

**The State of Oregon
Oregon Health Authority**

**Issues the Following
Request for Applications
for
Coordinated Care Organizations
RFA 3402**

Date of Issuance: March 19, 2012

Initial Round of Applications Due by:

CCO Letter of Intent to Apply Due	April 2, 2012
Technical Application Due	April 30, 2012 ¹
Financial Application Due	May 14, 2012*

All Application must be received through OHA's Web Portal located at: <http://cco.health.oregon.gov> in accordance with Section 4.2.

Subsequent Applications Due by Dates in Attachment 3, CCO Application Dates.

Issuing Office:

Tammy L. Hurst, Contract Specialist
Office of Contracts and Procurement
250 Winter Street NE, 3rd Floor
Salem, Oregon 97301
Telephone: 503-947-5298
Fax: 503-373-7365
Email: tammy.hurst@state.or.us
TTY: 503-378-3523

¹ Later Application dates also available. See Section 4.2 and Attachment 3.

Table of Contents

SECTION 1 – PURPOSE/OVERVIEW.....	5
1.1. Introduction	5
1.2. Background and Overview.....	5
1.3. Definitions.....	7
1.4. Authority	8
SECTION 2 – MINIMUM QUALIFICATIONS	8
2.1. Notice of Intent to Apply	8
2.2. Legal Entity	8
2.3. Governance.....	8
2.4. Application Cover Sheet	8
SECTION 3 – SCOPE OF WORK.....	8
3.1. Core Contract and Mandatory Statement of Work Provisions.....	8
3.2. Negotiable Scope of Work Provisions	8
SECTION 4 – RFA PROCESS.....	9
4.1. Communications.....	9
4.2. Timeline for RFA and Application Submission.....	10
4.3. Closing Dates; Methods for Electronic Submittal of Applications.....	12
4.4. Pre-Application Questions Relating to This RFA.....	13
4.5. Public Opening.....	13
SECTION 5 – APPLICATION REQUIREMENTS.....	13
5.1. General Application Requirements	13
5.2. Technical Application	14
5.3. Financial Application	14
5.4. Public Presentation by Applicant.....	14
SECTION 6 – APPLICATION EVALUATION	14
6.1. Pass/Fail Items.....	14
6.2. Technical Application Evaluation.....	15
6.3. Financial Application Evaluation.....	15
6.4. Revised Application	16
6.5. Responsible	16
6.6. Certification and Contract Award	16
6.7. Disposition of Applications.....	17
SECTION 7 – GENERAL INFORMATION.....	18
7.1. Changes/Modification and Clarifications.....	18
7.2. Reservation of OC&P Rights	18
7.3. Protest of RFA.....	19
7.4. Award Notices.....	19
7.5. Protest of Awards	19
7.6. Modification or Withdrawal.....	19
7.7. Release of Information	20
7.8. Public Information.....	20
7.9. Cost of Applications.....	20
7.10. Statutorily Required Preferences.....	20
7.11. Contract Period.....	20
7.12. Contractual Obligation	21
7.13. Contract Documents.....	21
7.14. Insurance Requirements	21
7.15. Code of Conduct.....	21
ATTACHMENT 1 – Application Cover Sheet	24

ATTACHMENT 2 – Applicant’s Designation of Confidential Materials.....	25
ATTACHMENT 3 – CCO Application Dates.....	27
Part 1 - Medicaid Application Schedule.....	27
Part 2 - Dual Eligible Application Schedule.....	28
ATTACHMENT 4 – CCO Definitions.....	29
1. Terms Defined by Rule.....	29
2. Terms Defined by Statute.....	32
3. Terms Defined by the RFA.....	32
APPENDIX A – CCO Criteria Questionnaire.....	35
1. Background Information about the Applicant.....	35
2. Community Engagement in Development of Application.....	37
Section 1 – Governance and Organizational Relationships.....	38
Section 2 – Member Engagement and Activation.....	43
Section 3 - Delivery System: Access, Patient-Centered Primary Care Homes, Care Coordination and Provider Network Requirements.....	44
Section 4 - Health Equity and Eliminating Health Disparities.....	50
Section 5 - Payment Methodologies that Support the Triple Aim.....	51
Section 6 - Health Information Technology.....	52
Section 7 - Proposed Scope of Work.....	54
Exhibit A: Framework Scope of Work.....	54
General Overview of Health Transformation.....	54
Part 1 – Governance and Organizational Relationships.....	55
Part 2 – Health Equity and Eliminating Health Disparities.....	56
Part 3 – Payment Methodologies that support the Triple Aim.....	57
Part 4 – Health Information Systems.....	58
APPENDIX B – Provider Participation and Operations Questionnaire.....	61
Section 1 - Service Area and Capacity	61
Section 2 - Standards Related To Provider Participation.....	62
Standard #1 - Provision of Coordinated Care Services.....	62
Standard #2 – Providers for Members with Special Health Care Needs.....	71
Standard #3 – Publicly funded public health and community mental health services.....	72
Standard #4 – Services for the American Indian/Alaska Native Population (AI/AN).....	73
Standard #5 – Indian Health Services (IHS) and Tribal 638 facilities.....	73
Standard #6 – Integrated Service Array (ISA) for children and adolescents.....	73
Standard #7 – Chemical Dependency Services.....	73
Standard #8 – Pharmacy Services and Medication Management.....	73
Standard #9 – Hospital Services.....	75
Section 3 - Operational Attestations	75
Assurance #1 - Emergency and Urgent Care Services.....	80
Assurance #2 - Continuity of Care.....	80
Assurance #3 - Medical Record Keeping.....	81
Assurance #4 - Quality Improvement.....	81
Assurance #5 - Accessibility.....	82
Assurance #6 - Grievance System.....	83
Assurance #7 - Potential Member Informational Requirements.....	83
Assurance #8 - Member Education.....	84
Assurance #9 - Member Rights and Responsibilities.....	84
Assurance #10 - Intensive Care Coordination.....	85
Assurance #11 - Billing and Payment Standard.....	85
Assurance #12 - Trading Partner Standard.....	86
Assurance #13 - Encounter Data Submission and Validation Standard – Health Services and Pharmacy Services.....	87

Assurance #14 - Enrollment and Disenrollment Data Validation Standard	87
Section 5 - Proposed Scope of Work.....	88
Exhibit A - Framework Scope of Work.....	88
Part 1 – Benefits.....	88
Part 2 – Patient Rights and Responsibilities, Engagement and Choice	88
Part 3 – Providers and Delivery System	90
APPENDIX C – Accountability Questionnaire.....	96
Section 1 – Accountability Standards	96
Section 2 – Quality Improvement Program	100
Section 3 – Proposed Scope of Work	102
Exhibit A - Framework Scope of Work.....	102
Part 1 - Quality and Performance Outcomes and Accountability.....	102
APPENDIX D – Financial Reporting and Solvency Questionnaire.....	105
Section 1 - Financial Organization	105
Section 2: Demonstration of Financial Solvency.....	106
Section 3 - Demonstration of Ability to Achieve the Financial Goals	110
Section 4 – Proposed Scope of Work	112
Exhibit A: Framework Scope of Work	112
APPENDIX E – Dual Eligibles Questionnaire.....	116
Section 1 - Background Information – Inclusion of Dually Eligible Individuals in CCOs.....	116
Section 2 - Participation in the Demonstration (Pending CMS approvals)	117
Section 3 – Proposed Scope of Work	118
APPENDIX F – Global Budget Questionnaire.....	119
1. Global Budget Methodology.....	119
2. Populations Included in Global Budget Calculations	119
3. Service/Program Inclusion and Alignment	119
4. Global Budget Development.....	120
5. Capitated Portion of the Global Budget Methodology.....	120
6. Non-capitated or “supplemental” portion of the Global Budget Methodology	121
7. Quality Incentive Payments	121
Section 1 - General Questions Regarding Global Budgeting	122
Section 2 – Proposed Scope of Work	122
Exhibit 1 - Medicaid Program and Services for Inclusion in the CCO Global Budget.....	123
Exhibit 2 - Instructions for Submitting Estimated Costs for Medicaid Services.....	127
Exhibit 3 - Estimated Costs and Capitation Rates Spreadsheet.....	130
Exhibit 4 - Pro Forma Projections for the First Five Years	162
APPENDIX G – Core Contract	163

SECTION 1 – PURPOSE/OVERVIEW

1.1. Introduction

The State of Oregon, Oregon Health Authority (OHA), requests Applications from qualified Applicants to be certified and awarded contracts as Coordinated Care Organizations (CCOs)

OHA expects to award one or more Contracts for each region for the period starting August 1, 2012, or such later date as OHA determines appropriate. All initial Contracts will expire December 31, 2013, and thereafter may be renewed for one-year periods at OHA's discretion.

Pending federal approvals, OHA expects, with CMS, to award one or more three-way contracts for the period starting January 1, 2013, or such later date as OHA and CMS determine appropriate. All initial three-way contracts will expire December 31, 2013, and thereafter may be renewed for one-year periods at the discretion of OHA and CMS.

All persons or firms submitting Applications are referred to as Applicants in this Request for Applications (RFA). After execution of the Contract, the awarded Applicant will be designated as Contractor, and the Applicant will be designated as the CCO.

The scope of the Contractor services and deliverables for the Contract is described in Section 3, "Scope of Work". The parties will negotiate the final Statement of Work to be included in the Contract.

1.2. Background and Overview

1.2.1. Improving Health, Improving Health Care and Reducing Cost

The OHA is soliciting applications from experienced and innovative entities with a strong community presence and commitment to improving health outcomes for those experiencing health disparities to become certified and enter into contracts as CCOs. CCOs are accountable for care management and provision of integrated and coordinated health care for each of their members, including members who are dually eligible for Medicare and Medicaid services, managed within a global budget, by providing care so that efficiency and quality improvements reduce medical cost inflation and improve health outcomes, in accordance with the objectives and requirements established in HB 3650 and SB 1580.

Studies nationwide and in Oregon have demonstrated that health systems that incorporate best clinical practices, coordination of benefits and care, and offer culturally specific care not only deliver better health outcomes but reduce health care costs.

CCOs are the primary agents of health system transformation. They will be responsible for integrated and coordinated health care for their community members' physical health, addictions and mental health services, and by 2014, oral health care—with a focus on prevention, improving quality (including culturally appropriate care), accountability, eliminating health disparities and lowering costs. HB 3650 directs CCOs' delivery system networks to emphasize patient-centered primary care homes, evidence-based practices, and health information technology to improve the coordination of care for individuals with chronic conditions as well as those experiencing health disparities and to increase preventive services that will improve health and health care for eligible members—all managed within a global budget. The CCO model of care will promote efficiency and quality improvements in an effort to reduce year-over-year cost

increases while supporting the development of local accountability for the health of CCO members in a manner that is culturally appropriate.

1.2.2. Description of Oregon’s Integrated and Coordinated Health Care Model

The Oregon Health Plan (OHP) implemented a Medicaid managed care system in the mid-1980s and the prioritized list of health services in 1994. Despite the many successes of the Oregon Health Plan, growth in Medicaid expenditures has continued to outpace state general fund revenue and beneficiaries with the greatest need for coordinated care often see multiple providers across multiple sites of care while facing complex treatment and medication regimens. In particular, the OHP goal of integrating care across physical, behavioral and dental health was never fully achieved, nor was the goal of seamless management of health care for individuals eligible for both Medicare and Medicaid. In addition, despite the fact that forty percent of Medicaid enrollees are people of color, these populations, along with other culturally and socially diverse groups, continue to experience the most disparities in access, quality and outcomes of care.

Oregon’s existing Medicaid delivery system is made up of 34 capitated managed care plans (14 FCHPs, 2 PCOs, 8 DCOs, and 10 MHOs) in addition to health services delivered using fee-for-service and the long-term care delivery system.

Oregon’s health system transformation represents an evolution of the OHP. CCOs will provide a stronger focus on preventive and primary care, evidence-based, culturally-specific services, and more effective management of care with the end goal of moving from fragmentation to organization and delivering the right care in the right place at the right time to patients who are meaningfully engaged.

The key elements of a coordinated and integrated health care delivery system envisioned by HB 3650 are patient-centered primary care homes, coordination of care across categories of care and funding streams, patient activation, and aligning incentives that reward providers and beneficiaries for achieving good outcomes. In order to incent integration and efficiency, CCOs will receive all eligible Medicaid and—in the case of individuals who are dually eligible—Medicare funding through a single global budget designed to allow maximum flexibility to support both innovation and investment in evidenced-based care. Triple Aim-oriented measures of health outcomes, quality and efficiency will help ensure that CCOs improve upon the existing managed care system and will enable incentives for exceptional performance.

Approximately 200,000 additional Oregonians will become eligible for Medicaid in 2014 with the implementation of Patient Protection and Affordable Care Act. With very few exceptions, all Medicaid populations in Oregon are to be enrolled in CCOs and paid under the global budget methodology. Currently, 78 percent of eligible individuals are enrolled in a managed physical health care plan, 88 percent in a MHO, and 90 percent in a DCO. HB 3650 directs that OHA will enroll as many of the remaining eligibles currently in a fee-for-service (FFS) plan into a CCO. By creating community-based CCOs that focus on prevention and primary care and the needs of their particular communities in a manner that is culturally appropriate, Oregon will be optimally positioned to provide for better health for the newly eligible members, many of whom will have been, at best, sporadically covered with no regular source of care.

At approximately the same time as this RFA is issued, Oregon will submit a demonstration proposal to CMS that will align and integrate Medicare and Medicaid benefits and financing to the greatest extent possible for individuals who are eligible for both programs. The proposal will detail how the state will structure, implement, and evaluate an integrated delivery system and

payment model aimed at improving the quality, coordination, and cost-effectiveness of care for individuals who are dually eligible. Pending federal approval, it is anticipated that under an approved demonstration, CMS will review and approve relevant elements of the overall health system transformation plan as they pertain to dually eligible beneficiaries, including the model of care, performance metrics, financial solvency criteria, and other aspects of the plan. A successful proposal will lead to a three-way contract between CMS, the state and each CCO in order to simplify and unify funding and rules that plans face when serving individuals who are dually eligible.

Applicants will be expected to have a thorough familiarity with Health System Transformation, the CCO Implementation Proposal, and any administrative rules or other formal guidance of OHA pertaining to CCOs. In addition, Applicants will be responsible for addressing CMS requirements for serving individuals who are dually eligible.

1.2.3. Objective of this Request for Application Process

This RFA process identifies the criteria an organization must meet to be certified as a CCO. Evaluation of CCO applications will account for the developmental nature of the CCO system. CCOs, OHA and partner organizations need time to develop capacity, relationships, systems and experience to fully realize the goals envisioned by HB 3650. In all cases, CCOs will be expected to have plans in place for meeting the criteria laid out in the application process and making sufficient progress in implementing plans and realizing the goals established by HB 3650 and the CCO Implementation Proposal.

