

In some areas the patterns of care may be such that members seek care in an adjoining county. Therefore, Applicants may choose to cover those contiguous zip codes, contiguous zip codes must be noted as such in order to be considered. The Applicant shall receive rates for each county, which shall include contiguous zip codes in an adjoining county. If a prospective Applicant has no provider panels, the Applicant must submit information that supports their ability to provide coverage for those CCO Members in the service area(s) they are applying. In determining service area(s) applicants must consider the allowable driving distance and time to Primary Care Physicians (PCP).

Section 2 - Standards Related To Provider Participation

Standard #1 - Provision of Coordinated Care Services

THE APPLICANT HAS THE ABILITY TO DELIVER OR ARRANGE FOR ALL THE COORDINATED CARE SERVICES THAT ARE MEDICALLY NECESSARY AND REIMBURSABLE.

In the context of the Applicant's community needs assessment and approach for providing integrated and coordinated care, to assess whether the Applicant has the ability to deliver services, the delivery system network data must be submitted and evaluated.

Based upon the Applicant's community needs assessment and plan for delivery of integrated and coordinated health, mental health, and chemical dependency treatment services and supports (and dental services if the Applicant has a contract with a Dental Care Organization), describe Applicant's comprehensive and integrated care management network and delivery system network serving Medicaid and dually eligible members for the following categories of services or types of service providers that has agreed to provide those services or items to members, whether employed by the Applicant or under subcontract with the Applicant.

- Acute inpatient hospital psychiatric care
- Addiction treatment
- Ambulance and emergency medical transportation
- Chemical dependency treatment providers
- Community health workers
- Community prevention services
- Federally qualified health centers
- Health Care Interpreters (qualified/certified)
- Health education, health promotion, health literacy
- Home health
- Hospice
- Hospital
- Imaging
- Mental health providers
- Navigators
- Oral health providers
- Palliative care
- Patient centered primary care homes
- Peer specialists
- Pharmacies and durable medical providers
- Rural health centers
- School-based health centers
- Specialty physicians
- Non-emergency medical transportation

- Tribal health services
- Urgent care center
- Others not listed but included in the Applicant’s integrated and coordinated service delivery network.

INSTRUCTIONS: Submit the following information about each provider or facility using the following format in Excel for each category of service provider or facility listed above. For example, all Addition Treatment providers should be listed together; all Ambulance and emergency medical transportation providers should be listed together.

The categories of community health workers, peer wellness specialist, and navigators may not be suitable for the following format. It is acceptable for Applicant to describe how Applicant proposes to develop and maintain its work force for the provision of these services, their training and supervision, and their integration into the Applicant’s integrated and coordinated care delivery system.

PARTICIPATING PROVIDER TABLE
Required Data Elements

LINE	VARIABLE NAME	TYPE	SIZE	SPECIAL INSTRUCTIONS
1	CONTRACTOR NAME	A	50	The name of the Contractor that this Provider Capacity Report pertains to and is submitted by.
2	LAST NAME	A	50	Last name of the Provider. If the Provider has practices in multiple areas, complete a record line for each practice location.
3	FIRST NAME	A	25	First name of the Provider.
4	BUSINESS/PRACTICE ADDRESS	A/N	50	Address of the Provider’s practice, including suite number. If the Provider does not have a practice address, list the business address. (i.e. lab/ diagnostic companies)
5	BUSINESS/PRACTICE CITY	A	20	City where the Provider’s business is located.
6	BUSINESS/PRACTICE ZIP CODE	N	10	Formatted zip code - (9999) four digit code (i.e. 97214-1014)
7	BUSINESS COUNTY	A	15	The county in which the Provider’s business is located.
8	PROVIDER TYPE	N	5	Provider Type Codes provided in the below table.
9	SPECIALTY	A/N	15	Provider Type Codes provided in the below table.
11	NPI	A/N	13	The Provider’s National Provider Identification number (NPI).
12	PRIMARY CARE PROVIDER (PCP) IDENTIFIER	A	1	Y = This Provider is a PCPCH. N = This Provider is not a PCPCH.
13	# MEMBERS ASSIGNED	N	4	Number of current MCO or current OHA contractor’s enrollees currently assigned to this PCP or clinic.
14	# OF ADDITIONAL MEMBERS THAT CAN BE ASSIGNED TO PCP	N	5	Estimated number of additional members PCP will accept. If #12 = N, answer “0”

LINE	VARIABLE NAME	TYPE	SIZE	SPECIAL INSTRUCTIONS
15	CREDENTIAL VERIFICATION	N	8	Date Applicant verified or certified Provider's credentials (mm/dd/yy) as required in OAR 410-161-0120(1)(a).
16	SANCTION HISTORY	A/N	50	Brief description of any sanctions, fines or disciplinary actions that are currently active from the appropriate licensing board(s), OHA including OHA, AMH, and APD, OHA audit unit, Oregon Medicaid Fraud Unit, Oregon Secretary of State, Oregon Insurance Division, Oregon Department of Justice, U.S. Attorney or Department of Justice, CMS, or DHHS Office of Inspector General. If this is not applicable, answer "not applicable".
17	CONTRACT START DATE	N	25	mm/dd/yy
18	CONTRACT END DATE	N	25	mm/dd/yy. If contract is open-ended, answer 99/99/99 for end date.

Provider Type Codes			
Provider Type		Provider Specialty	
01	Transportation Provider	001	Air Ambulance
01	Transportation Provider	025	Ambulance
01	Transportation Provider	500	Taxi
01	Transportation Provider	540	Common Carrier
02	Acupuncturist	003	Acupuncturist
03	Alcohol/Drug	005	A&D Acupuncture Clinic
03	Alcohol/Drug	011	Addiction Medicine - Family Practice
03	Alcohol/Drug	012	Addiction Medicine - Internal Medicine
03	Alcohol/Drug	013	Addiction Medicine - Neurology
03	Alcohol/Drug	014	Addiction Medicine - Psychiatry
03	Alcohol/Drug	015	Opioid Treatment Program
03	Alcohol/Drug	016	A&D Outpatient Treatment Program
03	Alcohol/Drug	017	A&D Residential Treatment
03	Alcohol/Drug	018	A&D Residential Treatment Program - Rehab
03	Alcohol/Drug	019	A&D Residential Treatment Program - Children
05	Ambulatory Surgical Provider	030	Ambulatory Surgical Center (ASC)
06	Behavioral Rehab Specialist	035	Behavioral Rehab Specialist
07	Billing Service	040	Billing Service
08	Freestanding Birthing Center	045	Free Standing Birthing Center
09	Billing Provider	051	Medical Clinic
09	Billing Provider	052	Nurse Practitioner Clinic
09	Billing Provider	053	Dental Clinic
09	Billing Provider	054	Therapy Clinic
09	Billing Provider	055	Pediatric Clinic
09	Billing Provider	056	Tuberculosis Clinic
09	Billing Provider	057	Speech/Hearing Clinic
10	Transportation Broker	065	Transportation Broker

Provider Type Codes			
Provider Type		Provider Specialty	
11	Capitated Provider	070	Capitated Provider (CDO)
11	Capitated Provider	071	Capitated Provider (DCO)
11	Capitated Provider	072	Capitated Provider (MHO)
11	Capitated Provider	073	Capitated Provider (PCO)
12	Copy Services	075	Copy Services
13	Cost Based Clinic	080	Cost Based Clinic
14	Rural Health Clinic	085	Rural Health - Clinic/Center
14	Rural Health Clinic	086	Rural Health - Community Hlth
14	Rural Health Clinic	087	Rural Health - Dental Clinic
14	Rural Health Clinic	088	Rural Health - Public Health, Federal
14	Rural Health Clinic	089	Rural Health - Public Health, State or Local
14	Rural Health Clinic	090	Rural Health - Primary Care
14	Rural Health Clinic	095	Rural Health
15	FQHC	020	FQHC - Rehabilitation, Substance Use Disorder
15	FQHC	081	FQHC -Community Health
15	FQHC	082	FQHC - Dental Clinic
15	FQHC	083	FQHC - Public Health, Fed
15	FQHC	084	FQHC - Public Health, State or Local
15	FQHC	091	(No Suggestions) - Primary Care
15	FQHC	096	FQHC - Clinic/Center
15	FQHC	097	Federal Qualified Health Cntr (FQHC)
15	FQHC	098	FQHC - Mental Health
15	FQHC	099	FQHC - Adolescent & Children Mental Health
15	FQHC	100	FQHC - Migrant Health
15	FQHC	101	FQHC School Based
16	Chiropractor	105	Chiropractor
17	Dentist	110	Dental Clinic
17	Dentist	111	Endodontist
17	Dentist	112	Gen. Dentistry Practitioner
17	Dentist	113	Orthodontist
17	Dentist	114	Oral Pathologist
17	Dentist	115	Oral Surgeon
17	Dentist	116	Prosthesis
17	Dentist	117	Periodontist
17	Dentist	118	Pediatric Dentist
18	Dental Hygienist (LAP)	125	Dental Hygienist (LAP)
19	Podiatrist	130	Podiatrist
20	Denturist	135	Denturist
21	Enteral / Parenteral	140	Enteral / Parenteral
22	Family Planning Clinic	145	Family Planning Clinic
23	Hearing Aid Dealer	150	Hearing Aid Dealer
24	Home Health Agency	155	Home Health Agency
25	Managed Care	160	Managed Care Org (MCO)
26	Hospital	165	Acute Care
26	Hospital	166	Critical Access
26	Hospital	167	Hospital Based Clinic
26	Hospital	168	Hospital Based Rural Health Clinic

