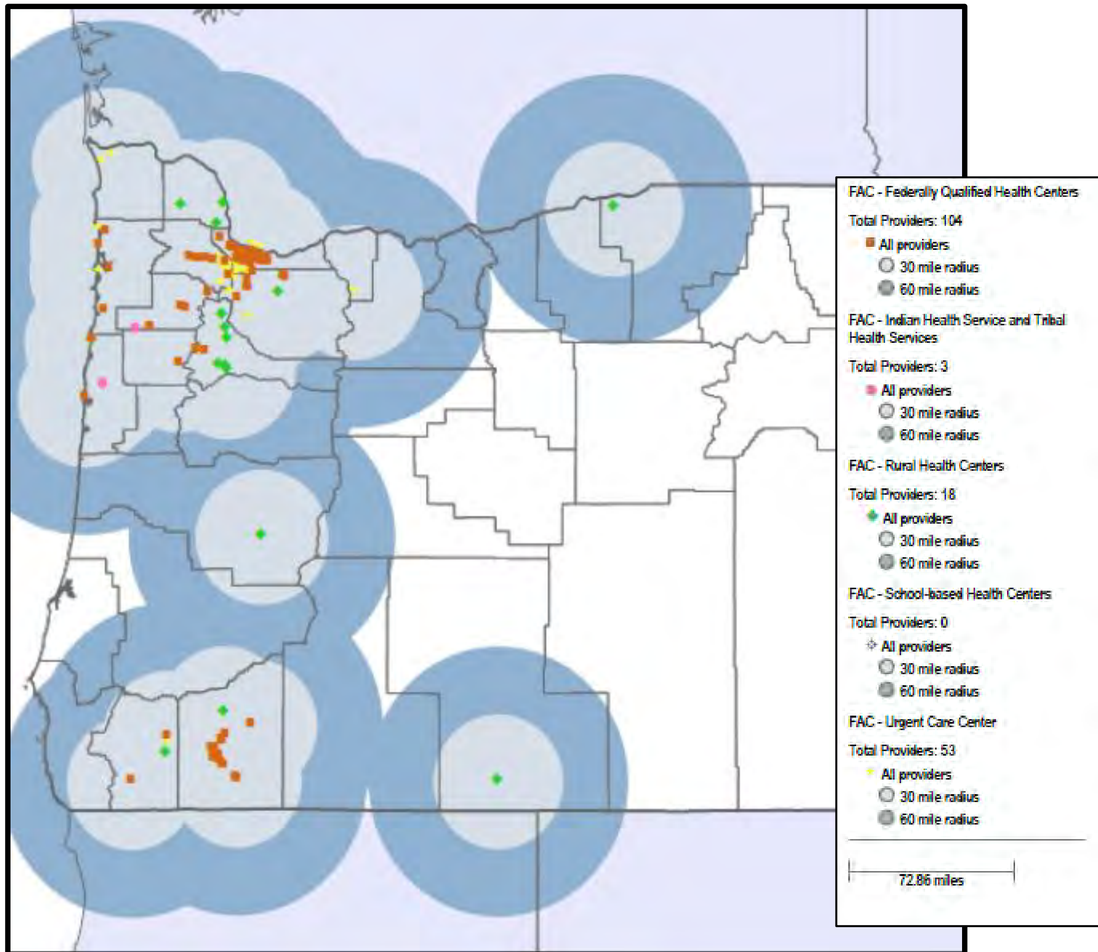

Figure B-7 displays the distribution of several clinic-based facilities within JCC's service areas, including FQHCs, Indian Health Services and Tribal Health Services, Rural Health Centers, School-Based Health Centers, and Urgent Care Centers. The map shows that the distribution of clinic-based facilities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

Appendix C. Phase 2 Evaluation Tool

[Pending completion of the Phase 2 RR]