Qualifying organizations will be certified as CCOs and certified for Dual Eligibles, for a period of up to 6 years. OHA may certify multiple organizations in an area.

Certified CCOs will contract with OHA. Consistent with the CCO's certification and the plans established for meeting the criteria laid out in the application process and making sufficient progress in implementing plans and realizing the goals established by Health System Transformation, the initial contract will establish initial baseline expectations and describe transformational expectations that will be included in the initial contract and updated annually through a contract amendment process.

Pending federal approval of Oregon's demonstration, this RFA submission and certification information will be reviewed jointly with CMS for purposes of certification for Dual Eligibles and entering into three-way contracts, contingent on satisfying readiness requirements, for CCOs to serve Medicare and Medicaid enrollees. The form of the three-way contract and further requirements applying to certification for Dual Eligibles will be announced by addendum to this contract.

OHA rules and contract language applicable to CCOs may be amended from time to time to incorporate requirements applicable to providing integrated and coordinated care services, including but not limited to changes associated with providing coordinated care services to individuals who are dually eligible for Medicare and Medicaid.

1.3. Definitions

For purposes of this RFA (including the Attachments and Appendices) and the resulting Contract, the definitions of terms in Attachment 4 shall apply. Applications should use terms as defined in Attachment 4 whenever applicable.

1.4. Authority

OHA issues this RFA under the authority of ORS 414.725. The procedures for this RFA are governed by the OHA's procedures in OAR 410-141-3010, Coordinated Care Organization Application, Certification, and Contracting Procedures, filed with the Secretary of State as a temporary rule effective March 15, 2012. A copy of this rule is on OHA's web site at *web address*.

SECTION 2 – MINIMUM QUALIFICATIONS

Applicants must meet all of the following minimum qualifications:

2.1. Notice of Intent to Apply

Applicant has submitted a CCO Letter of Intent to Apply pursuant to Section 4.2.3 of this RFA.

2.2. Legal Entity

Applicant is a Legal Entity domiciled in Oregon. (Applicant need not be formed at the time of the CCO Letter of Intent to Apply but must be formed at the time of the Application.)

2.3. Governance

Applicant has the governance structure described in the ORS 414.625(1)(o) at the time the Application is submitted.

2.4. Application Cover Sheet

Applicant has submitted an Application Cover Sheet in the form of Attachment 1, signed by an officer of Applicant who is authorized to bind Applicant.

SECTION 3 – SCOPE OF WORK

Work to be performed under the Contract awarded through this RFA is described in the CCO Implementation Proposal, the CCO Administrative Rules, the RFA Questionnaires (Appendices A-F), and the Core Contract (Appendix G). The scope of work for the three-way contract will be announced by addendum. Each Applicant's statement of work for the Contract will comprise the combination of the following:

3.1. Core Contract and Mandatory Statement of Work Provisions

The Core Contract (Appendix G) contains the Core Elements that are reasonably anticipated to be included in the Statement of Work. The Core Contract, including its Statement of Work, is not negotiable except to the extent Applicant has submitted a Request for Change or Clarification or a Protest within the time period set forth in Section 4.2.1. The Request for Change or Clarification or the Protest must explain the reason for the requested change or clarification. The Core Contract Core Contract Statement of Work provisions in Appendix G represent core federal and state law requirements. The OHA may not be able to agree to a request for change that would be inconsistent with federal or state laws.

3.2. Negotiable Scope of Work Provisions

Certification as a coordinated care organization in order to achieve the goals of health care transformation anticipates that Applicants may propose innovative strategies for use within their

delivery system network to ensure integrated and coordinated care for members, and request flexibilities to that may be appropriate to address community-directed objectives. Consequently, Applicants certified as CCOs will enter into contracts with the Authority that should be responsive to those models of care and service delivery. The Applicant's strategies and proposal will be elicited in the questionnaires included in this RFA. Each questionnaire (Appendices A through F) concludes with a question inviting the Applicant to submit a proposed scope of work to address the part of the Contract governing Work within the scope of that questionnaire.

This is Applicant's opportunity to facilitate the Contracting process by supplying language that translates its unique approach to coordination and integration of care into a form that can be the starting point for Contract negotiations. Applicant's proposed Scope of Work should fill in applicable details about how Applicant proposes to accomplish the tasks identified in the Questionnaires. Applicant is invited and encouraged to use its response the scope of work question to inform the OHA about how it proposes to accomplish the Work, including the flexibilities and local initiatives that are being proposed. Applicants have considerable flexibility to design integrated and coordinated care systems. Applications must identify the goals and performance measures that the CCO will strive to attain. (Applicant's proposed Scope of Work need not include the mandatory provisions described in Section 3.1. Applicant's scope of work responses will be negotiated for inclusion in the Statement of Work in the Contract.)

Four of the questionnaires (Appendices A through D) also include a Framework Scope of Work containing provisions that Applicant may, but is not required to, include in its proposed scope of work. The Framework Scope of Work attached to these four appendices is intended to furnish a starting point but not prescriptive. Applicant may revise or omit provisions of each Framework Scope of Work to the extent they are not aligned with Applicant's approach. Applicants may propose to provide services through a CCO in manner different than the framework scope of Work presented in the framework scope of work, but Applicants must explain how their integrated and coordinated care systems achieve the provisions of benefits packages, Provider panels and Delivery Service Network consistent with Triple Aim objectives, incorporate community engagement, demonstrate accountability, and eliminate health care disparities.

SECTION 4 – RFA PROCESS

4.1. Communications

4.1.1. Sole Point of Contact (SPC)

All communications with OC&P concerning this RFA must be directed only to the SPC named below:

Tammy L. Hurst, Contract Specialist
Office of Contracts and Procurement (OC&P)
250 Winter Street NE, 3rd Floor
Salem, Oregon 97301
Telephone: 503-947-5298
Fax: 503-373-7365
Email: tammy.hurst@state.or.us
TTY: 503-378-3523

Any unauthorized contact regarding this RFA with other State employees or officials may result in Application rejection.

4.1.2. Official and Binding Communications

An electronic web portal established for the administration of this RFA (web address) will be used to distribute all information regarding this RFA that applies to all Applicants. Any additional information received in writing from the SPC is also considered official. Any oral communications will be considered unofficial and non-binding. Any communications, written or oral, that precede the official posting of this RFA on the web portal established for administering this RFA (including communications in relation to any public comment draft) are not official and binding unless reflected in this RFA or an addendum thereto. Any communications in connection with CCO administrative rule process are not binding on this RFA unless reflected in administrative rule language filed with the Secretary of State.

4.2. Timeline for RFA and Application Submission

On due dates, the item is due at 3:00 P.M. local Pacific Time. All Application documents are to be submitted electronically to OHA's web portal located at: <http://cco.health.oregon.gov>. All other communications are to be submitted only to the SPC.

4.2.1. Initial Application Schedule

The following schedule governs the initial round of CCO Applications, for the earliest available effective date:

Event	1 st Application Date
Request for Applications Posted	March 19, 2012
RFA Questions Due	March 26, 2012
RFA Answers Returned	April 2, 2012
Notice of Intent to Apply Due to CMS* and Letter of Intent Due to OHA	April 2, 2012
RFA Protests Due	April 4, 2012
New Part D Formulary to CMS*	April 30, 2012
Technical Application Due	April 30, 2012
Financial Application Due	May 14, 2012
Dual Eligibles MTM Program to CMS*	May 7, 2012
Award of Certification and Contract	May 28, 2012
Previous Part D Formulary to CMS*	May 14, 2012
Medicaid Contract Signed	June 29, 2012
Dual Eligibles Benefit Package to CMS*	June 4, 2012
OHA sends Medicaid Contract to CMS	July 3, 2012
Medicaid Contract Effective	August 1, 2012
Certification for Dual Eligibles*	July 31, 2012
Three-Way Contract Signed*	Sept. 20, 2012
Dual Eligible Benefits Effective*	January 1, 2013

*Required for participation in CMS Financial Alignment Demonstration for Integrating Care for Individuals who are Dually Eligible. See Appendix E in the RFA for more information.

Dates not in bold face are estimated and are subject to change.

4.2.2. Subsequent Application Schedule

In light of the developmental nature of the CCO system, OHA will continue to accept applications from organizations after the initial application date. New applicants are encouraged to apply unless or until OHA determines that sufficient CCO capacity has been established in an area or a region or statewide. Applications received after that time will be returned to the Applicant.

For year one of the program, the schedule for subsequent Application Dates is set forth in Attachment 3, CCO Application Dates. Application Dates for subsequent years will be announced by addendum to this RFA.

4.2.3. CCO Letter of Intent to Apply

Organizations interested in becoming CCOs must complete a CCO Letter of Intent to Apply. The due date for the CCO Letter of Intent to Apply is in Section 4.2.1. It must be submitted electronically in text-readable pdf form to OHA's web portal.

A CCO Letter of Intent to Apply must be submitted for any Contract effective date during year one of the CCO program (see Attachment 3). If the Applicant's CCO Letter of Intent to Apply is submitted after the initial date set forth in Section 4.2.1, then unless OHA waives the Notice of Intent due date for Applicant, the earliest effective date of the Contract will be a future date to be announced by addendum.

The CCO Letter of Intent to Apply must contain:

- 4.2.3.a.** A statement that the document is a CCO Letter of Intent to Apply under Section 4.2.3 of RFA # 3402.
- 4.2.3.b.** The true legal entity name of the Applicant. (Applicant need not have formed the legal entity at the time of the Letter of Intent to Apply.)
- 4.2.3.c.** A brief narrative summary of Applicant's strategy for achieving the goals of Health Systems Transformation.
- 4.2.3.d.** Reference to any existing MCO contract or contracts of Applicant or an Affiliate of Applicant, and a statement whether Applicant expects that contract or contracts to be terminated immediately before the effective date of Applicants's CCO contract.
- 4.2.3.e.** Reference to any existing or expected Licensed Health Plan certificate of authority of Applicant, an Affiliate of Applicant, or an intended subcontractor of Applicant.
- 4.2.3.f.** Reference to any existing MA contract of Applicant, an Affiliate of Applicant, or a subcontractor of Applicant.
- 4.2.3.g.** The dates on which Applicant expects to submit its Technical and Financial Applications. (See Attachment 3 for dates available under this RFA. Later application dates may become available in the future by an addendum to this RFA.)

- 4.2.3.h.** The date on which the Applicant desires to have its Medicaid contract be effective. (The dates available under this RFA are set forth in Attachment 3. A letter of intent may indicate a later date, which may become available in the future by an addendum to this RFA.)
- 4.2.3.i.** The date on which the Applicant desires to have its Medicare demonstration (“three-way contract”) contract be effective. (The only date available under this RFA is January 1, 2013. A letter of intent may indicate a later date, which may become available in the future by an addendum to this RFA.)
- 4.2.3.j.** Applicant’s desired service area/region by county or zip code.
- 4.2.3.k.** Applicant’s desired member capacity, including the capacity for dual eligibles. If Applicant desires to have no limit on capacity, so state.
- 4.2.3.l.** An acknowledgement that the CCO Letter of Intent to Apply is binding, to the limited extent described in Section 4.2.3 of the RFA.

A representative authorized to bind the Applicant must sign the CCO Letter of Intent to Apply electronically. Failure of the authorized representative to sign the CCO Letter of Intent to Apply may subject it to rejection by OC& P.

The CCO Letter of Intent to Apply is binding, to the limited extent described in this paragraph. OHA will consider a CCO Letter of Intent to Apply to remain in effect and may rely on it until Applicant changes or withdraws it. Applicant must submit to the OHA SPC (not to the web portal) any changes or withdrawal of its CCO Letter of Intent to Apply, signed electronically by a representative authorized to bind the Applicant. Except as its CCO Letter of Intent to Apply is changed or withdrawn, Applicant must submit Technical and Financial Applications on the dates set forth in its CCO Letter of Intent to Apply. If Applicant alters its intent to submit Technical and Financial Applications on the dates set forth in its CCO Letter of Intent to Apply, Applicant must submit a change to or withdrawal of its CCO Letter of Intent to Apply.

OHA intends to post on its web site copies of all CCO Letters of Intent to Apply received.

4.2.4. Medicare Notice of Intent to Apply

In addition to the CCO Letter of Intent to Apply submitted to OHA, Applicant must submit a Medicare Notice of Intent to Apply to CMS using the CMS forms and by the date required by CMS. For year one of the CCO program, the Medicare Notice of Intent to Apply is due on the date set forth in Section 4.2.1. Applicant must provide a copy of its Medicare Notice of Intent to Apply to OHA at the same time it submits the OHA letter of intent to apply.

4.3. Closing Dates; Methods for Electronic Submittal of Applications

- 4.3.1.** For the initial Application schedule, the Technical and Financial Applications must be submitted to OHA’s web portal by the dates specified in Section 4.2.1, Initial Application Schedule, as elected by Applicant in its CCO Letter of Intent to Apply. For subsequent Application dates, the Technical and Financial Applications must be submitted to OHA’s web portal by the dates specified in Section 4.2.2, Subsequent Application Schedule, as elected by Applicant in its CCO Letter of Intent to Apply. Applications received in OHA’s web portal after the closing date and time are late and may be rejected in OHA’s sole discretion.

- 4.3.2.** The Technical and Financial Applications must be submitted electronically to OHA's web portal. The address of the portal and instructions for its use will be published by addendum to this RFA. The due dates in 4.2.1 and 4.2.2 apply to web portal submission. The web portal will post terms and conditions for its use, which Applicant must accept by its signature on its Application Cover Sheet, Attachment 1.
- 4.3.3.** OC&P will provide all Applicants with an email acknowledgment of receipt of delivery of the Application.

4.4. Pre-Application Questions Relating to This RFA

Questions about this RFA document, including specifications, Contract terms and conditions, or the Application process must be submitted and received by the SPC by the date and time specified in Section 4.2. Questions may be submitted by fax or e-mail. Notification of any substantive clarifications provided in response to any question will be provided and published on the Web Portal.

For complete RFA documentation, please go to OHA's web portal. OC&P will not automatically mail copies of any addenda or answers but will publish Addenda and Questions and Answers on OHA's web portal. Addenda may be downloaded from the OHA web portal. Applicants are responsible to frequently check the OHA web portal until date of RFA Closing.

4.5. Public Opening

In accordance with OAR 137-047-0450, the SPC will post on the OHA web portal a public opening after each Application deadline. Only the name of the Applicant will be revealed at the opening; no other information will be made available at that time. Applications received will not be available for inspection until after the evaluation process has been completed and the notice of intent to award is issued pursuant to OAR 137-047-0630.

SECTION 5 – APPLICATION REQUIREMENTS

All Applications shall include the items listed in this Section. Applications must address all Application and submission requirements set forth in this RFA, and must describe how the services will be provided. Applications that merely offer to provide services as stated in this RFA will be considered non-responsive to this RFA and will not be considered further.