Provider Type Codes			
Provider Type		Provider Specialty	
26	Hospital	208	Hospital Psychiatric Unit
27	Hospice	175	Hospice
28	Indian Health Clinics	185	Indian Health Services
28	Indian Health Clinics	186	Indian Health Urban Clinic
28	Indian Health Clinics	187	Indian Health FQHC / MOA
29	Independent Labs	190	Independent Lab
29	Independent Labs	191	Mobile Lab
31	Transportation Broker	195	Secured Medical Transport (VAN)
32	End-Stage Renal Disease (RSD) Clinic	200	Free-standing Renal Dialysis Clinic
33	MH Provider	92	Community Mental Health Clinic
33	MH Provider	93	Community MH Center, Adolescent / Children
33	MH Provider	205	Licensed Clinical Psychologist
33	MH Provider	206	Licensed Clinical Social Wkr
33	MH Provider	207	Community Mental Health Center, Adult
33	MH Provider	209	Outpatient Mental Hlth Clinic
33	MH Provider	209	Psychologist
33	MH Provider	211	MH Respite Care, Child
33	MH Provider	212	MH Secure Transport
33	MH Provider	225	Child & Adolescent Psychiatry
33	MH Provider	226	Geriatric Psychiatry
33	MH Provider	227	Psychiatrist
33	MH Provider	365	Psychiatric Mental Health Nurse Practitioner
33	MH Provider	445	Adult Residential Treatment Facility / Home
33	MH Provider	450	MH Adult Foster Home
33	MH Provider	470	Psychiatric Res Treatment Svcs, Child / Adolescent
33	MH Provider	471	MH Community Based Respite Care
34	Physician	115	Oral Surgeon
34	Physician	220	Allergist
34	Physician	221	Abdominal Surgery
34	Physician	222	Adolescent Medicine
34	Physician	223	Allergy & Immunology
34	Physician	224	Aviation Medicine
34	Physician	228	Anesthesiologist
34	Physician	229	Otologist Laryngologist
34	Physician	230	Blood Banking
34	Physician	231	Billing Service
34	Physician	232	Cardiologist
34	Physician	233	Congregate Care Physician
34	Physician	234	Cardiovascular Diseases
34	Physician	235	Broncho-Esophagology
34	Physician	236	Child Neurology
34	Physician	237	Critical Care Medicine
34	Physician	238	Clinic
34	Physician	239	Clinical Pathology
34	Physician	240	Colon & Rectal Surgery

Provider Type Codes			
Provider Type		Provider Specialty	
34	Physician	241	Cardiovascular Surgery
34	Physician	242	Dermatologist
34	Physician	243	Diabetes
34	Physician	244	Osteopathic Physician
34	Physician	245	Dermatopathology
34	Physician	246	Diagnosis Radiology
34	Physician	247	Emergency Med Practitioner
34	Physician	248	Forensic Pathology
34	Physician	249	Family Practitioner
34	Physician	250	Gastroenterologist
34	Physician	251	Geriatric Practitioner
34	Physician	252	General Practitioner
34	Physician	253	Gynecology
34	Physician	254	Hospital Administration
34	Physician	255	Hematology
34	Physician	256	Head & Neck Surgery
34	Physician	257	Hand Surgeon
34	Physician	258	Mobile Med Care (HS CALL)
34	Physician	259	Hypnosis
34	Physician	260	Infectious Diseases
34	Physician	261	Immunology
34	Physician	262	Internist
34	Physician	263	Industrial Medicine
34	Physician	264	Legal Medicine
34	Physician	265	Maxillofacial Surgery
34	Physician	266	Neuropathology
34	Physician	267	Neoplastic Diseases
34	Physician	268	Neurologist
34	Physician	269	Nephrologist
34	Physician	270	Nuclear Medicine
34	Physician	271	Nuclear Radiology
34	Physician	272	Neurological Surgeon
34	Physician	273	Nutritionist
34	Physician	274	Ophthalmology
34	Physician	275	Obstetrics
34	Physician	276	Obstetrics & Gynecology
34	Physician	277	Occupational Medicine
34	Physician	278	Oncologist
34	Physician	279	Orthopedic Surgeon
34	Physician	280	Otologist, Laryngologist, Rhinologist
34	Physician	281	Otologist, Laryngologist
34	Physician	282	Pathologist
34	Physician	283	Pediatrics
34	Physician	284	Pediatric Allergy
34	Physician	285	Pediatric Cardiology
34	Physician	286	Public Health
34	Physician	287	Pediatric Endocrinology

Provider Type Codes			
Provider Type		Provider Specialty	
34	Physician	288	Pediatric Radiology
34	Physician	289	Pediatric Surgery
34	Physician	290	Plastic Surgeon
34	Physician	291	Physical Medicine and Rehabilitation Practitioner
34	Physician	292	Pediatric Hematology-Oncology
34	Physician	293	Pediatric Nephrology
34	Physician	294	Pediatric Urology
34	Physician	295	Pulmonary Disease Specialist
34	Physician	296	Preventive Medicine
34	Physician	297	Psychosomatic Medicine
34	Physician	298	Pharmacology
34	Physician	299	Rheumatology
34	Physician	300	General Surgeon
34	Physician	301	Therapeutic Radiology
34	Physician	302	Traumatic Surgery
34	Physician	303	UOHSC Practitioner
34	Physician	304	Urologist
34	Physician	305	Rhinology
34	Physician	306	Thoracic Surgeon
34	Physician	307	Endocrinologist
34	Physician	308	Proctologist
34	Physician	309	Radioisotopic Pathology
34	Physician	310	Oregon State Hospital
36	DME/Medical Supply Dealer	315	DME/Medical Supply Dealer
36	DME/Medical Supply Dealer	316	Enteral / Parenteral Nutrition
36	DME/Medical Supply Dealer	317	Assistive Technology
36	DME/Medical Supply Dealer	318	Prosthesis
36	DME/Medical Supply Dealer	327	Oxygen Supplies
36	DME/Medical Supply Dealer	325	Nutritionist
37	Advance Practice Nurse	330	Certified Registered Nurse Anesthetist (CRNA)
38	Adv Comp Health care	335	Naturopath
39	Submitter	340	SPD Web Submitter
39	Submitter	341	Billing Service
39	Submitter	342	Clearinghouse
39	Submitter	343	Other Billing Entity
41	Midwife	355	Maternity
42	Advance Practice Nurse	360	Advance Practice Nurse
42	Advance Practice Nurse	361	Nurse Practitioner Clinic
42	Advance Practice Nurse	362	Pediatric Nurse Practitioner
42	Advance Practice Nurse	363	Obstetric Nurse Practitioner
42	Advance Practice Nurse	364	Family Nurse Practitioner
42	Advance Practice Nurse	366	Nurse Practitioner (other)
42	Advance Practice Nurse	367	Certified Nurse Midwife
43	Optometrist	380	Optometrist
44	Optician	385	Optician
44	Optician	386	Vision Contractor
45	Therapist	390	Occupational Therapist

Provider Type Codes			
Provider Type		Provider Specialty	
45	Therapist	420	Physical Therapist
45	Therapist	485	Speech / Language Pathologist
45	Therapist	486	Audio / Speech
45	Therapist	487	Audiologist
45	Therapist	488	Speech / Hearing Therapist
45	Therapist	550	Respiratory
45	Therapist	795	SPD - Occupational Therapist
45	Therapist	805	SPD - Physical Therapist
45	Therapist	885	SPD - Speech . Hearing
45	Therapist	886	Audiologist
45	Therapist	901	SPD - Respiratory
46	Physician Assistants	395	Physician Assistants
47	Clinic	79	Public Clinic
48	Pharmacy	400	Pharmacy
48	Pharmacy	401	Critical Access
48	Pharmacy	402	Nursing Facility
48	Pharmacy	403	Senior Drug Pharmacy
48	Pharmacy	404	Indian Hlth Svc / Tribal / Urban Indian Hlth Pharmacy
48	Pharmacy	405	Mail Order Pharmacy
48	Pharmacy	406	Specialty Pharmacy
48	Pharmacy	407	Home Infusion Therapy Pharmacy
49	Prenatal Clinic	415	Prenatal Clinic
52	X-Ray Clinic	430	Mobile X-ray Clinic
53	Psychologist Provider	435	Psychologist Admin Eval
56	Nurse	455	Registered Nurse (RN)
56	Nurse	456	Registered Nurse Clinical (RNC)
56	Nurse	457	Enteral / Parenteral
56	Nurse	458	Licensed Practical Nurse
57	RN 1st Assistant	465	RN 1st Assistant
58	Registered Dietician	326	Registered Dietician
58	Registered Dietician	865	SPD Registered Dietician
60	Smoking Cessation	480	Smoking Cessation
62	Education Agency	495	Education Agency
64	Targeted Case Mngt	505	Case Manager / care
64	Targeted Case Mngt	506	Child Welfare Targeted Case Management
64	Targeted Case Mngt	507	Target Case Management - In Home
64	Targeted Case Mngt	508	HIV Case Manager
64	Targeted Case Mngt	509	TCM 1st Time Mothers / Infants
64	Targeted Case Mngt	510	Target Case Management - Jobs - Teens
64	Targeted Case Mngt	511	Target Case Management - Jobs - Adults
64	Targeted Case Mngt	512	Target Case Management - A&D
64	Targeted Case Mngt	513	High Risk Pregnant Women
64	Targeted Case Mngt	514	Care Coordinator for Pregnant Women
64	Targeted Case Mngt	515	E.I Case Mnmt
64	Targeted Case Mngt	516	OJA Targeted Case
64	Targeted Case Mngt	517	DDSD / ICFMR Waiver