OHA will evaluate the overall quality of content and responsiveness of Applications to the purpose and specifications of this RFA.

5.1. General Application Requirements

- 5.1.1.** Electronic submissions must be in Word, Excel, Powerpoint, or Portable Document Format. Where possible, pdfs should be text-readable rather than scanned.
- 5.1.2.** The Applicant is responsible for assuring that all electronic submissions are complete, have all desired headers and footers, and are paginated.
- 5.1.3.** The Applicant is responsible for assuring that all electronic submissions contain no personal health information and are free of viruses and all other electronic security risks. An Applicant violating the preceding sentence is subject to civil penalties, damages, and criminal prosecution.

5.2. Technical Application

The Technical Application shall include the following items in the order listed below. Page limits are noted, when relevant. Unless otherwise specified, no particular form is required.

5.2.1. Application Cover Sheet

Complete all sections of the Application Cover Sheet (Attachment 1). A representative authorized to bind the Applicant must sign the Application Cover Sheet electronically. Failure of the authorized representative to sign the Application Cover Sheet may subject the Application to rejection by OC&P.

5.2.2. Letters of Support from Key Community Stakeholders: Provide letters of support from community partners and stakeholders, including but not limited to community mental health, public health, and other publicly funded programs.

5.2.3. Questionnaires: Furnish responses to the questionnaires in the following six appendices to this RFA:

APPENDIX A – CCO Criteria Questionnaire
APPENDIX B – Provider Participation and Operations Questionnaire
APPENDIX C – Accountability Questionnaire
APPENDIX D – Financial Reporting and Solvency Questionnaire
APPENDIX E – Dual Eligibles Questionnaire

5.3. Financial Application

Applicant may submit a Financial Application only if its Technical Application has been submitted.

The Financial Application comprises responses to the questionnaires in the following two appendices to this RFA:

APPENDIX F – Global Budget Questionnaire

5.4. Public Presentation by Applicant

Applicant will be required to provide a public presentation at a forum to be determined about the Technical Application that has been submitted to the OHA.

SECTION 6 – APPLICATION EVALUATION

Applications must be complete at the time of submission.

OC&P will verify the Applications received meet the Minimum Qualifications identified in Section 2 and General Application Requirements in Section 5.1. Those Applications meeting these requirements will then be evaluated by a Review Panel selected by OHA.

Award, if one is made, will be made to all responsive, responsible Applicants who meet the certification standards for CCOs, subject to Section 6.7.

6.1. Pass/Fail Items

The items listed below will be scored on a pass/fail basis.

6.1.1. Does the Applicant meet the requirements of Section 2 Minimum Qualifications?

6.1.2. Does the Application comply with all Section 5 Application Requirements?

6.2. Technical Application Evaluation

Evaluation of Applicant's Technical Application will include, but not be limited to, the Applicant's demonstrated experience and capacity for:

6.2.1. Developing and implementing alternative payment methodologies that are based on health care quality and improved health outcomes.

6.2.2. Coordinating the delivery of physical health care, mental health and chemical dependency services, oral health care and covered long-term care services.

6.2.3. Engaging community members and health care providers in improving the health of the community and addressing regional, cultural, socioeconomic and racial disparities in health care that exist among the coordinated care organization's members and in the coordinated care organization's community.

6.2.4. Performing all the Work described in this RFA.

6.2.5. Progressing from the baseline requirements for CCOs to the full requirements expected at maturity.

6.2.6. Satisfying all requirements for serving dual eligibles.

6.3. Financial Application Evaluation

Evaluation of Applicant's Financial Application will include, but not be limited to, the following questions: Does Applicant's Financial Application contain all required items and cost elements? Can the cost for each activity category in the Scope of Work be easily determined? Is it cost effective and within the expected scope of the project budget? Will it meet CMS and OHA actuarial requirements? Did Applicant sufficiently address all elements of financial solvency? Did the Applicant demonstrate the ability for sound fiscal policy either based on successful completion of similar projects, successful audits, or a copy of a recent business plan?

Evaluation of Applicant's Financial Application will include, but not be limited to, the Applicant's demonstrated experience and capacity for:

6.3.1. Managing financial risk and establishing financial reserves.

6.3.2. Meeting the following minimum financial requirements:

6.3.1.a. Maintaining restricted reserves of \$250,000 plus an amount equal to 50 percent of the coordinated care organization's total actual or projected liabilities above \$250,000.

6.3.1.b. Maintaining a net worth in an amount equal to at least five percent of the average combined revenue in the prior two quarters of the participating health care entities.

6.3.3. Operating within a fixed global budget.

6.4. Revised Application

The “Revised Application” permits OC&P to request a “Revised Application” from one or more Applicants if additional information is required to make a final decision. Applicant may be contacted asking that they submit their “Revised Application,” which must include any and all discussed and negotiated changes. OC&P reserves the right to request a “Revised Application” for this RFA based on any factor.

6.5. Responsible

Prior to award, OC&P intends to evaluate whether the Applicant meets the applicable standards of responsibility identified in OAR 410-141-3010. In doing so, OC&P may request information in addition to that already required in the RFA when OC&P, in its sole discretion, considers it necessary or advisable.

OC&P reserves the right, pursuant to OAR 410-141-3010, to investigate and evaluate, at any time prior to award and execution of the Contract, the Applicant’s responsibility to perform the Scope of Work. Submission of a signed Application shall constitute approval for OC&P to obtain any information OC&P deems necessary to conduct the evaluation. OC&P shall notify the Applicant in writing of any other documentation required, which may include but is not limited to: recent profit-and-loss history; current balance statements; assets-to-liabilities ratio, including number and amount of secured versus unsecured creditor claims; availability of short and long-term financing; bonding capacity; credit information; and facility and personnel information. Failure to promptly provide this information shall result in Application rejection.

OC&P may postpone the award of the Contract after announcement of the apparent successful Applicant in order to complete its investigation and evaluation. Failure of the apparent successful Applicant to demonstrate Responsibility, as required under OAR 410-141-3010, shall render the Applicant non-responsible.

6.6. Certification and Contract Award

6.6.1. Certification as a CCO will be made for the responsive, responsible Applicants who meet the certification standards. OHA may enter into negotiations with Applicant before or after certification. OHA may choose to not certify an Applicant or may determine that the Applicant may potentially be certified in the future if specified conditions are met. If an Application is rejected, Applicant will be promptly notified. At any time after initial certification, OHA may deny, revoke, debar, or revise Applicant’s certification as a CCO, based on updated information.

6.6.2. OHA may award a Contract to any Applicant that has been certified as a CCO. OHA is not required to award a Contract with the same scope that Applicant has applied for. OHA may enter into negotiations with Applicant before or after award. OHA may choose to not award a Contract.

6.6.3. Certification for Dual Eligibles will be made for the responsive, responsible Applicants who have been certified as a CCO and meet the certification standards for serving dual eligibles. OHA and CMS may enter into negotiations with Applicant before or after certification for Dual Eligibles. OHA and CMS may choose to not certify an Applicant for Dual Eligibles or may determine that the Applicant may potentially be certified for Dual Eligibles in the future if specified conditions are met. If an Application is rejected, Applicant will be promptly notified.

At any time after initial certification, OHA or CMS may deny, revoke, debar, or revise Applicant's certification for Dual Eligibles, based on updated information.

- 6.6.4.** OHA and CMS may award a three-way contract to any Applicant or CCO that has been certified for Dual Eligibles. OHA and CMS are not required to award a three-way contract with the same scope that Applicant has applied for. OHA and CMS may enter into negotiations with Applicant before or after award. OHA and CMS may choose to not award a three-way contract.
- 6.6.5.** If an Application for certification, for a Contract, for certification for Dual Eligibles, or for a three-way contract is rejected, Applicant will be promptly notified.
- 6.6.6.** OHA intends to exempt from state antitrust laws, and to provide immunity from federal antitrust laws through the state action doctrine, Applicants, CCOs, and persons forming CCOs that might otherwise be constrained by such laws. OHA's evaluation of an Application is intended to evidence appropriate state supervision necessary to promote state action immunity under state and federal antitrust laws. OHA's certification of a CCO is intended to evidence appropriate state supervision necessary to promote state action immunity under state and federal antitrust laws.
- 6.6.7.** OHA does not authorize Applicants, CCOs, persons forming a CCO, or other persons to engage in activities or to conspire to engage in activities that would constitute per se violations of state or federal antitrust laws including, but not limited to, agreements among competing health care providers as to the prices of specific health services. OHA will not be liable in the event that state, federal, or private antitrust enforcement, injunctive, or damages action is initiated against Applicant, a CCO, or persons forming a CCO.

6.7. Disposition of Applications

- 6.7.1. Mandatory Rejection:** OC&P will reject an Applicant's Application if the Applicant attempts to influence a member of the Application Review Panel regarding the Application review and evaluation process.
- 6.7.2. Discretionary Rejection:** OC&P may reject an Application for any of the following additional reasons:
 - 6.7.2.a.** The Applicant fails to substantially comply with all prescribed solicitation procedures and requirements, including but not limited to the requirement that Applicant's authorized representative sign the Application in ink; or
 - 6.7.2.b.** The Applicant makes any unauthorized contact regarding this RFA with State employees or officials other than the SPC.
- 6.7.3. Potential Certification:** OHA may determine that an Applicant is potentially capable of being certified as a CCO at a later date than the date applied for. In that event, OHA may establish conditions that the Applicant must meet in order to be certified as a CCO. OHA and CMS may determine that an Applicant is potentially capable of being certified for Dual Eligibles at a later date than the date applied for. In that event, OHA and CMS may establish conditions that the Applicant must meet in order to be certified for Dual Eligibles.
- 6.7.4. MCO Applicants:** If the Applicant is an MCO or is sponsored by one or more MCOs, then:
 - 6.7.4.a.** OHA will normally terminate the MCO contracts immediately before the effective date of the CCO contract.

- 6.7.4.b.** If the Applicant has been rejected or determined to be potentially qualified, OHA will normally renew the MCO contracts pending reapplication or satisfaction of conditions to become certified as a CCO.
- 6.7.5. Reapplication:** Subject to 6.7.6, an Applicant that has been rejected may reapply at a later date. Before submitting its reapplication, the Applicant must submit a revised CCO Letter of Intent to Apply.
- 6.7.6. Debarment:** OHA may reject an Application and determine that the Applicant is debarred from future application. Grounds for debarment include, but are not limited to, grounds set forth in ORS 279B.130 or exclusion from the federal Medicare or Medicaid programs. CMS may reject an Application for certification for Dual Eligibles and determine that the Applicant is debarred from future application. Grounds for debarment include, but are not limited to, exclusion from the federal Medicare or Medicaid programs.
- 6.7.7. Administrative Review:** An Applicant may seek administrative review under OAR 410-141-3010 of OHA's decision to potentially certify Applicant as a CCO or for Dual Eligibles; to deny, revoke, or revise Applicant's certification as a CCO or for Dual Eligibles; or to debar the Applicant. Administrative review is the process described in OAR 410-120-1580 applicable to provider applicants.

SECTION 7 – GENERAL INFORMATION

7.1. Changes/Modification and Clarifications

When appropriate, OC&P will issue revisions, substitutions, or clarifications as addenda to this RFA. Changes and modifications to the RFA shall be recognized *only* if in the form of written addenda issued by OC&P and posted on the OHA web portal at: <http://cco.health.oregon.gov>

7.2. Reservation of OC&P Rights

OC&P reserves all rights regarding this RFA, including, without limitation, the right to:

- Amend or cancel this RFA without liability if it is in the best interest of the State to do so;
- Reject any and all Applications received by reason of this RFA upon finding that it is in the best interest of the State to do so;
- Waive any minor informality;
- Seek clarification of each Application;
- Negotiate the statement of work within the scope of work described in this RFA and to negotiate the rate;
- Amend or extend the term of any Contract that is issued as a result of this RFA;
- Engage Applicant by selection or procurement for different or additional services independent of this RFA process and any contracts/agreements entered into pursuant hereto;
- Enter into direct negotiations to execute a Contract with a responsive Applicant, in the event that the Applicant is the sole Applicant to this RFA, and OC&P determines that the Applicant satisfies the minimum RFA requirements;
- Reject any Application upon finding that to accept the Application may impair the integrity of the procurement process or that rejecting the Application is in the best interest of the State;
- Not award a Contract to an Applicant that has been certified, or award a Contract more limited than what the Application sought.

- Not award a three-way contract to an Applicant that has been certified for Dual Eligibles, or award a three-way contract more limited than what the Application sought.
- Revoke or limit a certification based on an Applicant not achieving certification for Dual Eligibles.
- Revoke or limit a Contract based on a CCO not achieving the three-way contract.

7.3. Protest of RFA

Subject to OAR 410-141-3010 and OAR 137-047-0730, any prospective Applicant may submit a written protest of the procurement process or this RFA no later than the date identified in Section 4.2.1. Any written protest to the procurement process or this RFA shall be delivered to the SPC identified in Section 4.1 and shall contain the following information:

- 7.3.1.** Sufficient information to identify the solicitation that is the subject of the protest;
- 7.3.2.** The grounds that demonstrate how the procurement process is contrary to law or how the solicitation document is unnecessarily restrictive, is legally flawed or improperly specifies a brand name;
- 7.3.3.** Evidence or supporting documentation that supports the grounds on which the protest is based;
- 7.3.4.** The relief sought; and
- 7.3.5.** A statement of the desired changes to the procurement process or the RFA that the will remedy the conditions upon which the prospective Applicant based its protest.

7.4. Award Notices

The apparent successful Applicants for award of Contracts shall be notified in writing and OC&P will set the time lines for Contract negotiation as applicable. The apparent successful Applicants for award of three-way contracts shall be notified in writing and OC&P will set the time lines for three-way contract negotiation as applicable.

7.5. Protest of Awards

Every Applicant shall be notified of its selection status. An Applicant shall have 7 calendar days after the date of the notice of intent to award a Contract to submit a written protest to the SPC identified in Section 4.1. An Applicant shall also have 7 calendar days after the date of the notice of intent to award a three-way contract to submit a written protest to the SPC identified in Section 4.1. Award protests must meet the requirements of ORS 279B.410 to be considered. OC&P will not consider any protests that are received after this deadline.

7.6. Modification or Withdrawal

- 7.6.1.** Modifications: An Applicant may modify its Application in writing prior to the closing. An Applicant must prepare and submit any modification to its Application to OC&P in accordance with Paragraph 4.3, above. Any modification must include the Applicant's statement that the modification amends and supersedes the prior Application. The Applicant must mark the submitted modification "Application Modification RFA # 3402," and be addressed to the attention of the SPC.

7.6.2. Withdrawals: An Applicant may withdraw its Application by written notice submitted signed by an authorized representative of the Applicant, delivered to the SPC in person or in the same manner as set forth in Paragraph 4.3, above. The Applicant must mark the written request to withdraw “Application Withdrawal to RFA # 3402.”