Provider Type Codes			
Provider Type		Provider Specialty	
65	Translator	525	AMH - Translator Service
65	Translator	526	DMAP - Translator Services
65	Translator	895	SPD - Translator Services
66	Urban Clinic	530	Urban Clinic
69	Social Worker	545	Social Worker
69	Social Worker	900	SPD Social Worker
70	Foster Care	700	Adult APD
70	Foster Care	701	Adult DD
70	Foster Care	702	Adult APD Relative
71	Child Foster Care	703	Child DCR
71	Child Foster Care	704	Child DCW
71	Child Foster Care	705	Child Welfare DCR
71	Child Foster Care	706	Child Welfare DCW
72	SPD Transportation	715	SPD Transportation Broker
72	SPD Transportation	716	SPD Service Transportation Waiver
72	SPD Transportation	717	SPD Service Transportation Contract
72	SPD Transportation	718	SPD Client Service Brokerage
73	Home Care Worker	737	Home Care Worker
73	Home Care Worker	743	Personal Care Attendant DDMH
74	Client Support Services	725	Adult Day Services APD
74	Client Support Services	726	In Home Personal Care Attendant DDMH
74	Client Support Services	727	In home Personal Care Attendant MFCU
74	Client Support Services	728	Home Delivered Meals
74	Client Support Services	729	Chore
74	Client Support Services	730	Companion
74	Client Support Services	731	Homemaker
74	Client Support Services	732	Emergency Response (Lifeline)
74	Client Support Services	733	In Home Care Agency
74	Client Support Services	734	In Home Attendant
74	Client Support Services	735	Supported Employment
74	Client Support Services	736	Misc items & supplies retail provider
74	Client Support Services	738	Employment & Inclusion Services
74	Client Support Services	739	Financial Assistance / Counseling (not children)
74	Client Support Services	740	Misc Waivered Services
74	Client Support Services	741	Specialized Supplies
74	Client Support Services	742	Specialized equipment
75	Case Management	750	SPD - Case Management
75	Case Management	751	SPD DD - other
76	County Services	755	SPD County Services
77	Adaptive Modification	760	Home Modification
77	Adaptive Modification	761	Vehicle Modification
78	Habilitation	765	Habilitation
79	PACE	770	PACE All Inclusive
80	Intermediate Care Facility / Mental Retardation	775	ICF - MR
81	Nsg Facility	350	Nursing Facility / First 20 Days
81	Nsg Facility	780	Nursing Facility / 21 + days

Provider Type Codes			
Provider Type		Provider Specialty	
81	Nsg Facility	781	Nsg Facility Pediatric
81	Nsg Facility	782	Nsg Facility - out of state
81	Nsg Facility	783	Nsg Facility Swing - Hospital
81	Nsg Facility	784	Nsg Facility Swing - LTCF
81	Nsg Facility	785	Nsg Facility Extended
81	Nsg Facility	786	Nsg Facility Other
82	SPD Nutritionist	790	SPD Nutritionist
83	Behavioral Consultant	710	Behavioral Consultant
84	Personal Assistant	800	Behavioral
84	Personal Assistant	801	Mental Retardation & Developmental Disabilities
84	Personal Assistant	802	Adult Development & Aging
86	SPD Nursing Services	810	Contract RNs
86	SPD Nursing Services	813	Contract NPs
86	SPD Nursing Services	811	Delegating Nsg (MFCU) RN
86	SPD Nursing Services	814	Delegating Nsg (MFCU) NP
86	SPD Nursing Services	812	Shift Nurse RN
86	SPD Nursing Services	815	Shift Nurse LPN
88	Nursing Agency	720	Private Duty Nsg Agency
89	DD Living Facilities	707	Adult Proctor
89	DD Living Facilities	820	Child Proctor
89	DD Living Facilities	825	Residential Care DD Adult
89	DD Living Facilities	826	Residential Care DD Child
89	DD Living Facilities	827	24 -Group Beds
89	DD Living Facilities	835	Supported Living DD
89	DD Living Facilities	836	SOCP
89	DD Living Facilities	837	Respite Services
90	APD Living Residential	840	Residential Care APD
90	APD Living Residential	845	Assisted Living Facility APD
91	APD Living Settings	850	Specialized Living Services
91	APD Living Settings	855	Specialized Living - HUD
91	APD Living Settings	860	APD
97	Enhanced Service	870	Nsg Facility Enhanced - MH
97	Enhanced Service	874	Alzheimer Nsg Facility
97	Enhanced Service	871	Mental Health Residential Facility
97	Enhanced Service	872	Mental Health Outreach Service
97	Enhanced Service	873	Nsg Facility Specific Needs Contract
97	Enhanced Service	875	Alzheimer ALF
97	Enhanced Service	876	Alzheimer Facility

ADDITIONAL QUESTIONS ABOUT SPECIFIED INTEGRATED CARE SYSTEM COMPONENTS

Standard #2 – Providers for Members with Special Health Care Needs

In the context of the Applicant’s community needs assessment and approach for providing integrated and coordinated care, Applicant shall ensure those members who have special health care needs such as those who are aged, blind, disabled, or who have high health care needs, multiple chronic conditions, mental illness or chemical dependency or who are children/youths placed in a substitute care setting by Children, Adults and

Families (CAF) and the Oregon Youth Authority (OYA) (or children receiving adoption assistance from CAF) have access to primary care and referral providers with expertise to treat the full range of medical, mental health and chemical dependency conditions experienced by these members. If the Applicant is contracting with a Dental Care Organization, include the dental providers who meet this standard.

Required Response

From those providers and facilities identified in the Participating Provider Table or referral provider/facility (Standard #1 Table), identify those providers and specialists that have special skills or sub-specialties necessary to provide a comprehensive array of medical services to the elderly, disabled populations and children/youths in substitute care or members who have high health care needs, multiple chronic conditions, mental illness or chemical dependency. In narrative form, describe their qualifications and sub-specialties to provide coordinated care services to these members.

Standard #3 – Publicly funded public health and community mental health services

Under ORS 414.153, Applicants must execute agreements with publicly funded providers for authorization of and payment for point-of-contact services (i.e. immunizations, sexually transmitted diseases and other communicable diseases) and for cooperation with the local mental health authorities unless cause can be demonstrated that such an agreement is not feasible.

Required Response

Submit the following table in an Excel format, detailing Applicant’s involvement with publicly funded health care and service programs. Include those publicly funded health care and service programs with which you have subcontracts.

Name of publicly funded program	Type of public program (i.e. County Mental Health Department)	County in which program provides service	Specialty/Sub-Specialty Codes

Other formatting conventions that must be followed are: Provider type, specialty and sub-specialty codes will be limited to those outlined in the Participating Provider Table (Standard #1).

- (a) Describe how Applicant has involved publicly funded providers in the development of its integrated and coordinated Application.
- (b) Describe the agreements with counties in the service area that achieve the objectives in ORS 414.153(4), quoted above. If any of those agreements are under negotiation, the Applicant must submit the executed agreement prior to OHA issuing the CCO Contract.

- (c) If Applicant does not have signed agreements with counties, as providers of services or as required by ORS 414.153(4), describe good faith efforts made to obtain such agreements and why such agreements are not feasible.

Standard #4 – Services for the American Indian/Alaska Native Population (AI/AN)

- (a) Please describe your experience and ability to provide culturally relevant coordinated care services for the AI/AN population.

Standard #5 – Indian Health Services (IHS) and Tribal 638 facilities

From among the providers and facilities listed in the Participating Provider Table, please identify any that are Indian Health Service or Tribal 638 facilities.

- (a) Please describe your experience working with Indian Health Services and Tribal 638 facilities.
- Include your referral process when the IHS or Tribal 638 facility is not a participating panel provider.
 - Include your prior authorization process when the referral originates from an IHS or Tribal 638 facility that is not a participating provider.

Standard #6 – Integrated Service Array (ISA) for children and adolescents

- (a) Describe Applicant’s plan to provide the Integrated Service Array, which is a range of service components for children and adolescents, though and including age 17, that target the population with severe mental or emotional disorders whose needs have not been adequately addressed in traditional settings.
- (b) Describe how the Applicant has developed, or is developing, for implementation of an ISA system and other coordinated care services that promotes collaboration, within the laws governing confidentiality, between mental health, child welfare, juvenile justice, education, families and other community partners in the treatment of children with serious emotional, mental health and behavioral challenges.
- (c) Describe how the Applicant’s service delivery approach is family-driven, strength-based, culturally sensitive, and enhances community-based service delivery.

Standard #7 – Chemical Dependency Services

- (a) Describe how the Applicant will provide chemical dependency services to members, including withdrawal management, outpatient treatment services (including medication-assisted therapies) and intensive outpatient treatment services.
- (b) Describe how Applicant will screen all eligible members and use AMH approved screening tools for prevention, early detection, brief intervention and referral to chemical dependency treatment – especially at initial contact or physical exam, initial prenatal exam, when a member shows evidence of chemical dependency or abuse, or when a member overutilizes services.

Standard #8 – Pharmacy Services and Medication Management

- (a) Describe Applicant’s experience and ability to provide a prescription drug benefit as a Covered Service for funded condition/treatment pairs (and for drug classes covered by Medicare Part D for fully dual eligible clients for non-OHP Covered Services).