7.7. Release of Information

No information shall be given to any Applicant (or any other individual) relative to their standing during the RFA process. The information in the Application may be shared with the Authority, the Department of Consumer and Business Services, CMS, and those persons involved in the review and evaluation of the Application information at the request of the Authority.

7.8. Public Information

7.8.1. A CCO Letter of Intent to Apply, and any change or withdrawal thereto, is a public record subject to disclosure without exemption.

7.8.2. After the notice of intent to award, the procurement file is subject to public disclosure in accordance with OAR 137-047-0630, and the Oregon Public Records Law (ORS 192.410–192.505). If any part of an Application or protest is considered a trade secret as defined in Oregon Revised Statutes 192.501(2) or otherwise exempt from disclosure under Oregon Public Records Law, the Applicant shall, at the time of submission: (1) clearly designate that portion as confidential in Part I of Attachment 2 (Applicant’s Designation of Confidential Materials); and (2) explain the justification for exemption under the Oregon Public Records Law in Part II of Attachment 2, in order to obtain protection, if any, from disclosure. Application of the Oregon Public Records Law shall determine if the confidential information claimed to be exempt is in fact exempt from disclosure.

7.8.3. Any person may request copies of public information. However, copies of Applications will not be provided until the evaluation process has been closed and the notice of intent to award has been issued. Requests for copies of public information shall be in writing. Requestors will be charged according to the current policies and rates for public records requests in effect at the time OC&P receives the written request for public information. Fees, if applicable, must be received by OC&P before the records are delivered to the requestor.

7.8.4. Application information submitted to CMS may be subject to federal Freedom of Information Act (FOIA). OHA will provide CMS a copy of Applicant’s Designation of Confidential Materials but cannot control disclosure of information under FOIA.

7.9. Cost of Applications

All costs incurred in preparing and submitting an Application in response to this RFA will be the responsibility of the Applicant and will not be reimbursed by OHA.

7.10. Statutorily Required Preferences

No preferences apply to this RFA.

7.11. Contract Period

Initial term of the Contract and the three-way contract shall be for the period stated in Section 1.1. If OHA determines that the work performed has been satisfactory, OHA may, at its option, renew, amend

or extend the Contract and three-way contract for additional time and for additional dollars without further solicitation for a total term of certification and certification for Dual Eligibles of up to six years. Modifications or extensions shall be by written amendment duly executed by the parties to the original Contract; see Core Contract, Appendix G.

7.12. Contractual Obligation

All Applicants who submit an Application in response to this RFA understand and agree that OHA is not obligated thereby to enter into a Contract with any Applicant and, further, has absolutely no financial obligation to any Applicant.

7.13. Contract Documents

The final Contract will be based on the Core Contract, which is attached as Appendix G to this RFA, and will include all exhibits and attachments identified in the Contract. The terms and conditions included in Appendix G, "Core Contract," are not subject to negotiation, but may be changed through submission of a question or protest before the deadline identified in Section 4.2.1. The contract Statement of Work is negotiable, based on terms and conditions included in this RFA, Applicant's proposed Statement of Work submitted with its Application, and Applicant's response to the Questionnaires.

7.14. Insurance Requirements

The apparently successful Applicant will be required to secure insurance as described in the Appendix G "Core Contract", Exhibit F "Insurance Requirements" prior to execution of the Contract.

7.15. Code of Conduct

The Provisions of this Code of Conduct do not alter any stricter or different guidelines or prohibitions of OHA or the laws of the State of Oregon.

7.15.1. Prohibited Practices. Except as disclosed in writing to and accepted or authorized in writing by OHA, or as otherwise expressly permitted or required by the Contract, Applicant shall not, and shall assure that its Affiliates shall not, in any way:

7.15.1.a. Be party to or benefit from any agreement or understanding relating to the receipt or payment of, or receive, any Contingent Commission relating to this RFA.

7.15.1.b. Arrange for, be party to, or otherwise cause any Noncompetitive Response on a Procurement by or on behalf of OHA.

7.15.1.c. Take unfair advantage of OHA or the Members through manipulation, concealment, abuse of privileged information, misrepresentation of material facts or any other unfair practice.

7.15.1.d. Mislead OHA or the Members through deceptive acts or practices, false advertising claims, misrepresentations regarding the benefit plan of Applicant, or other unfair methods of competition.

7.15.1.e. Engage in any conduct, conspiracy, contract, agreement, arrangement or combination, or adopt or follow any practice, plan, program, scheme, artifice or

device similar to, or having a purpose and effect similar to, the conduct prohibited above.

7.15.2. Disclosure and Transparency. Applicant shall fully, clearly, completely, and adequately disclose to OHA the services it provides and all forms of income, compensation, or other remuneration it receives or pays or expects to receive or pay under or otherwise in connection with the Contract. The manner in which Applicant gets paid will be transparent and understandable to OHA.

7.15.3. Conflicts of Interest. Applications have been and renewals will be submitted so as to allow OHA using its best impartial judgment in a Procurement. Applicant and Affiliates will perform their duties using their best impartial judgment in all matters affecting OHA. A conflict of interest occurs when Applicant or its Affiliate has a personal interest or is involved in an activity that could interfere with OHA's ability to evaluate a Procurement, or Applicant's ability to perform its Work, in an objective, impartial and effective manner. An apparent conflict of interest occurs when personal interests or activities could lead others to doubt the objectivity or impartiality of OHA or of Applicant or its Affiliates. To maintain independence of judgment and action, Applicant and Affiliates shall avoid conflict of interest or an appearance of conflict that might arise because of economic or personal self-interest, except as disclosed in writing to and consented in writing by OHA. The Applicant's disclosure to OHA may include suggestions for mitigating or managing a conflict of interest, such as communications barriers with conflicted individuals. While it is impossible to list all situations that could constitute a conflict of interest, the following are some common examples:

7.15.3.a. Using property or non-public information of OHA or Members, or an Affiliate's position with or relationship with Applicant, for personal gain of the Applicant or Affiliate (other than compensation to Applicant expressly provided in the Contract).

7.15.3.b. Having an ownership or economic interest in a company that does business with Applicant or an Affiliate, where the owner or interested person is in a position to influence Applicant's or OHA's relationship with the company.

7.15.3.c. Having the representative of a Proposer, Applicant or Vendor to the State of Oregon be a family member of an employee of the State of Oregon who has authority over the Applicant or RFA.

7.15.3.d. Applicant or its Affiliates employing, for work connected with this RFA, a former employee of the State of Oregon who assisted in preparing the RFA.

7.15.4. Use of Funds or Assets. To the extent it uses funds and assets of the State of Oregon under the Contract, Applicant shall not, directly or indirectly:

- Use funds or assets for any purpose which would be in violation of any applicable law or regulation.
- Make contributions to any political candidate, party, or campaign either within or without the United States.
- Establish or maintain a fund, asset, or account that is not recorded and reflected accurately on the books and records of Applicant or the State of Oregon.
- Make false or misleading entries in the books and records of Applicant or the State of Oregon, or omit to make entries required for these books and records to be accurate and complete.

- Effect a transaction or make a payment with the intention or understanding that the transaction or payment is other than as described in the documentation evidencing the transaction or supporting the payment.

7.15.5. Marketing Practices. Except as authorized in writing by OHA, Applicant shall assure that all relationships with its Affiliates and business partners relating to the State of Oregon are conducted at arms-length using criteria approved by OHA and are based on fairness and the best interests of OHA and its Members.

In any dealings with a supplier, customer, government official, or other person or entity, Applicant or its Affiliate shall not request, accept, or offer to give any payments, gifts, trips, kickbacks, or other significant things of value, the purpose or result of which could be to influence the Services received by OHA and its Members or that may be construed as swaying OHA's RFA decisions based on other than the merits of and the evaluation criteria in the RFA. For this purpose, a "significant thing of value" will mean a thing that a person could not lawfully receive or be given as an employee of OHA.

In any dealings with a supplier, customer, government official, or other person or entity for or on behalf of OHA and its Members or in connection with a Procurement, Applicant and its Affiliates shall not exchange business gifts, meals, entertainment, or other business courtesies that are intended to interfere, or are in a magnitude that may have the effect of interfering, with the recipient's duty to act in the best interests of OHA and its Members or to interfere with the recipient's business judgment.

ATTACHMENT 1 – Application Cover Sheet

Applicant Information - RFA # 3402

Applicant Name: _____

Form of organization (business corporation, etc.) _____

State of domicile: _____

Primary Contact Person: _____ Title: _____

Address: _____

City, State, Zip: _____

Telephone: _____ Fax: _____

E-mail Address: _____

Name and title of the person(s) authorized to represent the Applicant in any negotiations and sign any Contract that may result:

Name: _____ Title: _____

By signing this page and submitting an Application, the Authorized Representative certifies that the following statements are true:

1. No attempt has been made or will be made by the Applicant to induce any other person or organization to submit or not submit an Application.
2. Applicant does not discriminate in its employment practices with regard to race, creed, age, religious affiliation, sex, disability, sexual orientation or national origin, nor has Applicant or will Applicant discriminate against a subcontractor in the awarding of a subcontract because the subcontractor is a minority, women or emerging small business enterprise certified under ORS 200.055.
3. Information and costs included in this Application shall remain valid for 180 days after the Application due date or until a Contract is approved, whichever comes first.
4. The statements contained in this Application are true and, so far as is relevant to the Application, complete. Applicant accepts as a condition of the Contract, the obligation to comply with the applicable state and federal requirements, policies, standards, and regulations.
5. The undersigned recognizes that this is a public document and will become open to public inspection, except as described in Section 7.8.
6. Applicant confirms that it has followed the instructions provided and has identified any deviations from specifications within its response. Applicant confirms that any instructions or specifications that it felt were unclear have been questioned in advance of this Application.
7. Applicant acknowledges receipt of all addenda issued under this RFA.
8. If Applicant is awarded a Contract as a result of this RFA, the Applicant will be required to complete, and will be bound by, a Contract described in this RFA. Applicant agrees to the RFA sample contract terms and conditions in Appendix G, except to the extent Applicant has timely requested a change or clarification or filed a protest in accordance with the RFA.
9. Applicant, if awarded a Contract, agrees to meet the highest standards prevalent in the industry or business most closely involved in providing the appropriate goods or services as stated in the scope of work.
10. Applicant and its Affiliates complied with the Code of Conduct in Section 7.15 of the RFA in connection with the RFA.
11. Applicant agrees to the terms and conditions for OHA’s web portal, as posted on the web portal.

Signature: _____ Title: _____ Date: _____

(Authorized to Bind Applicant)

ATTACHMENT 2 – Applicant’s Designation of Confidential Materials
RFA # 3402

Applicant Name: _____

Instructions for completing this form:

As a public entity, OC&P is subject to the Oregon Public Records Law which confers a right for any person to inspect any public records of a public body in Oregon, subject to certain exemptions and limitations. *See* ORS 192.410 through 192.505. Exemptions are generally narrowly construed in favor of disclosure in furtherance of a policy of open government. Your Application will be a public record that is subject to disclosure except for material that qualifies as a public records exemption.

It is OC&P’s responsibility to redact from disclosure only material exempt from the Oregon Public Records Law. It is the Applicant’s responsibility to only mark material that legitimately qualifies under an exemption from disclosure. To designate a portion of an Application as exempt from disclosure under the Oregon Public Records Law, the Applicant should do the following steps:

1. Clearly identify in the body of the Application only the limited material that is a trade secret or would otherwise be exempt under public records law. If an Application fails to identify portions of the Application as exempt, Applicant is deemed to waive any future claim of non-disclosure of that information.
2. List, in the space provided below, the portions of your Application that you have marked in step 1 as exempt under public records law and the public records law exemption (e.g., a trade secret) you believe applies to each portion. If an Application fails to list in this Attachment a portion of the Application as exempt, Applicant is deemed to waive any future claim of non-disclosure of that information.
3. Provide, in your response to this Attachment, justification how each portion designated as exempt meets the exemption criteria under the Oregon Public Records Law. If you are asserting trade secret over any material, please indicate how such material meets all the criteria of a trade secret listed below. Please do not use broad statements of conclusion not supported by evidence.

Application of the Oregon Public Records Law shall determine whether any information is actually exempt from disclosure. Prospective Applicants are advised to consult with legal counsel regarding disclosure issues. Applicant may wish to limit the amount of truly trade secret information submitted, providing only what is necessary to submit a complete and competitive Application.

In order for records to be exempt from disclosure as a trade secret, the records must meet all four of the following requirements:

- The information must not be patented;
- It must be known only to certain individuals within an organization and used in a business the organization conducts;
- It must be information that has actual or potential commercial value; and,
- It must give its users an opportunity to obtain a business advantage over competitors who do not know or use it.

Keep in mind that the trade secret exemption is very limited. Not all material that you might prefer be kept from review by a competitor qualifies as your trade secret material. OC&P is required to release information in

the Application *unless* it meets the requirements of a trade secret or other exemption from disclosure and it is the Applicant’s responsibility to provide the basis for which exemption should apply.

In support of the principle of an open competitive process, “bottom-line pricing” – that is, pricing used for objective cost evaluation for award of the RFA or the total cost of the Contract or deliverables under the Contract – will not be considered as exempt material under a public records request. Examples of material that would also not likely be considered a trade secret would include résumés, audited financial statements of publicly traded companies, material that is publicly knowable such as a screen shot of a software interface or a software report format.

To designate material as confidential and qualified under an exemption from disclosure under Oregon Public Records Law, an Applicant must complete this Attachment form as follows:

Part I: List all portions of your Application, if any, that Applicant is designating as exempt from disclosure under Oregon Public Records Law. For each item in the list, state the exemption in Oregon Public Records Law that you are asserting (e.g., trade secret).

“This data is exempt from disclosure under Oregon Public Records Law pursuant to [*insert specific exemption from ORS 192, such as a “ORS 192.501(2) ‘trade secret’”*], and is not to be disclosed except in accordance with the Oregon Public Records Law, ORS 192.410 through 192.505.”

In the space provided below, state Applicant’s list of material exempt from disclosure and include specific pages and section Letters of Support of your Application.

1. _____
2. _____
3. _____

[This list may be expanded as necessary.]

Part II: For each item listed above, provide clear justification how that item meets the exemption criteria under Oregon Public Records Law. If you are asserting trade secret over any material, state how such material meets all the criteria of a trade secret listed above in this Attachment.

In the space provided below, state Applicant’s justification for non-disclosure for each item in the list in Part I of this Attachment:

1. _____
2. _____
3. _____

[This list may be expanded as necessary.]

**ATTACHMENT 3 – CCO Application Dates
RFA # 3402**

Part 1 - Medicaid Application Schedule

Event	1st Application Date	2nd Application Date	3rd Application Date	4th Application Date
RFA Posted	March 19, 2012	March 19, 2012	March 19, 2012	March 19, 2012
Letter of Intent Due to OHA	April 2, 2012	April 2, 2012	April 2, 2012	April 2, 2012
Technical Application Due	April 30, 2012	June 4, 2012	July 2, 2012	August 1, 2012
Financial Application Due	May 14, 2012	June 11, 2012	July 9, 2012	August 8, 2012
Award of Certification	May 28, 2012	July 2, 2012	August 6, 2012	September 5, 2012
Medicaid Contract Signed	June 29, 2012	July 30, 2012	August 29, 2012	September 28, 2012
Medicaid Contract to CMS	July 3, 2012	August 1, 2012	August 31, 2012	October 1, 2012
Medicaid Contract Effective	August 1, 2012	September 1, 2012	October 1, 2012	November 1, 2012

Part 2 - Dual Eligible Application Schedule

Event*	1 st Application Date	2 nd Application Date	3 rd Application Date	4 th Application Date
Notice of Intent to Apply Due to CMS	April 2, 2012	April 2, 2012	April 2, 2012	April 2, 2012
New Part D Formulary Due to CMS Medication Therapy Management Program Due to CMS	April 30, 2012	April 30, 2012	April 30, 2012	***
Previously Submitted Part D Formulary Due to CMS	May 7, 2012	May 7, 2012	May 7, 2012	***
Dual Eligible Benefit Package Due to CMS	May 14, 2012	May 14, 2012	May 14, 2012	***
CMS and OHA Certification for Dual Eligible	June 4, 2012	June 4, 2012	June 4, 2012	***
Three-Way Contract Signed	July 31, 2012	July 31, 2012	August 6, 2012**	***
Dual Eligible Benefits Effective	Sept. 20, 2012	Sept. 20, 2012	Sept. 20, 2012	***
	January 1, 2013	January 1, 2013	January 1, 2013	***

*Required for participation in CMS Financial Alignment Demonstration for Integrating Care for Individuals who are Dually Eligible. *See RFA Appendix E for more information.*

**Currently under discussion with CMS due to risk that joint CMS/OHA readiness review for participation in CMS Financial Alignment Demonstration will not be completed in time to sign three-way contracts by Sept. 20, 2012.

***OHA is requesting that CMS allow CCOs to enter three-way contracts after Sept. 20, 2012, with details to be determined during the CMS/OHA Memorandum of Understanding process. Plans on later timelines may risk losing the ability to passively enroll individuals dually eligible for Medicare and Medicaid or other advantages.

ATTACHMENT 4 – CCO Definitions
RFA # 3402

For purposes of this RFA (including its Attachments and Appendices) and the resulting Contract, the terms below shall have the following meanings:

1. Terms Defined by Rule

In this RFA, the following terms have the meanings defined in OAR 410-141-3000 and 410-120-0000:

Terms Defined in OAR 410-141-3000

Action	Health Insurance Portability and Accountability Act (HIPAA) of 1996
Appeal	Health Plan New/noncategorical client (HPN)
Coordinated Care Services	Health Services
Capitated Services	Health Systems Transformation (HST)
Capitation Payment	Line Items
CCO Payment	Local
Chemical Dependency Organization (CDO)	Marketing
Children Receiving Children, Adults and Families (CAF) Child Welfare or Oregon Youth Authority (OYA) Services	Medical Case Management Services
Cold Call Marketing	Medicare Advantage
Comfort Care	Mental Health Assessment
Community Advisory Council	Mental Health Case Management
Community Health Worker	Mental Health Organization (MHO)
Community Mental Health Program (CMHP)	National Drug Code or (NDC)
Co-morbid Condition	Non-Participating Provider
Community Standard	Ombudsman Services
Condition/Treatment Pair	Oregon Health Plan (OHP)
Coordinated Care Organization (CCO)	Participating Provider
Corrective Action or Corrective Action Plan	PCM Member
Covered Services	Peer Wellness Specialist
Declaration for Mental Health Treatment	Person Centered Care
Dentally Appropriate	Personal Health Navigator
Dental Care Organization (DCO)	Physician Care Organization (PCO)
Dental Case Management Services	Post Hospital Extended Care Benefit
Diagnostic Services	Primary Care Management Services
Disenrollment	Primary Care Manager (PCM)
Enrollment	Primary Care Dentist (PCD)
Enrollment Area	Prioritized List of Health Services
Enrollment Year	Quality Improvement
Exceptional Needs Care Coordination (ENCC)	Representative
Family Health Insurance Assistance Program (FHIAP)	Rural
Free-Standing Mental Health Organization (MHO)	Service Area
Fully-Capitated Health Plan (FCHP)	Stabilize
Grievance	Triage
Grievance System	Urban
Health Care Professionals	Urgent Care Services
	Valid Pre-Authorization

Terms defined in OAR 410-120-0000

AAA
Abuse
Acupuncturist
Acupuncture Services
Acute
Acquisition Cost
Addiction and Mental Health Division (AMH)
Adequate Record Keeping
Administrative Medical Examinations and Reports
Advance Directive
Aging and People with Disabilities (APD)
Adverse Event
All-Inclusive Rate
Allied Agency
Alternative Care Settings
Ambulance
Ambulatory Surgical Center (ASC)
American Indian/Alaska Native (AI/AN)
American Indian/Alaska Native (AI/AN) Clinic
Ancillary Services
Anesthesia Services
Area Agency on Aging (AAA)
Atypical Provider
Audiologist
Audiology
Authority
Automated Voice Response (AVR)
Benefit Package
Billing Agent or Billing Service
Billing Provider (BP)
Buying Up
By Report (BR)
Case Management Services
Children, Adults and Families Division (CAF)
Children's Health Insurance Program (CHIP)
Chiropractor
Chiropractic Services
Citizen/Alien-Waived Emergency Medical (CAWEM)
Claimant
Client
Clinical Social Worker
Clinical Record
Contested Case Hearing
Contiguous Area
Contiguous Area Provider
Comfort Care
Continuing Treatment Benefit
Co-Payments"
Cost Effective
Current Dental Terminology (CDT)
Current Procedural Terminology (CPT)
Date of Receipt of a Claim
Date of Service
Dental Emergency Services
Dental Services
Dentist
Denturist
Denturist Services
Dental Hygienist
Dental Hygienist with an Expanded Practice Permit
Dentally Appropriate
Department of Human Services (Department)
Department Representative
Diagnosis Code
Diagnosis Related Group (DRG)
Division of Medical Assistance Programs (Division)
Member
Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (aka, Medichex)
Electronic Data Interchange (EDI)
EDI Submitter
Electronic Verification System (EVS)
Emergency Department
Emergency Medical Condition
Emergency Medical Transportation
Emergency Services
Evidence-Based Medicine
False Claim
Family Health Insurance Assistance Program (FHIAP)
Family Planning Services
Federally Qualified Health Center (FQHC)
Fee-for-Service Provider
Flexible Service
Flexible Service Approach
Fraud
Fully Dual Eligible
General Assistance (GA)
Health Care Professionals
Healthcare Common Procedure Coding System (HCPCS)
Health Evidence Review Commission
Health Insurance Portability and Accountability Act (HIPAA) of 1996 (HIPAA)
Health Maintenance Organization (HMO)
Health Plan New/noncategorical client (HPN)
Hearing Aid Dealer

Home Enteral Nutrition
Home Health Agency
Home Health Services
Home Intravenous Services
Home Parenteral Nutrition
Hospice
Hospital
Hospital-Based Professional Services
Hospital Laboratory
Indian Health Program
Indian Health Care Provider
Indian Health Service (IHS)
Individual Adjustment Request Form (DMAP 1036)
Inpatient Hospital Services
Institutional Level of Income Standards (ILIS)
Institutionalized
International Classification of Diseases, 9th
Revision, Clinical Modification (ICD-9-CM)
Laboratory
Laboratory Services
Licensed Direct Entry Midwife
Liability Insurance
Managed Care Organization (MCO)
Maternity Case Management
Medicaid
Medical Assistance Eligibility Confirmation
Medical Assistance Program
Medical Care Identification
Medical Services
Medical Transportation
Medically Appropriate
Medicare Advantage
Medicare
Medicare Prescription Drug Coverage (Part D)
Mental Health Case Management
Medicheck for Children and Teens
National Correct Coding Initiative (NCCI)
National Drug Code or (NDC)
National Provider Identification (NPI)
Naturopath
Naturopathic Services
Non-covered Services
Nurse Anesthetist, C.R.N.A.
Nurse Practitioner
Nurse Practitioner Services
Nursing Facility
Nursing Services
Nutritional Counseling
Occupational Therapist
Occupational Therapy
Ombudsman Services

Optometric Services
Optometrist
Oregon Health Authority (OHA)
Oregon Health Plan (OHP)
Oregon Health Plan (OHP) Client (Client)
Oregon Youth Authority (OYA)
Out-of-State Providers
Outpatient Hospital Services
Overdue Claim
Overpayment
Overuse
Panel
Payment Authorization
Peer Review Organization (PRO)
Pharmaceutical Services
Pharmacist
Physical Capacity Evaluation
Physical Therapist
Physical Therapy
Physician
Physician Assistant
Physician Services
Podiatric Services
Podiatrist
Post-Payment Review
Practitioner
Premium Sponsorship
Prepaid Health Plan (PHP)
Primary Care Dentist (PCD)
Primary Care Physician
Primary Care Provider (PCP)
Prior Authorization (PA)
Prioritized List of Health Services
Private Duty Nursing Services
Provider
Provider Organization
Public Health Clinic
Public Rates
Qualified Medicare Beneficiary (QMB)
Qualified Medicare and Medicaid Beneficiary
(QMM)
Quality Improvement
Quality Improvement Organization (QIO)
Radiological Services
Recipient
Recreational Therapy
Recoupment
Referral
Remittance Advice (RA)
Representative
Request for Hearing

Retroactive Medical Eligibility
Rural
Sanction
School Based Health Service
Seniors and People with Disabilities Division (SPD)
Service Agreement
Sliding Fee Schedule
Social Worker
Speech-Language Pathologist
Speech-Language Pathology Services
Spend-Down
State Facility
Subparts (of a Provider Organization)
Subrogation
Supplemental Security Income (SSI)
Surgical Assistant
Suspension

Targeted Case Management (TCM)
Termination
Third Party Resource (TPR)
Transportation
Type A Hospital
Type B AAA
Type B AAA Unit
Type B Hospital
Urban
Urgent Care Services
Usual Charge (UC)
Utilization Review (UR)
Valid Claim
Vision Services

2. Terms Defined by Statute

In this RFA, the following terms have the meanings defined in ORS 414.025:

- (1) Alternative payment methodology
- (2) Category of aid
- (3) Categorically needy
- (9) Income
- (13) Patient centered primary care home
- (17) Quality measure
- (18) Resources

3. Terms Defined by the RFA

- a. **Affiliate** of, or person “affiliated” with, a specified person means a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.
- b. **Applicant** means the person or entity that submits an Application.
- c. **Application** means a written response submitted to OC&P in response to this RFA.
- d. **Certification** means a determination by OHA that an Applicant or CCO is qualified to hold a CCO contract.
- e. **Certification for Dual Eligibles** means a determination by CMS and OHA that an Applicant or CCO is qualified to hold a three-way contract.
- f. **CCO Administrative Rules** means OHA’s rules governing CCOs at OAR 410-141-3000 to 410-141-3XXX.
- g. **CCO Implementation Proposal** means the OHA document entitled *Coordinated Care Organizations Implementation Proposal: House Bill 3650 Health Care Transformation* (January

24, 2012), as approved by SB 1580. The CCO Implementation Proposal may be found at <http://health.oregon.gov/OHA/OHPB/health-reform/docs/cco-implementation-proposal.pdf>.

- h. CMS Medicare/Medicaid Alignment Demonstration** means a demonstration proposal by OHA to CMS that will align and integrate Medicare and Medicaid benefits and financing to the greatest extent feasible for individuals who are eligible for both programs. CMS will establish its timelines and requirements for participation in the CMS Medicare/Medicaid Alignment Demonstration, with the objective that CCOs demonstrating readiness may receive a three-way contract with the CCO, the Authority and CMS for the Dual Eligibles members of a CCO.
- i. Contract** means a Contract awarded as a result of this RFA.
- j. Contractor** means an Applicant selected through this RFA to enter into a Contract with OHA to perform the Work.
- k. Control**, including its use in the terms “controlling,” “controlled,” “controlled by” and “under common control with,” means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, 10 percent or more of the voting securities of any other person. For this purpose, voting security includes any security convertible into a voting security or evidencing a right to acquire a voting security. This presumption may be rebutted by a showing made to OHA in the manner provided by ORS 732.568 that control does not exist in fact. OHA may determine that control exists in fact, notwithstanding the absence of a presumption to that effect.
- l. DCBS** means the Oregon Department of Consumer and Business Services, Insurance Division.
- m. HB 3650** means 2011 Oregon House Bill 3650, 2011 Or Laws Chapter 602, as modified and supplemented by the 2012 Senate Bill 1580 (enrolled). Most 2011 provisions of HB 3650 are codified at ORS 414.610 to 414.685.
- n. Legal Entity** means an Oregon domestic corporation. A Legal Entity may be a business, nonprofit, insurance, public, or professional corporation.
- o. Licensed Health Carrier** means an organization that holds a Certificate of Authority from DCBS as a health care service contractor or health insurance company.
- p. Office of Contracts and Procurement (OC&P)** means the entity that is responsible for the procurement process for OHA.
- q. OHPB** means the Oregon Health Policy Board.
- r. Orange Blank** means the Health Annual Statement promulgated from time to time by the National Association of Insurance Commissioners (NAIC).
- s. RFA** means Request for Applications.

- t. **SB 1580** means 2012 Oregon Senate Bill 1580,
- u. **Three-Way Contract** means a contract between OHA, CMS, and a CCO that includes services for dual eligible.
- v. **Work** means the required activities, tasks, deliverables, reporting, and invoicing requirements, as described in Section 3-Scope of Work of this RFA.

DRAFT

APPENDIX A – CCO Criteria Questionnaire

APPLICANT MUST RESPOND TO EACH ITEM IN THE QUESTIONNAIRE ADDRESSING THE HEALTH SERVICES TRANSFORMATION AND CCO CRITERIA REQUIREMENTS

This questionnaire consists of six sections, corresponding to the sections of Chapter 5 of the CCO Implementation Proposal:

- Section 1:** Governance and Organizational Relationships
- Section 2:** Member Engagement and Activation
- Section 3:** Delivery System: Access, Patient-Centered Primary Care Homes, Care Coordination and Provider Network Requirements
- Section 4:** Health Equity and Eliminating Health Disparities
- Section 5:** Payment Methodologies that Support the Triple Aim
- Section 6:** Health Information Technology
- Section 7:** Framework Scope of Work

For background and further information, see Chapter 5 of the CCO Implementation Proposal, “Coordinated Care Organization (CCO) Criteria.”