- (b)** Specifically describe the Applicant's:
- Ability to use a restrictive formulary as long as it allows access to other drug products not on the formulary through some process such as prior authorization.
 - Formulary development that includes FDA approved drug products for each therapeutic class and at least one item in each therapeutic class of over-the-counter medications sufficient to ensure the availability of covered drugs with minimal prior approval intervention by the providers of pharmaceutical services, e.g. pharmacies.
 - Development of clinically appropriate utilization controls.
 - Ability to revise a formulary periodically and the evidence based review processes utilized and whether this work will be contracted out or staffed in-house.
- (c)** Describe Applicant's ability to ensure an adequate pharmacy network to provide sufficient access to all enrollees and how Applicant will communicate formulary choices and changes to the network and other medical professionals and how to make non-formulary, i.e. prior Authorization, requests.
- (d)** Describe Applicant's capacity to process pharmacy claims using a real-time claims adjudication and provider reimbursement system and capture all relevant clinical and historical data elements for claims paid in their entirety by the CCO and when the coordination of benefits is needed to bill Third Party Liability (TPL) when the CCO is the secondary coverage.
- (e)** Describe Applicant's capacity to process pharmacy Prior Authorizations (PA) either with in-house staff or through a Pharmacy Benefits Manager and the hours of operation that prescribers or pharmacies will be able to submit PAs
- (f)** Affirm Applicant's willingness, as demonstrated with policies and procedures, to authorize the provision of a drug requested by the Primary Care Physician (PCP) or referral Provider, if the approved prescriber certifies medical necessity for the drug such as: the formulary's equivalent has been ineffective in the treatment or the formulary's drug causes or is reasonably expected to cause adverse or harmful reactions to the DMAP member and to reimburse providers for dispensing a 72-hour supply of a drug that requires prior authorization in accordance with OAR 410-141-0070.
- (g)** Describe Applicant's contractual arrangements with a PBM, including:
- The contractual discount percentage(s) from Average Wholesale Price (AWP) or the percentage above Wholesale Acquisition Cost (WAC) the Contractor will receive from the PBM including rebate and incentive agreements or other funds received from the PBM by the CCO or any other type of any pricing arrangements between the CCO and PBM not based on a percentage discount from AWP or the percentage above WAC.
 - The dispensing fees associated with each category or type of prescription (for example: generic, brand name).
 - The administrative fee paid to be paid to the PBM by CCO on a quarterly basis including a description of the associated administrative fee for each category or type and a description of the amount and type of any other administrative fees paid to PBM by Contractor.
- (h)** Describe Applicant's ability to engage and utilize 340B enrolled providers and pharmacies as a part of the CCO.
- (i)** Describe Applicant's ability to use Medication Therapy Management (MTM) as part of a Patient Centered Primary Care Home

- (j) Describe Applicant's ability to utilize E-prescribing and its interface with Electronic Medical Records (EMR).
- (k) If Applicant is approved to participate in the CMS Medicare/Medicaid Alignment Demonstration, specifically describe the Applicant's experience in the development of Medicare Part D compliant formularies.
- (l) Describe Applicant's relationship with a Part D plan.
- (m) Describe Applicant's ability to provide a drug benefit for Dual Eligibles, e.g. formulary relationship with a Part D plan etc.

Standard #9 – Hospital Services

- (a) Describe how the Applicant will assure access for members to inpatient and outpatient hospital services addressing timeliness, amount, duration and scope equal to other people within the same service area.
 - Indicate what services, if any, cannot be provided locally and what arrangements have been made to accommodate members who require those services.
 - Describe Applicant's system for monitoring equal access of members to referral inpatient and outpatient hospital services.
- (b) Describe how the Applicant will educate members about how to appropriately access care from Ambulance, Emergency Rooms, and urgent care/walk-in clinics other than their Primary Care home. Specifically, please discuss:
 - What procedures will be used for tracking members' inappropriate use of Ambulance, Emergency Rooms, and urgent care/walk-in clinics, other than their Primary Care home.
 - Procedures for improving appropriate use of Ambulance, Emergency Rooms, and urgent care/walk-in clinics.
- (c) Describe how the Applicant will monitor and adjudicate claims for Provider Preventable Conditions based on Medicare guidelines for the following:
 - Adverse Events;
 - Hospital Acquired Conditions (HACs).
- (d) Describe the Applicant's hospital readmission policy, how it will enforce and monitor this policy.
- (e) Please describe the methodology used to determine outlier payments for inpatient DRG hospitals when they have extremely extended length of stays?

Section 3 - Operational Attestations

This section contains attestations about CCOs operational requirements for contracts and oversight for contractors, subcontractors, and other entities. The intent of the attestations is to ensure services provided by these parties meet contractual obligations, laws, regulations, and OHA instructions. The CCO is held responsible for compliance of its providers and subcontractors with all contractual, legal, regulatory, and operational obligations. Members shall be protected from payment or fees that are the obligation of the CCO.

Complete the table below and submit it electronically with the Application. If Applicant has submitted this information to CMS for purposes of Medicare Advantage application, Applicant may provide a copy of its CMS submission, updated as appropriate to address the Medicaid coordinated care services to be provided under a CCO contract.

RESPOND “YES” OR “NO” TO EACH OF THE FOLLOWING STATEMENTS: PROVIDER CONTRACTS AND AGREEMENTS	YES	NO
1. Applicant agrees to comply with all applicable provider requirements of Medicaid law under 42 CFR Part 438, including provider certification requirements, anti-discrimination requirements, provider participation and consultation requirements, the prohibition on interference with provider advice, limits on provider indemnification, rules governing payments to providers, and limits on physician incentive plans.		
2. Applicant agrees that all provider and supplier contracts or agreements contain the required contract provisions that are described in the CCO Contracts.		
3. Applicant has executed provider, facility, and supplier contracts in place to demonstrate adequate access and availability of covered services throughout the requested service area.		
4. Applicant agrees to have all provider contracts and/or agreements available upon request.		

Note: As part of the application review process, Applicants will need to provide signature pages for physician and provider contracts that the OHA reviewers select based upon the OHA Provider and Facility tables that are a part of the initial application submission.

B.3.1. Contracts for Administrative & Management Services

Complete the table below and submit it electronically with the Application. If Applicant has submitted this information to CMS for purposes of Medicare Advantage application, Applicant may provide a copy of its CMS submission, updated as appropriate to address the Medicaid coordinated care services to be provided under a CCO contract.

RESPOND “YES” OR “NO” TO EACH OF THE FOLLOWING STATEMENTS: CONTRACTS FOR ADMINISTRATIVE MANAGEMENT SERVICES	YES	NO
1. Applicant has contracts with related entities, contractors and subcontractors to perform, implement or operate any aspect of the CCO operations for the CCO contract.		
2. Applicant has administrative/management contract/agreement with a delegated entity to manage/handle all staffing needs with regards to the operation of all or a portion of the CCO program.		
3. Applicant has an administrative/management contract/agreement with a delegated entity to perform all or a portion of the systems		

RESPOND “YES” OR “NO” TO EACH OF THE FOLLOWING STATEMENTS: CONTRACTS FOR ADMINISTRATIVE MANAGEMENT SERVICES	YES	NO
or information technology to operate the CCO program for Applicant.		
4. Applicant has an administrative/management contract/agreement with a delegated entity to perform all or a portion of the claims administration, processing and/or adjudication functions.		
5. Applicant has an administrative/management contract/agreement with a delegated entity to perform all or a portion of the enrollment, disenrollment and membership functions.		
6. [Reserved]		
7. Applicant has an administrative/management contract/agreement with a delegated entity to perform all or a portion of the credentialing functions.		
8. Network-model Applicant has an administrative/management contract/agreement with a delegated entity to perform all or a portion of the utilization operations management.		
9. Network-model Applicant has an administrative/management contract/agreement with a delegated entity to perform all or a portion of the quality improvement operations.		
10. Applicant has an administrative/management contract/agreement with a delegated entity to perform all or a portion of its call center operations.		
11. Applicant has an administrative/management contract/agreement with a delegated entity to perform all or a portion of the financial services.		
12. Applicant has an administrative/management contract/agreement with a delegated entity to delegate all or a portion of other services that are not listed.		
13. Applicant agrees that as it implements, acquires, or upgrades health information technology (HIT) systems, where available, the HIT systems and products will meet standards and implementation specifications adopted under section 3004 of the Public Health Services Act as added by section 13101 of the American Recovery and Reinvestment Act of 2009,P.L. 111-5.		
14. Applicant agrees that all contracts for administrative and management services contain the OHA required contract provisions.		

B.3.2. Coordinated Care Services Management & Delivery

The purpose of the Coordinated Care Service Management and Delivery attestations is to ensure that all Applicants deliver timely and accessible coordinated care services for members. OHA recognizes the importance of ensuring continuity of care and developing policies for medical necessity determinations. Therefore, CCOs will be required to select, evaluate, and credential providers that meet OHA’s standards, in addition, to ensuring the availability of a range of providers necessary to meet the health care needs of CCO members.

Complete the table below and submit it electronically with the Application. If Applicant has submitted this information to CMS for purposes of Medicare Advantage application, Applicant may provide a copy of its CMS submission, updated as appropriate to address the Medicaid coordinated care services to be provided under a CCO contract.

RESPOND “YES” OR “NO” TO EACH OF THE FOLLOWING STATEMENTS: CONTRACTS FOR ADMINISTRATIVE MANAGEMENT SERVICES	YES	NO
<p>1. Applicant agrees to establish, maintain, and monitor the performance of a comprehensive network of providers to assure sufficient access to Medicaid covered services as well as supplemental services offered by the CCO in accordance with written policies, procedures, and standards for participation established by the CCO. Participation status will be revalidated at appropriate intervals as required by OHA regulations and guidelines.</p>		
<p>2. Applicant has executed written agreements with providers (first tier, downstream, or other entity instruments) structured in compliance with OHA regulations and guidelines.</p>		
<p>3. Applicant, through its contracted or deemed participating provider network, along with other specialists outside the network, community resources or social services within the CCO’s service area, agrees to provide ongoing primary care and specialty care as needed and guarantee the continuity of care and the integration of services through:</p> <ul style="list-style-type: none"> a. Prompt, convenient, and appropriate access to covered services by enrollees 24 hours a day, 7 days a week; b. The coordination of the individual care needs of enrollees in accordance with policies and procedures as established by the Applicant; c. Enrollee involvement in decisions regarding treatment, proper education on treatment options, and the coordination of follow-up care; d. Effectively addressing and overcoming barriers to enrollee compliance with prescribed treatments and regimens; and e. Addressing diverse patient populations in a culturally competent manner. 		
<p>4. Applicant agrees to establish policies, procedures, and standards that:</p> <ul style="list-style-type: none"> a. Assure and facilitate the availability, convenient, and timely access to all Medicaid covered services as well as any supplemental services offered by the CCO, b. Ensure access to medically necessary care and the development of medically necessary individualized care plans for enrollees; c. Promptly and efficiently coordinate and facilitate access to 		

RESPOND “YES” OR “NO” TO EACH OF THE FOLLOWING STATEMENTS: CONTRACTS FOR ADMINISTRATIVE MANAGEMENT SERVICES	YES	NO
clinical information by all providers involved in delivering the individualized care plan of the enrollee; d. Communicate and enforce compliance by providers with medical necessity determinations; and e. Do not discriminate against Medicaid enrollees.		
5. Applicant has verified that contracted providers included in the CCO Facility Table are Medicaid certified and the Applicant certifies that it will only contract with Medicaid certified providers in the future. ¶		
6. Applicant agrees to provide all services covered by Medicaid and to comply with OHA coverage determinations. ¶		

The intent of these attestations is to ensure services provided by these parties meet contractual obligations, laws and regulations. The CCO is responsible for compliance of its providers and subcontractors with all contractual, legal, regulatory and operational obligations.