The information requested in this questionnaire should be provided in narrative form, answering specific questions in each section and providing enough information for the OHA to evaluate the response. Include reasons why your organization is able to effectively complete the CCO service delivery and program design requirements, and how this will be accomplished in time to meet the needs of CCO members on implementation.

While HB 3650 excludes Medicaid-funded long term care services and supports from being directly provided by CCOs, CCOs will still be responsible for providing physical and behavioral health services for individuals receiving Medicaid-funded Long Term Care, and will be responsible for coordinating with the Medicaid-funded LTC system. The requirements for coordinating with the Medicaid-funded LTC system are integrated throughout this section of the application.

1. Background Information about the Applicant

In narrative form, provide an answer to each of the following questions.

- a. Describe the Applicant’s legal entity status, and where domiciled.
- b. Describe Applicant’s Affiliates as relevant to the Contract.
- c. What is the Applicant’s intended effective date for serving Medicaid populations?
- d. Is the Applicant invoking Alternative Dispute Resolution with respect to any provider (*see* OAR 410-141-3005) If so, describe.
- e. Does the Applicant take exception to or desire to negotiate any terms and conditions in the sample contract, other than those mandated by Medicaid or Medicare? If so, set forth alternative language requested.
- f. What is the proposed service area/region by zip code?

- g.** What is the address for the Applicant's primary office and administration located within the proposed service area?
- h.** What counties or portions of counties are included in this service area? Describe the arrangements the Applicant has made to coordinate with county governments and establish written agreements as required by ORS 414.153.
- i.** What are the demographic estimates of the member populations for the region the Applicant proposes to serve, including race, ethnicity and language?
- j.** Prior history as a managed care organization with the OHA. Did this legal entity have a contract with the OHA as a managed care organization as of July 1, 2011 (hereinafter called "current MCO")? If so, what type of managed care organization?
- Fully capitated health plan
 - Physician care organization
 - Mental health organization
 - Dental care organization
- k.** Is this the identical organization with a current MCO contract, or has that entity been purchased, merged, acquired, or otherwise undergone any legal status change since July 1, 2011?
- l.** Does the Applicant include more than one current MCO (e.g., a combination of a current fully capitated health plan and mental health organization)? If so, provide the information requested in this section regarding each applicable current MCOs.
- m.** Does the current MCO make this application for the identical service area that is the subject of the current MCO's contract with OHA? Does this application propose any change in the current service areas?
- n.** Current experience as an OHA contractor, other than as a current MCO. Does this Applicant currently have a contract with the OHA as a Licensed Health Plan or health plan third party administrator for any of the following (hereinafter called "current OHA contractor")? If so, please provide that information in addition to the other information required in this section.
- Oregon Medical Insurance Pool
 - Healthy Kids Connect
 - Public Employees Benefit Board
 - Oregon Educators Benefit Board
 - Adult Mental Health Initiative
- o.** Does the Applicant have experience as a Medicare Advantage contractor? Does the Applicant have a current contract with Medicare as a Medicare Advantage contractor? What is the service area for the Medicare Advantage plan?
- p.** Does the Applicant hold a current certificate of insurance in the State of Oregon Department of Consumer and Business Services Insurance Division?
- q.** Applicants must describe their demonstrated experience and capacity for:

- (1) Developing and implementing alternative payment methodologies that are based on health care quality and improved health outcomes.
 - (2) Coordinating the delivery of physical health care, mental health and chemical dependency services, oral health care and covered long-term care services.
 - (3) Engaging community members and health care providers in improving the health of the community and addressing regional, cultural, socioeconomic and racial disparities in health care that exist among the entity's enrollees and in the entity's community.
- r. In order to organize and operate a CCO, will Applicant need to engage in activities (specifically, collaboration among public payers, private health carriers, third party purchasers and providers to identify appropriate service delivery systems and reimbursement methods to align incentives in support of integrated and coordinated health care delivery) for which it seeks state action immunity under state and federal antitrust laws? If yes, furnish a complete explanation, identifying additional documentation that OHA may request for further details.
- s. Is Applicant now, or does Applicant intend to form, a corporation:
- Whose purpose is to operate a CCO by contracting with Affiliates or other entities that hold the assets or provider contracts of the CCO, or
 - Whose solvency will be primarily assured by a guarantee from an Affiliate, or
 - Which is intended to insulate Affiliates from the financial risk or the regulation of the CCO, or
 - Which in any other manner depends upon Affiliate relationships in order to operate a CCO
- (a "Special Purpose Corporation")? If yes, furnish a detailed explanation, an assurance that the the operations and ownership of the Special Purpose Corporation will be transparent and open to inspection by OHA, and copies of all applicable guaranties, contracts, and other documents between the Applicant and its Affiliates. The explanation must include how the Special Purpose Corporation will be bankruptcy-remote. Applicant must be prepared to provide OHA with customary legal opinions on the Special Purpose Corporation, including a substantive non-consolidation opinion.]*
- [OHA is considering whether SPCs will be acceptable and invites comment on the issue.]***

2. Community Engagement in Development of Application

Applicant is encouraged to obtain community involvement in the development of the Application. The term "community" is defined in ORS 414.018 for this purpose:

"Community" means the groups within the geographic area served by a CCO and includes groups that identify themselves by age, ethnicity, race, economic status, or other defining characteristic that may impact delivery of health care services to the group, as well as the governing body of each county located wholly or partially within the CCO's service area.

- a. Describe the process used for engaging its community in the development of this Application.

Section 1 – Governance and Organizational Relationships

A.1.1. Governance

This section should describe the governing board, community advisory council, and how the governance model will support a sustainable and successful organization that can deliver the greatest possible health within available resources, where success is defined through the Triple Aim.

A.1.1.a. Applicant may provide a brief description of your organization and all the strengths you consider are an asset to your program.

A.1.2. Governing Board

A.1.2.a. Describe the individuals who serve on the governing board of the CCO, specifying:

- Persons who share in the financial risk of the organization who must constitute a majority of the governance structure;
- Persons who represent the major components of the health care delivery system;
- At least two health care providers in active practice, including:
 - A physician licensed under ORS chapter 677 or a nurse practitioner certified under ORS 678.375, whose area of practice is primary care; and
 - A mental health or chemical dependency treatment provider;
- At least two members from the community at large; and
- At least one member of the community advisory council.

A.1.2.b. Provide a description of the relationship of the governing board with the community advisory council.

A.1.3. Community Advisory Council (CAC)

CCOs are also required to have a community advisory council to assure that the health care needs of the consumers and community are being addressed.

A.1.3.a. Describe the individuals who serve on the community advisory council (CAC), specifying:

- Persons who represent the community, including consumer representatives; and
- Persons who represent each county government served by the CCO;

A.1.3.b. Identify the membership of the committee that selected the community advisory council, specifying:

- Members who were county representatives from each county served by the CCO and
- Members of the governing body of the CCO.

A.1.3.c. Describe how the CCO governance structure will reflect the needs of members receiving Medicaid-funded LTC services and supports through representation on the governing board or community advisory council.

A.1.4. Clinical Advisory Panel

An Applicant is encouraged but not required to establish a Clinical Advisory Panel (CAP) as a means of assuring best clinical practices across the CCO's entire network of providers and facilities.

A.1.4.a. If a CAP is established, describe the role of the CAP and its relationship to the CCO governance and organizational structure.

A.1.4.b. If a CAP is not established, the Applicant should describe how its governance and organizational structure will achieve best clinical practices consistently adopted across the CCO's entire network of providers and facilities.

A.1.5. Leadership Personnel

The purpose of this section is to ensure that qualified staff is available to ensure successful implementation and sustainable operation of the CCO in meeting the policy objectives of Health Systems Transformation.

A.1.5.a. Identify and furnish résumés for the following key leadership personnel (by whatever titles designated):

- Chief Executive Officer
- Chief Financial Officer
- Chief Medical Officer
- Chief Information Officer
- Chief Administrative or Operations Officer

A.1.5.b. Attest that the CCO has an individual accountable for each of the following operational functions:

- Contract administration
- Outcomes and evaluation
- Performance measurement
- Health management and care coordination activities
- System coordination and shared accountability between Medicaid Funded LTC system and CCO
- Mental health and addictions coordination and system management
- Communications management to providers and members
- Provider relations and network management, including credentialing
- Health information technology and medical records
- Privacy officer
- Compliance officer

A.1.5.c. Provide an organizational chart showing the relationships of the various departments.

A.1.6. Agreements with Type B Area Agencies on Aging and DHS local offices for Aging and People with Disabilities (APD)

While Medicaid-funded long term care services are legislatively excluded in HB 3650 from CCO responsibility, and will be paid for directly by the Department of Human Services, CCOs will still be responsible for providing physical and behavioral health services for individuals receiving Medicaid funded LTC services, and will be responsible for coordinating with the LTC system. To implement and formalize coordination and ensure relationships exist between CCOs and the local LTC providers, CCOs will be required to work with the local type B AAA or DHS' Aging and People with Disabilities (APD) local office to develop a Memorandum of Understanding (MOU) or contract, detailing their system coordination agreements regarding members receiving Medicaid-funded LTC services.

A.1.6.a. Describe the Applicant's current status in obtaining MOU(s) with Type B AAAs or DHS local APD office.

A.1.6.b. If MOUs have not been executed, describe the Applicant's good faith efforts to do so and how the Applicant will obtain the MOU.

A.1.7. Social and support services in the service area

A.1.7.a. Describe how the Applicant has established and will maintain relationships with social and support services in the service area, such as:

- DHS Children's Adults and Families field offices in the service area
- Oregon Youth Authority (OYA) and Juvenile Departments in the service area
- Department of Corrections and local community corrections and law enforcement, local court system, problem solving courts (drug courts/mental health courts) in the service area
- School districts, education service districts that may be involved with students having special needs, and higher education in the service area
- Developmental disabilities programs
- Tribes and services provided for the benefit of Native Americans and Alaska Natives
- Housing
- Culturally-specific health care, behavioral health and social services providers
- Faith-based organizations
- Community-based family and peer support organization
- Other social and support services important to communities served

A.1.8. Community Needs Assessment and Community Health Improvement Plan

This section should detail the Applicant's annual community needs assessment process, including conducting the assessment and development of the resultant Community Health Improvement Plan. Applicant should describe how they will use the plan to inform the model of care and to realize health system transformation triple aim goals. Applicants should include information on approaches to coordinate care across the spectrum of services, as well as to encourage prevention and health promotion to create healthier communities.

The Applicant is required to work with the OHA, including the Office of Equity and Inclusion, to identify the components of the community needs assessment. Applicant is encouraged to partner with their local public health authority, hospital system, type B AAA, APD field office, community mental health authority, multi-cultural health and social services providers, culturally-diverse community based

organizations and service providers and other community partners to develop a shared community needs assessment that includes a focus on health disparities associated with race, ethnicity, language, health literacy, age, disability, gender, sexual orientation, geography or other factors in their service area.

The Public Health Institute's "Advancing the State of the Art in Community Benefit" offers a set of principles that provide guidance for this work:

- Emphasis on disproportionate unmet, health-related need
- Emphasis on primary prevention
- Building a seamless continuum of care
- Building community capacity
- Emphasis on collaborative governance of community benefit

The community health assessment is expected to be analyzed in accordance with OHA's race, ethnicity and language data policy.

CCOs are not expected to generate new data during their first year of operation and are encouraged to draw on existing resources. The OHA has assembled relevant resources used in current community health assessments performed by local public health agencies, mental health agencies, hospitals, etc., to be found at the following web site: TBD. Additionally, CCOs are expected to collaborate with community partners to provide additional relevant perspectives and information to help identify health disparities in the CCO's service area. The Office of Equity and Inclusion and other agencies in OHA will assist CCOs in:

- identifying and analyzing available data,
- developing a preliminary identification of health disparities,
- developing plans for gathering additional information and performing analyses on identifying more accurately and completely the significant health disparities in the CCOs service area, and
- developing a community health improvement plan for the first year's operation, to be amended based on further information gathered and analyzed in subsequent years.

The CCO's initial community health assessment methodology and approach should describe assessments currently in process and describe the model(s) being used, including data sources, and address:

- Preliminary findings from any preliminary assessment that impact the description of the care model used in this Application
- Mechanisms by which representatives of critical populations and community stakeholders will be meaningfully and systematically engaged in future health assessments
- How targets for community-level prevention will be set and how achievement will be measured, as well as mechanisms by which the Applicant will adjust its models of care to improve physical and mental health outcomes, and reduce health disparities.

In order to avoid duplication the community needs assessment should build upon, coordinate with or take the place of the community health assessments required of community mental/behavioral health, community public health and hospital system community benefit reporting. Resources: Internal Revenue Code for community needs assessments conducted by hospitals (see Internal Revenue Bulletin 2011- 52) and follows the community health assessment best practices recommended by the U.S. Centers for Disease Control and Prevention and required by the National Public Health Accreditation Board.

A.1.8.a. The Applicant should describe:

- Applicant's community needs assessment process that addresses the requirements noted above
- How in its first year of operation the CCO plans to use existing assessments and whether it has initiated or conducted a preliminary community health assessment or otherwise analyzed population health, mental health, and healthcare utilization data relevant to the service area
- Whether it has initiated or conducted a preliminary community needs assessment, and if so, any findings. If a community health improvement plan has been developed, please include.
- Mechanisms by which the CAC will meaningfully and systematically engage diverse populations as well as individuals receiving Medicaid-funded LTSS, in the community needs assessment process.

A.1.8.b. If a community needs assessment or the community health improvement plan is not available to support the Applicant's model of care used in this Application, describe what the Applicant's plan and time lines to conduct the community needs assessment and health improvement plan.

A.1.8.c. Describe the Applicant's strategy to update, on an ongoing basis, the community needs assessment and the resulting community health improvement plan to reflect changes in diverse communities and the changing needs of the community's health needs.

Section 2 – Member Engagement and Activation

A.2.1. Member and Family Partnerships

Members should be actively engaged partners in the design and implementation of their treatment and care plans through ongoing consultations regarding preferences cultural preferences and goals for health maintenance and improvement. Member choices should be reflected in the selection of their providers and in the development of treatment plans ensuring member dignity and culture will be respected.

A.2.1.a. Describe the ways in which members (and their families and support networks, where appropriate) are meaningfully engaged as partners in the care they receive as well as in organizational quality improvement activities.

A.2.1.b. The Applicant should articulate and demonstrate how it will:

- Encourage members to be active partners in their health care, understanding to the greatest extent feasible how the approach to activation accounts for the social determinants of health
- Engage members in culturally and linguistically appropriate ways
- Educate members on how to navigate the coordinated care approach and ensure access to advocates including peer wellness and other non-traditional healthcare worker resources
- Encourage members to use effective wellness and prevention resources and to make healthy lifestyle choices in a manner that is culturally and linguistically appropriate
- Provide plain language narrative that informs patients about what they should expect from the CCO with regard to their rights and responsibilities
- Meaningfully engage the community advisory council to monitor and measure patient engagement and activation

Section 3 - Delivery System: Access, Patient-Centered Primary Care Homes, Care Coordination and Provider Network Requirements

Transformation relies on ensuring that CCO members have access to high quality care: “right care, right place, right time”. This will be accomplished by the CCO through a provider network capable of meeting health systems transformation objectives. The Applicant is transforming the health and health care delivery system in its service area and communities – taking into consideration the information developed in the community needs assessment – by building relationships that develop and strengthen network and provider participation, and community linkages with the provider network.

A.3.1. Patient-Centered Primary Care Homes

Integral to transformation is the patient-centered primary care home (PCPCH), as currently defined by Oregon’s statewide standards. These standards advance the Triple Aim goals of better health, better care, lower costs by focusing on effective wellness and prevention, coordination of care, active management and support of individuals with special health care needs, a patient and family-centered approach to all aspects of care, and an emphasis on whole-person care in order to address a patient’s physical and behavioral health care needs.

A.3.1.a. Demonstrate how the Applicant will use PCPCH capacity to achieve the goals of health system transformation, including:

- How the Applicant will partner with and/or implement a network of PCPCHs as defined by Oregon’s standards to the maximum extent feasible, as required by ORS 414.655, including but not limited to the following:
 - Assurances that the Applicant 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 the Applicant will require its other contracting health and services providers to communicate and coordinate with the PCPCH in a timely manner for comprehensive care management

A.3.1.b. Describe how the Applicant will engage their members to be fully informed partners in transitioning to this model of care.

A.3.1.c. Describe how the Applicant’s PCPCH delivery system will coordinate PCPCH providers and services with Medicaid-funded long term care providers and services.

A.3.1.d. Describe how the Applicant will encourage the use of federally qualified health centers, rural health clinics, migrant health clinics, school-based health clinics and other safety net providers that qualify as patient centered primary care homes.

A.3.2. Other models of patient-centered primary health care

A.3.2.a. If the Applicant proposes to use other models of patient-centered primary health care in addition to the use of PCPCH, describe how the Applicant will assure member access to

coordinated care services that provides effective wellness and prevention, coordination of care, active management and support of individuals with special health care needs, a patient and family-centered approach to all aspects of care, and an emphasis on whole-person care in order to address a patient's physical and behavioral health care needs.

- A.3.2.b.** Describe how the Applicant's use of this model will achieve the goals of health care transformation.
- A.3.2.c.** Describe how the Applicant will require its other contracting health and services providers to communicate and coordinate with these patient-centered primary health care providers in a timely manner for comprehensive care management
- A.3.2.d.** Describe how the Applicant will engage their members to be fully informed partners in transitioning to this model of care.
- A.3.2.e.** Describe how the Applicant's patient centered primary health care delivery system will coordinate with PCPCH providers and services with Medicaid-funded long term care providers and services.

A.3.3. Access

Applicant's network of providers will be adequate to serve members' health care and service needs, meet access to care standards, and allow for appropriate choice for members.

- A.3.3.a.** Describe the actions the Applicant has taken to assure that coordinated care services are geographically located in settings that are as close to where members reside as possible and are, if available, offered in non-traditional settings and are accessible to families, diverse communities, and underserved populations.
- A.3.3.b.** Describe actions the Applicant will take to provide access to and inform members about how to receive assistance from non-traditional health care workers, including community health workers, personal health navigators and certified and qualified interpreters in providing culturally appropriate and whole-person care.
- A.3.3.c.** Describe agreements and arrangements by the Applicant with long term care providers in the service area.
- A.3.3.d.** Describe any formal contractual relationship with any dental care organization that serves members in the proposed service area.

A.3.4. Provider Network Development and Contracts

- A.3.4.a.** Describe how the Applicant will build on existing provider networks that deliver coordinated care and a team-based approach
- A.3.4.b.** Describe how the Applicant's provider agreements and operating policies and procedures address and support the Applicant's transformation goals and model of care,

- A.3.4.c.** Describe how the Applicant will provide support to both PCPCHs and other providers related to technical assistance, tools for care coordination, management of provider concerns, relevant member data and other supports.

A.3.5. Coordination, Transition and Care Management

Care Coordination: Applicants will describe:

- A.3.5.a.** How the Applicant will support the flow of information between providers, including Medicaid-funded LTC care providers, in order avoid duplication of services, medication errors and missed opportunities to provide effective preventive and primary care.
- A.3.5.b.** Describe how the Applicant will work with its providers to develop the partnerships necessary to allow for access to and coordination with social and support services, including crisis management services, and community prevention and self-management programs.
- A.3.5.c.** Describe how the Applicant will develop a tool for provider use to assist in the culturally and linguistically appropriate education of members about care coordination, and the responsibilities of both providers and members in assuring effective communication.
- A.3.5.d.** Describe how the Applicant will work with providers to implement uniform methods of identifying members with multiple diagnoses and who are served with multiple healthcare and service systems. Describe how Applicant will implement an intensive care coordination and planning model in collaboration with member's primary care health home that effectively coordinates services and supports for the complex needs of these members.
- A.3.5.e.** Describe the Applicant's plan for utilizing non-traditional health workers in the coordination of care for its members.
- A.3.5.f.** Describe how the Applicant will meet state goals and expectations for coordination of care for member receiving Medicaid-funded LTC services, given the exclusion of Medicaid funded long term care services from global budgets.
- A.3.5.g.** Describe the evidence-based or innovative strategies the Applicant will use within their delivery system network to ensure coordinated care, especially for members with intensive care coordination needs, and those experiencing health disparities.

Assignment of responsibility and accountability: The Applicant must demonstrate that each member has a primary care provider or primary care team that is responsible for coordination of care and transitions.

- A.3.5.h.** Describe the Applicant's standards that ensure access to care and systems in place to engage members with appropriate levels of care and services beginning not later than 30 days after enrollment with the CCO.
- A.3.5.i.** Describe how the Applicant will provide access to primary care to conduct culturally and linguistically appropriate health screenings for members to assess individual care needs or to determine if a higher level of care is needed.

Comprehensive transitional care: The Applicant must ensure that members receive comprehensive transitional care so that members' experience of care and outcomes are improved. Care coordination and transitional care should be culturally and linguistically appropriate to the member's need.

- A.3.5.j.** Describe the Applicant’s plan to address appropriate transitional care for members facing admission or discharge from hospital, hospice or other palliative care, home health care, adult foster care, skilled nursing care, residential or outpatient treatment for mental health or chemical dependency or other care settings. This includes transitional services and supports for children, adolescents and adults with serious behavioral health conditions facing admissions or discharge from residential treatment settings.
- A.3.5.k.** Describe the applicant’s plan to coordinate and communicate with Type B AAA or APD to incent and monitor improved transitions of care for members receiving Medicaid-funded LTC services and supports, so that these members receive comprehensive transitional care.
- A.3.5.l.** Describe the Applicant’s plan to develop an effective mechanism to track member transitions from one care setting to another, including engagement of the member and family members in care management and treatment planning.

Individual care plans: As required by ORS 414.625, the Applicant will use individualized care plans to address the supportive and therapeutic needs of members with intensive care coordination needs. Care plans will reflect member or family/caregiver preferences and goals to ensure engagement and satisfaction.

- A.3.5.m.** Describe the Applicant’s standards and procedures that ensure the development of individualized care plans, including any priorities that will be followed in establishing such plans for those with intensive care coordination needs.
- A.3.5.n.** Describe the Applicant’s universal screening process that assesses individuals for critical risk factors that trigger intensive care coordination for high needs members, including those receiving Medicaid funded LTC services.
- A.3.5.o.** Describe how the Applicant will factor in relevant referral, risk assessment and screening information from local type B AAA and APD offices and Medicaid-funded LTC providers; and how they will communicate and coordinate with type B AAA and APD offices
- A.3.5.p.** Describe how the Applicant will reassess high-needs CCO members at least annually to determine whether their care plans are effectively meeting their needs in a person-centered, person-directed manner.
- A.3.5.q.** Describe how individualized care plans will be jointly shared and coordinated with relevant staff from type B AAA and APD with and Medicaid-funded LTC providers

Communication:

- A.3.5.r.** Demonstrate that providers have the tools and skills necessary to communicate in a linguistically and culturally appropriate fashion with members and their families or caregivers and to facilitate information exchange between other providers and facilities (e.g, addressing issues of health literacy, language interpretation, having EHR capabilities, etc.)

A.3.6. Care Integration

Mental Health and Chemical Dependency Services and Supports

- A.3.6.a.** Describe how the Applicant has a sufficient provider network, including providers from culturally, linguistically and socially diverse backgrounds for members needing access to mental health and chemical dependency treatment and recovery management services. This includes members in all age groups, from all cultural and social backgrounds and different levels of symptom and condition severity.
- A.3.6.b.** Describe how the Applicant will provide care, treatment engagement and follow-up services for members with serious mental health and chemical dependency conditions requiring medication-assisted therapies, residential and hospital levels of care. This includes members who may not be motivated to seek these services even when it would be in their best health interest to do so and members with limited social support systems.
- A.3.6.c.** Describe how the Applicant has integrated care and service delivery to address mental health and chemical dependency issues by proactively identifying members with them, arranging and facilitating the provision of care, and coordinating care with related health services including Medicaid-funded long term care services and other health services not funded by the Applicant. This includes members from all cultural, linguistic and social backgrounds at different ages and developmental stages.
- A.3.6.d.** Describe how the Applicant has organized a system of services and supports for mental health and chemical dependency services, including integration of primary care across systems, including partnering with culturally diverse community based organizations.

Oral Health

No later than July 1, 2014, ORS 414.625 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.

- A.3.6.e.** Describe the Applicants plan for developing a contractual arrangement with any DCO that serves members in the area where they reside by July 1, 2014. Identify major elements of this plan, including target dates and benchmarks.
- A.3.6.f.** Describe the Applicant's plan for coordinating care for member dental needs, including facilitating appropriate referrals to dental care and for medical care of chronic disease issues related to oral health.

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.

- A.3.6.g.** Describe how the Applicant's agreements with its hospital and specialty care providers will address:
- Coordination with a member's patient-centered primary care home or primary care provider
 - Processes for PCPCH or primary care provider to refer for hospital admission or specialty services and coordination of care..

- Performance expectations for communication and medical records sharing for hospital and specialty treatments, at the time of hospital admission or discharge, for after-hospital follow up appointments
- A plan for achieving successful transitions of care for CCO members, with the PCPCH or primary care provider and the member in central treatment planning roles.

A.3.7. Medicaid-funded Long Term Care Services

CCOs will be responsible for the provision of coordinated care services to members receiving Medicaid funded LTC services. Medicaid funded Long Term Care Services include, but are not limited to, in-home supports/services, Adult Foster Care, Residential Care Facilities, Assisted Living Facilities, LTC nursing facility state plan, State Plan Personal Care for APD, Adult Day Services, Contract Nursing Program, administrative examinations and reports, non-medical transportation (except in some regions where contracted to transportation brokerages) and PACE state plan (including Medicare benefits).

A.3.7.a. Describe how the Applicant

- Will effectively provide coordinated care services to members receiving Medicaid-funded LTC services whether served in their own home, community-based care or nursing facility and coordinate with the Applicant’s Medicaid-funded LTC delivery system in its service area, including the role of type B AAA or the APD office;
- Will use best practices applicable to individuals in LTC settings including best practices related to care coordination and transitions of care;
- Will use any of the following models for better coordinating care between the medical and LTC systems, or describe any alternative models for coordination of care?
 - Co-Location: co-location of staff such as type B AAA and APD case managers in medical settings or co-locating behavioral health specialists in medical or care settings where members live or spend time,
 - Team approaches: care coordination positions jointly funded by the LTC and medical systems, or team approaches such as a multi-disciplinary care team including LTC representation,
 - Services in Congregate Settings: Includes a range of LTC and medical services provided in congregate settings.. Services can be limited to one type of services such as “in home” personal care services provided in an apartment complex or can be a comprehensive model such as the Program of All-Inclusive Care for the Elderly (PACE).
 - Clinician/Home-Based Programs: These include increased use of Nurse Practitioners, Physician Assistants, or Registered Nurses who perform assessments, plan treatments, and provide interventions to the person in their home, community-based or nursing facility setting.

A.3.8. Utilization management

A.3.8.a. In the context of achieving the Applicant’s strategy for implementing health system transformation, describe how the utilization management system assures that coordinated care services address member needs, in consideration of individual care plans where appropriate, including safeguards against underutilization or inappropriate denial of covered services.

A.3.9. Learning Collaborative

Attest that the Applicant will participate in the learning collaboratives required by ORS 442.210.

Section 4 - Health Equity and Eliminating Health Disparities

Health equity and identifying and addressing health disparities are an essential component of health systems transformation. Health Equity is the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing efforts to eliminate health disparities.

- A.4.1.** Coordinated Care Organizations and their providers are encouraged to work together to develop best practices of culturally appropriate care and service delivery to reduce health disparities and improve health and well-being of members. If applicable, describe how the Applicant and its providers will achieve this objective.
- A.4.2.** Applicant will attest to collect maintain and analyze race, ethnicity, and primary language data for all members on an ongoing basis in accordance with standards jointly established by OHA and Oregon's Department of Human Services in order to identify and track the elimination of health inequities. (Attach Standards)
- A.4.3.** Describe how the Applicant and its culturally diverse community based partners will track and report on quality measures by these demographic factors.
- A.4.4.** Describe how the Applicant and its culturally diverse community based partners will develop, implement, and evaluate strategies to improve health equity among members as part of its long-range planning.

Section 5 - Payment Methodologies that Support the Triple Aim

- A.5.1.** Describe how the Applicant will move from a predominantly fee-for-service system to alternative payment methods that base reimbursement on the quality rather than quantity of services provided, promote patient-centered care and continually improve member and community health outcomes over time.
- A.5.2.** Demonstrate how Applicant's payment methodologies promote or will promote the following principles:
- Reimburse providers on the basis of health outcomes and quality measures instead of the volume of care;
 - Hold organizations and providers accountable for the efficient delivery of quality care;
 - Reward good performance;
 - Limit increases in medical costs;
 - Promote primary prevention, early identification and intervention of risk factors and health conditions that lead to chronic illnesses and complications and discourage care that doesn't improve health;
 - Provide comprehensive coordination or create shared responsibility across provider types and levels of care and creates incentives for using such delivery systems such as patient-centered primary care homes;
 - Provide financial support, differentially based on the tier level achieved, to patient-centered primary care homes for meeting the PCPCH standards;
 - Utilize evidence-based practices and health information technology to improve patient and community health and health care and health equity; and
 - Include the member, the providers, and the CCO itself in the alignment of incentives to promote improved outcomes, elimination of health inequities and increased efficiency.
- A.5.3.** Describe how the Applicant will rely on previously developed and tested payment approaches where available.
- A.5.4.** Describe how the Applicant will create and align incentives for evidence-based and best practices to increase health care quality and patient safety and to result in more efficient use of health care services.
- A.5.5.** To ensure successful transition to new payment methods, describe how the Applicant will build network capacity and help restructure systems and workflows to be able to respond effectively to new payment incentives.