B.3.3. Operations: Business Integrity

Complete the table below and submit it electronically with the Application. If Applicant has submitted this information to CMS for purposes of Medicare Advantage application, Applicant may provide a copy of its CMS submission, updated as appropriate to address the Medicaid coordinated care services to be provided under a CCO contract.

RESPOND “YES” OR “NO” TO EACH OF THE FOLLOWING STATEMENTS: BUSINESS INTEGRITY	YES	NO
1. Applicant, Applicant staff and its affiliated companies, subsidiaries or subcontractors (first tier, downstream, and related entities), and subcontractor staff agree that they are bound by 2 CFR 376 and attest that they are not excluded by the Department of Health and Human Services Office of the Inspector General or by the General Services Administration. Please note that this attestation includes any member of the board of directors, key management or executive staff or major stockholder of the Applicant and its affiliated companies, subsidiaries or subcontractors (first tier, downstream, and related entities).		
2. Applicant attests that the neither the state nor federal government has brought any past or pending investigations, legal actions, administrative actions, or matters subject to arbitration involving the Applicant (and Applicant’s parent corporation if applicable) or its subcontractors, including key management or executive staff, or major shareholders over the past three years on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services.		

Section 4 - Assurances of Compliance with Medicaid Regulations and Requirements

The following Assurances address specific Medicaid regulatory requirements that must be met in order for the Applicant to qualify for certification as a Coordinated Care Organization. For purposes of this section and the federal Medicaid regulations in 42 CFR Part 438, a CCO falls within the definition of a “managed care organization” in 42 CFR 438.2. The format of this section is that of (a) providing a brief narrative of how the Applicant meets the applicable Assurance; and (b) providing the Assurances requested for each requirement. The Applicant must provide supporting materials available to the OHA upon request – which may occur before or after approval.

This section addresses Medicaid required terms and conditions to be qualified as a CCO. These Assurances in this section provide baseline Medicaid assurances for purposes of determining an Applicant’s qualifications.

Assurance #1 - Emergency and Urgent Care Services

THE APPLICANT SHALL HAVE WRITTEN POLICIES AND PROCEDURES AND MONITORING SYSTEMS THAT PROVIDE FOR EMERGENCY AND URGENT SERVICES FOR ALL MEMBERS ON A 24-HOUR, 7-DAYS-A-WEEK BASIS. THE APPLICANT SHALL COMMUNICATE THESE POLICIES AND PROCEDURES TO PROVIDERS, REGULARLY MONITOR PROVIDERS’ COMPLIANCE AND TAKE ANY CORRECTIVE ACTION NECESSARY TO ENSURE PROVIDER COMPLIANCE. (SEE 42 CFR 438.114 AND OAR 410-141-3140)

Requirement: Applicant must provide a narrative statement describing how it meets this Standard that comply with the requirements of 42 CFR 438.114 and OAR 410-141-3140.

Assurance:

_____ (Applicant) warrants and represents that it has written policies, procedures, or processes that ensure the provision of triage services for all members on a 24-hour, - 7-days-a-week basis and that address all the current requirements of 42 CFR 438.114 and OAR 410-141-0140 at the date of Application, and will continue if OHA approves this Application. Applicant agrees to provide all such policies and procedures to the OHA upon request.

Signature

Title

Print Name

Date

Assurance #2 - Continuity of Care

THE APPLICANT SHALL HAVE WRITTEN POLICIES AND PROCEDURES THAT ENSURE A SYSTEM FOR THE COORDINATION OF CARE AND THE ARRANGEMENT, TRACKING AND DOCUMENTATION OF ALL REFERRALS AND PRIOR AUTHORIZATIONS TO OTHER PROVIDERS. THE APPLICANT SHALL COMMUNICATE THESE POLICIES AND PROCEDURES TO PROVIDERS, REGULARLY MONITOR PROVIDERS’ COMPLIANCE AND TAKE ANY CORRECTIVE ACTION NECESSARY TO ENSURE PROVIDER COMPLIANCE. [SEE 42 CFR 438.208 AND OAR 410-141-3160]

Requirement:

Applicant must provide a narrative statement describing how it meets this Standard that comply with the requirements of 42 CFR 438.208 and OAR 410-141-3160.

Assurance:

_____(Applicant) warrants and represents that its policies, procedures, or processes applicable to coordination of care address all the current requirements of 42 CFR 438.208 and OAR 410-141-3160 at the date of Application and will continue once OHA has approved this Application. Applicant agrees to provide all such policies and procedures to the OHA upon request.

Signature

Title

Print Name

Date

Assurance #3 - Medical Record Keeping

APPLICANT SHALL HAVE WRITTEN POLICIES AND PROCEDURES THAT ENSURE MAINTENANCE OF A RECORD KEEPING SYSTEM THAT INCLUDES MAINTAINING THE PRIVACY AND SECURITY OF RECORDS AS REQUIRED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA), 42 USC § 1320-D ET SEQ., AND THE FEDERAL REGULATIONS IMPLEMENTING THE ACT, AND COMPLETE CLINICAL RECORDS THAT DOCUMENT THE CARE RECEIVED BY CCO MEMBERS FROM THE APPLICANT’S PRIMARY CARE AND REFERRAL PROVIDERS. APPLICANTS SHALL COMMUNICATE THESE POLICIES AND PROCEDURES TO PARTICIPATING PROVIDERS, REGULARLY MONITOR PARTICIPATING PROVIDERS’ COMPLIANCE WITH THESE POLICIES AND PROCEDURES AND TAKE ANY CORRECTIVE ACTION NECESSARY TO ENSURE PARTICIPATING PROVIDER COMPLIANCE. APPLICANTS SHALL DOCUMENT ALL MONITORING AND CORRECTIVE ACTION ACTIVITIES. SUCH POLICIES AND PROCEDURES SHALL ENSURE THAT RECORDS ARE SECURED, SAFEGUARDED AND STORED IN ACCORDANCE WITH APPLICABLE LAW. [SEE 45 CFR PARTS 160 – 164, 42 CFR 438.242, ORS 414.679 AND OAR 410-141-3180]

Requirement:

Applicant must provide a narrative statement describing how it meets this Standard that comply with the requirements of 45 CFR Parts 160 – 164, 42 CFR 438.242, ORS 414.679 and OAR 410-141-3180

Assurance:

_____(Applicant) warrants and represents that the policies, procedures, or processes used to maintain a medical record keeping system necessary to fully disclose and document the condition of members and the extent of services both arranged for and provided to members address all the current requirements of 45 CFR Parts 160 – 164, 42 CFR 438.242, ORS 414.679 and OAR 410-141-3180 at the date of the Application and will continue if OHA has approved this Application. Applicant agrees to provide all such policies and procedures to the OHA upon request.

Signature

Title

Print Name

Date

Assurance #4 - Quality Improvement

THE APPLICANT SHALL HAVE AN ONGOING QUALITY PERFORMANCE IMPROVEMENT PROGRAM FOR THE SERVICES IT FURNISHES TO ITS CCO MEMBERS. THE PROGRAM SHALL INCLUDE AN INTERNAL QUALITY

IMPROVEMENT PROGRAM BASED ON WRITTEN POLICIES, STANDARDS AND PROCEDURES THAT ARE DESIGNED TO ACHIEVE THROUGH ONGOING MEASUREMENTS AND INTERVENTION, SIGNIFICANT IMPROVEMENT, SUSTAINED OVER TIME, IN CLINICAL CARE AND NON-CLINICAL CARE AREAS AND THAT ARE EXPECTED TO HAVE A FAVORABLE EFFECT ON HEALTH OUTCOMES AND OHA MEMBER SATISFACTION. THE IMPROVEMENT PROGRAM SHALL TRACK OUTCOMES BY RACE, ETHNICITY AND LANGUAGE. THE APPLICANT SHALL COMMUNICATE THESE POLICIES AND PROCEDURES TO PROVIDERS, REGULARLY MONITOR PROVIDERS' COMPLIANCE AND TAKE ANY CORRECTIVE ACTION NECESSARY TO ENSURE PROVIDER COMPLIANCE. [SEE 42 CFR 438.200 AND 438.240; OAR 410-141-0200]

Requirement:

Applicant must provide a narrative statement describing how it meets this Standard that comply with the requirements of 42 CFR 438.200-438.240 and OAR 410-141-0200.

Assurance:

_____ (Applicant) warrants and represents that the policies, procedures, or processes that address all the current requirements for quality improvement programs in 42 CFR 438.200 and 438.240, and OAR 410-141-0160 at the date of Application and will continue if OHA has approved this Application. Applicant agrees to provide all such policies and procedures to the OHA upon request.

Signature

Title

Print Name

Date

Assurance #5 - Accessibility

THE APPLICANT SHALL MAKE COORDINATED CARE SERVICES ACCESSIBLE TO ENROLLED CCO MEMBERS. THE APPLICANT SHALL NOT DISCRIMINATE BETWEEN CCO MEMBERS AND NON-CCO MEMBERS AS IT RELATES TO BENEFITS TO WHICH THEY ARE BOTH ENTITLED. THE APPLICANT SHALL COMMUNICATE THESE POLICIES AND PROCEDURES TO PROVIDERS, REGULARLY MONITOR PROVIDERS' COMPLIANCE AND TAKE ANY CORRECTIVE ACTION NECESSARY TO ENSURE PROVIDER COMPLIANCE. [SEE 42 CFR 438.206 TO 438.210; AND OAR 410-141-3220]

Requirement:

Applicant must provide a narrative statement describing how it meets this Standard that comply with the requirements of 42 CFR 438.206 to 438.210 and OAR 410-141-3220.

Assurance:

_____ (Applicant) warrants and represents that the policies, procedures, or processes related to making coordinated care services accessible to CCO members consistent with all the current requirements of 42 CFR 438.206 – 438.210 and OAR 410-141-3220 at the date of Application and will continue if OHA has approved this Application. Applicant agrees to provide all such policies and procedures to the OHA upon request.

Signature

Title

Print Name

Date

Assurance #6 - Grievance System

THE APPLICANT MUST HAVE WRITTEN PROCEDURES APPROVED IN WRITING BY OHA FOR ACCEPTING, PROCESSING, AND RESPONDING TO ALL COMPLAINTS AND APPEALS FROM CCO MEMBERS OR THEIR REPRESENTATIVES THAT ARE CONSISTENT WITH EXHIBIT I OF THE APPENDIX G “CORE CONTRACT”. THE APPLICANT SHALL COMMUNICATE THESE POLICIES AND PROCEDURES TO PROVIDERS, REGULARLY MONITOR PROVIDERS’ COMPLIANCE AND TAKE ANY CORRECTIVE ACTION NECESSARY TO ENSURE PROVIDER COMPLIANCE. [SEE 42 CFR 438.228, 438.400 – 438.424; AND OAR 410-141-3260 TO 410-141-3266]

Requirement:

Applicant must provide a narrative statement describing how it meets this Standard that comply with the requirements of 42 CFR 438.228, 438.400 – 438.424 AND OAR 410-141-3260 to 410-141-3266.

Assurance:

(Applicant) warrants and represents that policies, and procedures for accepting, processing, responding, resolving and monitoring all complaints from members or their representatives address all the current requirements of 42 CFR 438.228, 438.400 through 438.424, and OAR 410-141-0260 through OAR 410-141-0266, and will continue if OHA approves this Application. Applicant agrees to provide all such policies and procedures to the OHA upon request.

Signature

Title

Print Name

Date

Assurance #7 - Potential Member Informational Requirements

THE APPLICANT MUST DEVELOP AND DISTRIBUTE INFORMATIONAL MATERIALS TO POTENTIAL MEMBERS THAT MEET THE LANGUAGE AND ALTERNATIVE FORMAT REQUIREMENTS OF POTENTIAL MEMBERS. THE APPLICANT SHALL COMMUNICATE THESE POLICIES AND PROCEDURES TO PROVIDERS, REGULARLY MONITOR PROVIDERS’ COMPLIANCE AND TAKE ANY CORRECTIVE ACTION NECESSARY TO ENSURE PROVIDER COMPLIANCE. [SEE 42 CFR 438.10; OAR 410-141-3280]

Requirement:

Applicant must provide a narrative statement describing how it meets this Standard that comply with the requirements of 42 CFR 438.10 and OAR 410-141-3280 to provide informational materials for potential members.

Assurance:

(Applicant) warrants and represents that policies, and procedures for developing and distributing informational materials to potential members that address all the current requirements of 42 CFR 438.10 and OAR 410-141-0280 at the date of Application, and will

continue if OHA approves this Application. Applicant agrees to provide all such policies and procedures to the OHA upon request.

Signature

Title

Print Name

Date

Assurance #8 - Member Education

THE APPLICANT MUST HAVE AN ON-GOING PROCESS OF MEMBER EDUCATION AND INFORMATION SHARING THAT INCLUDES APPROPRIATE ORIENTATION TO THE APPLICANT, MEMBER HANDBOOK, HEALTH EDUCATION, AVAILABILITY OF INTENSIVE CARE COORDINATION FOR MEMBERS WHO ARE AGED, BLIND AND/OR DISABLED AND APPROPRIATE USE OF EMERGENCY FACILITIES AND URGENT CARE. THE APPLICANT SHALL COMMUNICATE THESE POLICIES AND PROCEDURES TO PROVIDERS, REGULARLY MONITOR PROVIDERS' COMPLIANCE AND TAKE ANY CORRECTIVE ACTION NECESSARY TO ENSURE PROVIDER COMPLIANCE. [SEE 42 CFR 438.10; AND OAR 410-141-3300]

Requirement:

Applicant must provide a narrative statement describing how it meets this Standard that comply with the requirements of 42 CFR 438.10 and OAR 410-141-3300.

Assurance:

(Applicant) warrants and represents that the process of member education and information sharing that address all the current requirements of 42 CFR 438.10 and OAR 410-141-3300 at the date of Application, and will continue if the OHA approves the Application. Applicant agrees to provide all such policies and procedures to the OHA upon request.

Signature

Title

Print Name

Date

Assurance #9 - Member Rights and Responsibilities

THE APPLICANT SHALL HAVE WRITTEN POLICIES AND PROCEDURES TO ENSURE MEMBERS ARE TREATED WITH THE SAME DIGNITY AND RESPECT AS OTHER PATIENTS WHO RECEIVE SERVICES FROM THE APPLICANT THAT ARE CONSISTENT WITH ATTACHMENT 4, CORE CONTRACT. THE APPLICANT SHALL COMMUNICATE THESE POLICIES AND PROCEDURES TO PROVIDERS, REGULARLY MONITOR PROVIDERS' COMPLIANCE AND TAKE ANY CORRECTIVE ACTION NECESSARY TO ENSURE PROVIDER COMPLIANCE. [SEE 42 CFR 438.100, ORS 414.635 AND OAR 410-141-3320]

Requirement:

Applicant must provide a narrative statement describing how it meets this Standard that comply with the requirements of 42 CFR 438.100, ORS 414.635 and OAR 410-141-3320.

Assurance:

_____(Applicant) warrants and represents that members will be treated with the same dignity and respect as other patients who receive services, and assure compliance with member rights and responsibilities that follow the current requirements of 42 CFR 438.100, ORS 414.635 and OAR 410-141-3320 and at the date of Application and will continue if OHA approves this Application. Applicant agrees to provide all such policies and procedures to the OHA upon request.

Signature

Title

Print Name

Date

Assurance #10 - Intensive Care Coordination

THE APPLICANTS SHALL PROVIDE INTENSIVE CARE COORDINATION (OTHERWISE KNOWN AS EXCEPTIONAL NEEDS CARE COORDINATION OR ENCC) TO CCO MEMBERS WHO ARE AGED, BLIND OR DISABLED. THE APPLICANT SHALL COMMUNICATE THESE POLICIES AND PROCEDURES TO PROVIDERS, REGULARLY MONITOR PROVIDERS' COMPLIANCE AND TAKE ANY CORRECTIVE ACTION NECESSARY TO ENSURE PROVIDER COMPLIANCE. [SEE 42 CFR 438.208 AND OAR 410-141-3405]

Requirement:

Applicant must provide a narrative statement describing how it meets this Standard that comply with the requirements 42 CFR 438.208 related to members with special health care needs in accordance with 42 CFR 438.208 and OAR 410-141-3405.

Assurance:

_____(Applicant) warrants and represents that CCO Members who are aged, blind or disabled will be informed of the availability of intensive care coordination (or ENCC services) and that its policies and procedures address all the current requirements of 42 CFR 438.208 and OAR 410-141-3405 at the date of Application, and will continue if OHA approves this Application request. Applicant agrees to provide all such policies and procedures to the OHA upon request.

Signature

Title

Print Name

Date

Assurance #11 - Billing and Payment Standard

THE APPLICANT SHALL MAINTAIN AN EFFICIENT AND ACCURATE BILLING AND PAYMENT PROCESS BASED ON WRITTEN POLICIES, STANDARDS, AND PROCEDURES THAT ARE IN ACCORDANCE WITH ACCEPTED PROFESSIONAL STANDARDS, OHP ADMINISTRATIVE RULES AND OHA PROVIDER GUIDES. THE APPLICANT AND ITS PROVIDERS WILL NOT HOLD MEMBERS RESPONSIBLE FOR THE APPLICANTS OR PROVIDERS DEBT IF THE ENTITY BECOMES INSOLVENT. THE APPLICANT SHALL HAVE MONITORING SYSTEMS IN OPERATION AND REVIEW THE OPERATIONS OF THESE SYSTEMS ON A REGULAR BASIS. THE APPLICANT SHALL COMMUNICATE THESE POLICIES AND PROCEDURES TO PROVIDERS, REGULARLY MONITOR PROVIDERS' COMPLIANCE AND TAKE ANY CORRECTIVE ACTION NECESSARY TO ENSURE PROVIDER COMPLIANCE. [SEE 42 CFR 447.46 AND OAR 410-141-0420]

Requirement:

Applicant must provide a narrative statement describing how it meets this Standard that comply with the requirements of 42 CFR 447.46 and OAR 410-141-xxxx.

Assurance:

_____ (Applicant) warrants and represents that its the date of Application,

policies, standards and procedures for billing and payment are in accordance with accepted professional standards and current OHP administrative rules as cited in 42 CFR 447.46 and 410-141-0420. These systems are reviewed on a regular basis for accuracy and will continue in effect if OHA approves this Application. Applicant agrees to provide all such policies and procedures to the OHA upon request.

Signature

Title

Print Name

Date

Assurance #12 - Trading Partner Standard

THE APPLICANT SHALL PARTICIPATE AS A TRADING PARTNER OF THE OHA IN ORDER TO TIMELY AND ACCURATELY CONDUCT ELECTRONIC TRANSACTIONS IN ACCORDANCE WITH THE HIPAA ELECTRONIC TRANSACTIONS AND SECURITY STANDARDS. APPLICANT HAS EXECUTED NECESSARY TRADING PARTNER AGREEMENTS AND CONDUCTED BUSINESS-TO-BUSINESS TESTING THAT ARE IN ACCORDANCE WITH ACCEPTED PROFESSIONAL STANDARDS, OHP ADMINISTRATIVE RULES AND OHA PROVIDER GUIDES. THE APPLICANT SHALL HAVE MONITORING SYSTEMS IN OPERATION AND REVIEW THE OPERATIONS OF THESE SYSTEMS ON A REGULAR BASIS. THE APPLICANT SHALL COMMUNICATE THESE POLICIES AND PROCEDURES TO PROVIDERS, REGULARLY MONITOR PROVIDERS’ COMPLIANCE AND TAKE ANY CORRECTIVE ACTION NECESSARY TO ENSURE PROVIDER COMPLIANCE. [SEE 45 CFR PART 162; OAR 943-120-0100 TO 943-120-0200]

Requirement:

Applicant must provide a narrative statement describing how it meets this Standard that comply with the requirements of 45 CFR PART 162; AND OAR 943-120-0100 TO 943-120-0200.

Assurance:

_____ (Applicant) warrants and represents that it has completed business-to-business testing and received a trading partner agreement with the OHA and has implemented written policies, standards and procedures in accordance with accepted professional standards and current OHP administrative rules as cited in 45 CFR PART 162; AND OAR 943-120-0100 TO 943-120-0200. These electronic transaction systems are reviewed on a regular basis for accuracy and the trading partner agreement will continue in effect if OHA approves this Application. Applicant agrees to provide all such policies and procedures to the OHA upon request.

Signature

Title

Print Name

Date

Assurance #13 - Encounter Data Submission and Validation Standard – Health Services and Pharmacy Services

THE APPLICANT SHALL MAINTAIN AN EFFICIENT AND ACCURATE SYSTEM FOR CAPTURING ENCOUNTER DATA, TIMELY REPORTING THE ENCOUNTER DATA TO OHA, AND VALIDATING THAT ENCOUNTER DATA BASED ON WRITTEN POLICIES, STANDARDS, AND PROCEDURES THAT ARE IN ACCORDANCE WITH ACCEPTED PROFESSIONAL STANDARDS, CCO AND OHP ADMINISTRATIVE RULES AND OHA PROVIDER GUIDES. THE APPLICANT SHALL HAVE MONITORING SYSTEMS IN OPERATION AND REVIEW THE OPERATIONS OF THESE SYSTEMS ON A REGULAR BASIS. THE APPLICANT SHALL COMMUNICATE THESE POLICIES AND PROCEDURES TO PROVIDERS, REGULARLY MONITOR PROVIDERS’ COMPLIANCE AND TAKE ANY CORRECTIVE ACTION NECESSARY TO ENSURE PROVIDER COMPLIANCE. [SEE 42 CFR 438.242; AND THE CONTRACT]

Requirement:

Applicant must provide a narrative statement describing how it meets this Standard that comply with the requirements of 42 CFR 438.242 and the Contract.

Assurance:

(Applicant) warrants and represents that it has the proven capability and will timely provide encounter data and validation to OHA in accordance with 42 CFR 438.242 and the Contract. These encounter data submission and validation requirements are reviewed on a regular basis for accuracy and will continue in effect if OHA approves this Application. Applicant agrees to provide all such policies and procedures to the OHA upon request.

Signature

Title

Print Name

Date

Assurance #14 - Enrollment and Disenrollment Data Validation Standard

THE APPLICANT SHALL MAINTAIN AN EFFICIENT AND ACCURATE PROCESS THAT CAN BE USED TO VALIDATE MEMBER ENROLLMENT AND DISENROLLMENT BASED ON WRITTEN POLICIES, STANDARDS, AND PROCEDURES THAT ARE IN ACCORDANCE WITH ACCEPTED PROFESSIONAL STANDARDS, OHP ADMINISTRATIVE RULES AND OHA PROVIDER GUIDES. THE APPLICANT SHALL HAVE MONITORING SYSTEMS IN OPERATION AND REVIEW THE OPERATIONS OF THESE SYSTEMS ON A REGULAR BASIS. THE APPLICANT SHALL COMMUNICATE THESE POLICIES AND PROCEDURES TO PROVIDERS, REGULARLY MONITOR PROVIDERS’ COMPLIANCE AND TAKE ANY CORRECTIVE ACTION NECESSARY TO ENSURE PROVIDER COMPLIANCE. [SEE 42 CFR 438.242 AND 438.604; AND CONTRACT]

Requirement:

Applicant must provide a narrative statement describing how it meets this Standard that comply with the requirements of 42 CFR 438.242 and 438.604, and the Contract.

Assurance:

_____ (Applicant) warrants and represents that it has the proven capability and will timely provide encounter data and validation to OHA in accordance with 42 CFR 438.242 and 438.604, and the Contract. These encounter data submission and validation requirements are reviewed on a regular basis for accuracy and will continue in effect if OHA approves this Application. Applicant agrees to provide all such policies and procedures to the OHA upon request.

Signature

Title

Print Name

Date

Section 5 - Proposed Scope of Work

Applicant is invited and encouraged to submit a proposed scope of work to address the part of the Contract governing the health services transformation strategies and model of care described within the scope of this questionnaire. Exhibit A to this questionnaire offers a Framework Scope of Work containing provisions that Applicant may, but is not required to, include in its proposed scope of work. Please see RFA Section 3.2 for further information about Applicant's proposed scope of work.

Exhibit A - Framework Scope of Work

Part 1 – Benefits

1. Flexible Services and Supports

In addition to traditional service and supports for physical, mental health, chemical dependency and dental services, Covered Services include the provision of flexible services and supports that are consistent with achieving wellness and the objectives of an individualized care plan. A Flexible Service or Support must be ordered by and under the supervision of a Network Provider in accordance with Contractor policy for authorizing Flexible Services or Supports.

2. Children's Wraparound Demonstration Project Responsibilities

As mandated by ORS 418.975 to 418.985, Contractor creates a system of care by implementing a Children's Wraparound Demonstration Project, providing oversight and, in collaboration with OHA, evaluation.

Contractor shall develop local and state level partnerships to collaborate with OHA on the implementation of ORS 418.975 to 418.985 in the development of the Statewide Children's Wraparound Initiative.

SEE ALSO MANDATORY LANGUAGE IN APPENDIX G

Part 2 – Patient Rights and Responsibilities, Engagement and Choice

1. Member and Member Representative Engagement

Contractor actively engages Members as partners in the design and, where applicable, implementation of their individual treatment and care plans through ongoing consultation regarding individual and cultural preferences and goals for health maintenance and improvement. Member choices should be reflected in the development of treatment plans and member dignity will be respected. Under this definition, members will be better positioned to fulfill their responsibilities as partners in the primary care team at the same time that they are protected against underutilization of services and inappropriate denials of services.

Contractor implements its proposal approved during certification demonstrating the means by Contractor will:

- a. Use Community input and the Community needs assessment process to help determine the best, most culturally appropriate methods for patient activation, with the goal of ensuring that Member act as equal partners in their own care.
- b. Encourage Members to be active partners in their health care and, to the greatest extent feasible, develop approaches to patient engagement and responsibility that account for the social determinants of health and health disparities relevant to their members.
- c. Engage Members in culturally and linguistically appropriate ways.
- d. Educate members on how to navigate the coordinated care approach.
- e. Encourage Members to use wellness and prevention resources, including culturally-specific resources provided by community based organizations and service providers, and to make healthy lifestyle choices.
- f. Meaningfully engage the Community Advisory Council to monitor patient engagement and activation.
- g. Provide plain language narrative, and alternative (video or audio) formats for individuals with limited literacy that informs patients about what they should expect from the Coordinated Care Organization with regard to their rights and responsibilities.
- h. Shall be encouraged to work with the member's care team, including providers and community resources appropriate to the member's individual and cultural needs as a whole person.

2. Member Engagement and Activation

Contractor shall implement policies and procedures assuring that each member:

- a. Must be encouraged to be an active partner in directing the member's health care and services and not a passive recipient of care.
- b. Must be educated about the coordinated care approach being used in the community and how to navigate the coordinated health care system.
- c. Must have access to advocates, including qualified peer wellness specialists where appropriate, personal health navigators, and qualified community health workers who are part of the member's care team to provide assistance that is culturally and linguistically appropriate to the

member's need to access appropriate services and participate in processes affecting the member's care and services.

- d. Shall be encouraged within all aspects of the integrated and coordinated health care delivery system to use wellness and prevention resources and to make healthy lifestyle choices.
- e. Shall be encouraged to work with the member's care team, including providers and community resources appropriate to the member's needs as a whole person

SEE ALSO MANDATORY LANGUAGE IN APPENDIX G

Part 3 – Providers and Delivery System

1. Integration and Coordination

Contractor develops, implements and participates in activities supporting a continuum of care that integrates mental health, addiction, dental health and physical health interventions in ways that are seamless and whole to the Member. Integration activities may span a continuum ranging from communication to coordination to co-management to co-location to the fully integrated Patient Centered Primary Care Home.

2. Delivery System Features

Transformation relies on ensuring that CCO Members have access to high quality appropriate integrated and coordinated care. This will be accomplished by the Contractor through a Provider Network capable of meeting health systems transformation objectives. The following criteria focus on elements of a transformed delivery system critical to improving the member's experience of care as a partner in care rather than as a passive recipient of care.

a. Patient-Centered Primary Care Homes

Integral to transformation is the Patient-Centered Primary Care Home (PCPCH), as currently defined by Oregon's statewide standards.

Building on this work, Contractor implements its proposal approved during certification demonstrating the method and means by which Contractor will use PCPCH capacity to achieve the goals of health system transformation including:

- How Contractor will partner with and implement a network of PCPCHs as defined by Oregon's standards to the maximum extent feasible, as required by HB 3650, including but not limited to the following
 - Assurances that the Contractor will enroll a significant percentage of members in PCPCHs certified as Tier 1 or higher according to Oregon's standards; and
 - A concrete plan for increasing the number of enrollees that will be served by certified PCPCHs over the first five years of operation, including targets and benchmarks
 - A concrete plan for Tier 1 PCPCHs to move toward Tier 2 and 3 of the Oregon standard over the first five years of operation, including targets and benchmarks
- How Contractor will require Contractor's other contracting health and services providers to communicate and coordinate care with the PCPCH in a timely manner using electronic health information technology, where available, as required by HB 3650., in order to assure a comprehensive delivery system network with the PCPCH at the center, and with other health

care providers and local services and supports under accountable arrangements for comprehensive care management.

- How Contractor's PCPHC delivery system elements will ensure that Members of all communities in its service area will receive integrated, culturally and linguistically appropriate person-centered care and services, as described in the HB 3650, and that Members are fully informed partners in transitioning to this model of care.
- How Contractor will encourage the use of federally qualified health centers, rural health clinics, school-based health clinics and other safety net providers that qualify as PCPCHs to ensure the continued critical role of those providers in meeting the needs of underserved populations.

b. Care Coordination

Care coordination is a key activity of health system transformation. Without it, the health system suffers costly duplication of services, conflicting care recommendations, medication errors, and Member dissatisfaction, which contribute to poorer health outcomes and unnecessary increases in medical costs.

Contractor implements its proposal approved during certification demonstrating the methods and means by which Contractor will address the following elements of care coordination in their applications for certification:

- How Contractor will support the flow of information, identify a lead Provider or care team to confer with all providers responsible for a Member's care, and, in the absence of full health information technology capabilities, how Contractor will implement a standardized approach to patient follow-up.
- How Contractor will work with Providers to develop the partnerships necessary to allow for access to and coordination with social and support services, including culturally specific community based organizations, long-term care services and crisis management services.
- How Contractor will develop culturally and linguistically appropriate tools for provider use to assist in the education of Members about care coordination and the responsibilities of each in the process of communication.
- How Contractor will meet OHA goals and expectations for coordination of care for individuals receiving Medicaid-funded long term care services given the exclusion of Medicaid funded long term services from CCO global budgets.
- How Contractor will meet OHA goals and expectation for coordination of care for individuals receiving both Medicaid-funded and non-Medicaid-funded residential addictions and mental health services given the initial exclusion of these services from CCO global budgets.
- How the contractor will coordinate with the state institutions to facilitate incoming Member's transition to the community.

Contractor must implement its proposal approved during certification demonstrating the methods and means by which Contractor will utilize evidence-based or innovative strategies within Contractor's delivery system networks to ensure coordinated care, especially for Members with intensive care coordination needs, as follows.

- *Assignment of responsibility and accountability:* Contractor demonstrates that each Member has a primary care Provider or primary care team that is responsible for coordination of care and transitions, as required by HB 3650.

- *Individual care plans:* As required by HB 3650, Contractor uses individualized care plans to the extent feasible to address the supportive and therapeutic and cultural and linguistic needs of each Member, particularly those with intensive care coordination needs. Plans will reflect Member, Family or caregiver preferences and goals to ensure engagement and satisfaction.
- *Communication:* Contractor demonstrates that Providers have the tools and skills necessary to communicate in a linguistically and culturally appropriate fashion with Members and their Families, extended family, kinship networks or caregivers and to facilitate information exchange between other providers and facilities (e.g., addressing issues of health literacy, language interpretation, having electronic health record (her) capabilities, etc.).

Effective transformation requires the development of a coordinated and integrated delivery system Provider Network that demonstrates communication, collaboration and shared decision making across the various providers and care settings. Contractor implements the proposal approved during certification demonstrating the methods and means by which Contractor will begin to demonstrate, over time:

- How Contractor will ensure a network of Providers to serve Members' health care and service needs, meet access-to-care standards, and allow for appropriate choice for members as required by HB 3650. The bill also requires that services and supports should be geographically as close to where Members reside as possible and, to the extent necessary, offered in nontraditional settings that are accessible to families, socially, culturally, and linguistically diverse communities, and underserved populations.
- How Contractor will build on existing Provider Networks and transform them into a cohesive network of providers.
- How it will work to develop formal relationships with providers, community health partners, including culturally and socially diverse community based organizations and service providers, and state and local government support services in its service area(s), as required by HB 3650, and how Contractor will participate in the development of coordination agreements between those groups.

c. Care Integration

- *Mental Health and Chemical Dependency Treatment:* Outpatient mental health and chemical dependency treatment will be integrated in the person-centered care model and delivered through and coordinated with physical health care services by Contractor. HB 3650 requires OHA to continue to renew contracts or ensure that counties renew contracts with providers of residential chemical dependency treatment until the provider enters into a contract with a CCO but no later than July 1, 2013.
- *Oral Health:* By July 1, 2014, HB 3650 requires each CCO to have a formal contractual relationship with any dental care organization that serves members of the CCO in the area where they reside. Shared financial accountability will encourage aligned financial incentives for cost-effectiveness and to discourage cost shifting.
- *Hospital and Specialty Services:* Adequate, timely and appropriate access to hospital and specialty services will be required. Hospital and specialty service agreements should be established that include the role of patient-centered primary care homes and that specify: processes for requesting hospital admission or specialty services; performance expectations for communication and medical records sharing for specialty treatments, at the time of hospital admission or discharge, for after-hospital follow up appointments. CCOs should

demonstrate how hospitals and specialty services will be accountable to achieve successful transitions of care.

d. Health Leadership Council High Value Medical Home

Contractor cooperates with OHA project for clinics as Patient Centered Medical Homes (PCMHs) as follows:

- (1) OHA will pay Contractor a PCMH reimbursement payment in addition to the CCO Payment in accordance with the CCO Payments calculation reflected in the rate schedule in Appendix G, Exhibit C, Attachment 2. OHA will from time to time determine the PCMH reimbursement payment for each PCMH clinic designated by OHA, in an amount not to exceed \$XX per Member assigned to PCMH per month.
- (2) Contractor distributes all of such PCMH reimbursement payment amounts to eligible clinics, designated by OHA, located in the State that receive PCMH reimbursement payment determined by Enrollment of designated high risk Members, in accordance with requirements established by OHA, for services outside the scope of services for which Contractor is compensated by the CCO Payments.
- (3) Contractor submits to OHA all Claims, financial and other required data elements within 45 days from the date of service.

3. Delivery System Dependencies

a. Shared Accountability for Long-term Care

Medicaid-funded long-term care services are legislatively excluded in HB 3650 from CCO global budgets and will be paid for directly by the state, creating the possibility of misaligned incentives and cost-shifting between the CCOs and the long-term care (LTC) system. Cost-shifting is a sign that the best care for a beneficiary's needs is not being provided. In order to prevent cost-shifting and ensure shared responsibility for delivering high quality, culturally and linguistically appropriate person-centered care, CCOs and the LTC system will need to share accountability, including financial accountability.

A shared financial accountability system will be developed based on incentives and/or penalties linked to performance metrics applied to the Contractor and/or to the LTC system in its Service Area. Other elements of shared accountability between Contractor and the LTC system in its Service Area will include contractual elements such as specific requirements for coordination between the two systems; requirements to clearly define roles and responsibilities between the two systems, through a memorandum of understanding, a contract, or other mechanism; and reporting of metrics related to better coordination between the two systems.

Further, since individuals receiving Medicaid-funded LTC services and supports represent a significant population served by Contractor, Contractor must include these individuals and the LTC delivery system in its Service Area in the community needs assessment processes and policy development structure

b. Intensive Care Coordination for Special Needs Members

- (1) Contractor prioritizes working with Members who have high health care needs, multiple chronic conditions, mental illness or chemical dependency and communities experiencing health disparities (as identified in the community needs assessment) and involve those Members in accessing and managing appropriate preventive, remedial and supportive care and services to reduce the use of avoidable emergency room visits and hospital admissions.
- (2) Contractor provides intensive care coordination or case management services to Members who are aged, blind, disabled or who have complex medical needs consistent with ORS 414.712.
- (3) Contractor implements procedures to share the results of its identification and Assessment of any Member identified as aged, blind, disabled or having complex medical needs with Participating Providers serving the Member so that those activities need not be duplicated. Contractor creates the procedures and shares information under ORS 414.679 in compliance with the confidentiality requirements of this Contract.
- (4) Contractor establishes policies and procedures, including a standing referral process for direct access of specialists, in place for identifying, assessing and producing a treatment plan for each Member identified as having a special healthcare need. Each treatment plan will be:
 - (a) Developed by the Member's designated practitioner with the Member's participation;
 - (b) Include consultation with any specialist caring for the Member;
 - (c) Approved by the Contractor in a timely manner, if this approval is required; and
 - (d) In accordance with any applicable State quality assurance and utilization review standards.

c. State and Local Government Agencies and Community Social and Support Services Organizations

Contractor acknowledges and agrees that better communication and coordination with state and local government agencies and culturally diverse community social and support services organizations, including early child education, special education, behavioral health and public health is critical for the development and operation of an effective Delivery System Network (DSN). Contractor consults and collaborates with Contractor DSN Providers to maximize Provider awareness of available resources for different Members' needs, and to assist DSN Providers to able to make referrals to the appropriate providers or organizations. The assistance that Contractor provides to DSN Providers in making referrals to State and local governments and to community social and support services organizations takes into account the following referral and service delivery factors:

d. Cooperation with Dental Care Organizations

Contractor coordinates preauthorization and related services with DCOs to ensure the provision of dental care that is required to be performed in an outpatient hospital or ambulatory surgical setting due to the age, disability, or medical condition of the Member.

e. Cooperation with Residential, Nursing Facilities, Foster Care & Group Homes

Contractor arranges to provide medication that is part of Capitated Services to nursing or residential facility and group or foster home residents in a format that is reasonable with the individual facility's delivery, dosage and packaging requirements and Oregon law.

f. Financial responsibility, risk and solvency

Contractor engages in alternative reimbursement methodologies, provided that Contractor does not delegate or relieve itself of the financial responsibility, risk and solvency requirements of Appendix G, Exhibit B, Part 10, except as permitted by OAR 410-141-3340 to 410-141-3395.

REVIEW the MANDATORY CONTRACT LANGUAGE IN APPENDIX G

Applicant should review the provisions in the Core Contract and Mandatory Statement of Work in Appendix G. Applicant's proposed scope of work and provisions of the framework scope of work, will be integrated into the pertinent portions of the Contract for a single integrated document.