Section 6 - Health Information Technology

A.6.1. Electronic Health Record Systems (EHRs)

- A.6.1.a.** What is the estimated current EHR adoption rate in Applicant's service area, divided by provider type (and possibly by geographic region) within the service area (including certified and non-certified EHRs)?
- A.6.1.b.** What are the Applicant's strategies to increase adoption rates of certified EHRs? Specifically, how will Applicant:
- Track EHR adoption rates; rates may be divided by provider type and/or geographic region.
 - Develop and implement strategies to increase adoption rates of certified EHRs.

A.6.2. Health Information Exchange (HIE)

- A.6.2.a.** Describe how the Applicant will facilitate HIE in a way that will allow all providers within the CCO network to exchange a patient's health information electronically with any other provider in the network.
- A.6.2.b.** Describe what the Applicant's plan is to ensure that every provider in its network either:
- Is registered with a statewide or local Direct-enabled Health Information Services Provider (registration will ensure the proper identification of participants and secure routing of health care messages and appropriate access to the information); or
 - Is a member of an existing Health Information Organization (HIO) with the ability for providers any EHR system (or with no EHR system) to be able to share electronic information with any other provider within the CCO network.
- A.6.2.c.** Describe how the Applicant will establish minimum requirements for HIE, including rates of e-prescribing and electronic lab orders, over time.

A.6.3. Additional Health Information Technology (HIT)

- A.6.3.a.** Describe how the Applicant will leverage HIT tools (beyond EHRs & HIE) to transform from a volume-based to a value-based delivery system.
- A.6.3.b.** Identify Applicant's current capacity in the following areas:
- Data Analytics (to assess provider performance, effectiveness and cost-efficiency of treatment, etc.)
 - Quality Reporting (to facilitate quality improvement within the CCO as well as to report the data on quality of care that will allow the OHA to monitor the performance of the CCO)
 - Patient Engagement through HIT (using existing tools such as e-mail, personal health records, etc.)
 - Other HIT (telehealth, mobile devices, etc.)
 - Health record/information exchange, in key areas (e.g. care coordination and transitions) with the Medicaid-funded LTC system

A.6.3.c. Describe how the Applicant will develop and implement a plan for improvement (including goals/milestones, etc.) in these areas.

DRAFT

Section 7 - 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

General Overview of Health Transformation

In 2011 the Oregon Legislature and Governor John Kitzhaber created CCO's in House Bill 3650 (2011), aimed at achieving the Triple Aim of improving health, improving health care and lowering costs by transforming the delivery of health care. The legislation builds on the work of the Oregon Health Policy Board since 2009. Essential elements of that transformation are:

- Integration and coordination of benefits and services;
- Local accountability for health and resource allocation;
- Standards for safe and effective care, including culturally and linguistically competent care; and
- A global Medicaid budget tied to a sustainable rate of growth.

The CCO Implementation Proposal of the Oregon Health Policy Board dated January 24, 2012, explained that CCOs are community-based organizations governed by a partnership among providers of care, socially and culturally diverse community members and those taking financial risk. A CCO will have a single global Medicaid budget that grows at a fixed rate, and will be responsible for the integration and coordination of physical, mental, behavioral and dental health care for people eligible for Medicaid or dually eligible for both Medicaid and Medicare. CCOs will be the single point of accountability for the health quality and equitable outcomes for the Medicaid population they serve. They will also be given the financial flexibility within available resources to achieve the greatest possible outcomes for their membership.

Certified as a CCO, Contractor acts as an agent of health system transformation as called for by HB 3650 (2011) and SB 1580 (2012) and applicable administrative rules. At a general level, this Work will include providing a single benefit package that includes physical, oral and mental health services covered under Medicaid and Medicare benefits, to Members including Medicaid, CHIP, and Medicaid/Medicare Dual Eligible, managed within a fixed global budget. The policy objectives of OHA Health Systems Transformation and Contractor's Work will help to achieve the triple aims of health reform: a healthy population, extraordinary patient care and reasonable costs. These objectives include:

- Ensuring access to an appropriate delivery system network centered on patient-centered primary care homes;
- Ensuring member rights and responsibilities;
- Working to eliminate health disparities among their member populations and communities;
- Using alternative provider payment methodologies to reimburse on the basis of outcomes and quality;
- Developing a health information technology (HIT) infrastructure and participating in health information exchange (HIE);
- Ensuring transparency, reporting quality data, and;
- Assuring financial solvency.

Part 1 – Governance and Organizational Relationships

1. Governing Board and Governance Structure

Contractor establishes, maintains and operates with a governance structure complies with the requirements of ORS 414.625(1)(o).

2. Community Advisory Council (CAC)

a. Contractor shall establish a Community Advisory Council (CAC). The CAC must:

- (1)** Include representatives of the community and of each county government served by the Contractor, but consumer representatives must make up the majority of membership
- (2)** Meet no less frequently than once every three months; and
- (3)** Have its membership selected by a committee composed of equal numbers of county representatives from each county served by the Contractor and members of the governing body of the Contractor.

b. The duties of the CAC include, but are not limited to:

- (1)** Identifying and advocating for preventive care practices to be utilized by the Contractor;
- (2)** Overseeing a community health assessment and adopting a community health improvement plan to serve as a strategic population health and health care system service plan for the community served by the Contractor; and
- (3)** Annually publishing a report on the progress of the community health improvement plan.

3. Clinical Advisory Panel

Contractor establishes an approach within its governance structure to assure best clinical practices. This approach will be subject to OHA approval, and may include a clinical advisory panel. If Contractor convenes a clinical advisory panel, this group should have representation on the governing board. The clinical advisory panel shall have representation from behavioral health and physical health systems and member representation.

4. Community Needs Assessment

Contractor's CAC partners with the local public health authority, local mental health authority, community based organizations and hospital system to develop a shared community needs assessment and adopts a community health improvement plan to serve a strategic population health and health care system service plan for the community served by Contractor. Community needs assessment will include a focus on health disparities experienced by various dimensions of the community, including but not limited to racial and ethnic disparities in the Community. The needs assessment is transparent and public in both process and result.

The Community Needs Assessment adopted by the CAC should describe the scope of the activities, services and responsibilities that the Contractor will consider upon implementation of the plan. The activities, services and responsibilities defined in the plan may include, but are not limited to:

- a. Analysis and development of public and private resources, capacities and metrics based on ongoing community health assessment activities and population health priorities;
- b. Health policy;
- c. System design;
- d. Outcome and quality improvements;
- e. Integration of service delivery; and
- f. Workforce development

Through its Community needs assessment, Contractor identifies health disparities associated with race, ethnicity, language, health literacy, age, disability, gender, sexual orientation, geography, occupation or other factors in its service areas. Contractor and Contractor's CAC will work with OHA Office of Equity and Inclusion to develop meaningful baseline data on health disparities.

5. Community Health Improvement Plan

The Contractor, through its CAC, develops and implements a community health improvement plan. The community health improvement plan should describe the scope of the activities, services and responsibilities that the Contractor will consider upon implementation of the plan. The activities, services and responsibilities defined in the plan may include, but are not limited to:

- a. Analysis and development of public and private resources, capacities and metrics based on ongoing community health assessment activities and population health priorities;
- b. Health policy;
- c. System design;
- d. Outcome and quality improvement;
- e. Integration of service delivery; and
- f. Workforce development.

Part 2 – Health Equity and Eliminating Health Disparities

Health equity means reaching the highest possible level of health for all people. Historically, health inequities result from health, economic, and social policies that have disadvantaged communities. These systemic shortcomings result in tragic health consequences for vulnerable populations and increased health care costs to the entire system, costs which are borne by taxpayers, employers, workers, and the uninsured. CCO must implement its proposal approved during certification demonstrating how it will work toward the goal of

ensuring that everyone is valued and health improvement strategies are tailored to meet the individual needs of all members, with the ultimate goal of eliminating health disparities.

This annual assessment will include an action plan, the components of which will be developed by the OHA Office of Equity and Inclusion, based on current and emerging best practices for eliminating health disparities, in order of priority, to improve the health of diverse communities in its service area. An annual report of activities, progress towards goal of eliminating health disparities, and accomplishments will be required.

Contractor must collect and maintain race, ethnicity, and primary language data for all Members on an ongoing basis in accordance with standards jointly established by OHA and DHS. Contractor shall track and report on any quality performance improvements and outcome measures by these demographic factors and will be expected to develop, implement, and evaluate strategies to improve health equity among members.

Contractor will be expected to partner with local public health and culturally, linguistically and professionally diverse community partners to address the causes of health disparities, many of which originate outside of the clinical environment, including chronic stress, access to fresh and affordable produce, educational and economic attainment, safe work places, and healthy and affordable housing and healthy indoor and outdoor environments.

Part 3 – Payment Methodologies that support the Triple Aim

To achieve improvements in quality and efficiency in the delivery system, it will be necessary for CCOs to move from a traditionally fee-for-service payment system to alternative methods that link payment to desired outcomes, promote patient-centered care, and compensate providers for prevention, care coordination, and other activities necessary for keeping people healthy. These methods should include transparent measurement of outcomes aligned with the Triple Aim and be guided by the principles outlined by the OHPB Incentives and Outcomes Committee in 2010:

- *Equity* - Payment for health care should provide incentives for delivering evidence-based culturally and linguistically appropriate care (or emerging best practices) to all people;
- *Accountability* - Payment for health care should create incentives for providers and health plans to deliver health care and supportive services necessary to reach Oregon's Triple Aim goals;
- *Simplicity* - Payment for health care should be as simple and standardized as possible to reduce administrative costs, increase clarity and lower the potential for fraud and abuse;
- *Transparency* - Payment for health care should allow consumers, providers and purchasers to understand the incentives created by the payment method, the price of treatment options and the variations in price and quality of care across providers; and
- *Affordability (Cost Containment)* - Payment for health care should create incentives for providers and consumers to work together to control the growth of health care costs by encouraging prevention and wellness, discouraging care that does not improve health, and rewarding efficiency and the elimination of health disparities.

CCO must implement its proposal approved during certification demonstrating how it will use alternative payment methods alone or in combination with delivery system changes to achieve better care, controlled costs, and better health for their members. Examples include but are not limited to:

- Per-member per-month or other payments designed to support Patient-Centered Primary Care Homes, recognizing the tier level achieved;
- Bundled payments (case rates, fee-for-service rates with risk sharing, or other) for acute episodes, or for episodes of chronic care defined by a calendar period;

- Incentives for service agreements between specialty and primary care physicians;
- Gain-sharing arrangements with providers, if volume is sufficient;
- Quality bonuses or other payment incentives for performance improvement on Triple Aim-focused quality, efficiency, and outcomes metrics; and
- Incentives for the use of evidence-based and emerging best practices and health information technology.

1. **Phased-In Approach**

The schedule by which Contractor shall implement alternative payment methodologies shall be defined by Contractor's proposal approved during certification. Payments to Patient-Centered Primary Care Homes for individuals with chronic conditions as defined in section 5c shall be implemented immediately.

2. **Additional Statutory Requirements**

Contractor's payment methodologies comply with additional requirements established in law in conjunction with those requirements under Health Systems Transformation that encourage efficiency and the elimination of care defects and waste, including:

- a. Contractor pays hospitals other than Type A and B rural hospitals using Medicare-like payment methodologies that pay for bundles of care rather than paying a percentage of charges (SB 204); and
- b. Contractor may not pay any provider for services rendered in a facility if the condition is a health care acquired condition for which Medicare would not pay the facility.
- c. In addition to the base CCO Payment rate paid to Contractor, OHA will pay a hospital reimbursement adjustment to the CCO Payment rate to Contractor in accordance with the CCO Payments calculation reflected in the rate schedule in Appendix G, Exhibit C, Attachment 2. Contractor distributes such hospital reimbursement adjustment amounts to eligible hospitals located in Oregon that receive Medicare reimbursement based upon diagnostic related groups, in accordance with requirements established by OHA.
- d. Contractor or its Subcontractors are responsible for appropriate management of all federal and state tax obligations applicable to compensation or payments paid to Subcontractors under this Contract.

Part 4 – Health Information Systems

3. **Electronic Health Information**

OHPB requested that the Health Information Technology Oversight Council (HITOC) provide advice on appropriate health information technology (HIT) certification criteria for CCOs. In order to ensure that coordinated care delivery is enabled through the availability of electronic information to all participants, HITOC suggests that CCOs will need to develop the HIT capabilities described below. CCOs will span different provider types across the continuum of care and different geographic regions across the state, each of which is at different stages of HIT adoption and maturity. The proposed approach for achieving advanced HIT capability is to meet providers and communities where they are and require improvement over time.

Contractor must implement its proposal approved during certification demonstrating how it will ultimately achieve minimum standards in foundational areas of HIT use (electronic health records, health information exchange) and to develop its own goals for transformational areas of HIT use (analytics, quality reporting, patient engagement, and other health IT).

a. Electronic Health Records Systems (EHRs)

Consistent with its proposal approved during certification, Contractor facilitates Providers' adoption and meaningful use of EHRs. Electronic Health Records are a foundational component of care coordination because they enable Providers to capture clinical information in a format that can be used to improve care, control costs, and more easily share information with patients and other providers. In order to achieve advanced EHR adoption and meaningful use, Contractor is expected to:

- (1) Identify EHR adoption rates; rates may be divided by provider type and/or geographic region.
- (2) Develop and implement strategies to increase adoption rates of certified EHRs.
- (3) Consider establishing minimum requirements for EHR adoption over time. Requirements may vary by region or provider type;

b. Health Information Exchange (HIE)

(1) Consistent with its proposal approved during certification, Contractor will facilitate electronic health information exchange in a way that allows all Providers to exchange a patient's health information with any other Provider in that CCO. Health Information Exchange is a foundational component of care coordination because it enables Providers to access pertinent health information when and where it is needed to provide the best care possible and to avoid performing duplicative services. CCOs will be expected to ensure that every Provider is:

- (a) Either registered with a statewide or local Direct-enabled Health Information Service Provider (HISP)

Direct is a way for one provider to send secure information directly to another Provider without using sophisticated information systems. Direct secure messaging will be available to all providers as a statewide service, and while EHR vendors will continue to develop products with increasingly advanced Direct functionality, using Direct secure messaging does not require an EHR system. Registration will ensure the proper identification of participants and secure routing of health care messages, and the e-mail address provided with Direct secure messaging registration will be accessible from a computer, smart phone or tablet, and through EHR modules over time.

- (b) Or is a member of an existing Health Information Organization (HIO) with the ability for providers on any EHR system (or with no EHR system) to be able to share electronic information with any other provider within the CCO network.

- (2) Consistent with its proposal approved during certification, Contractor should also consider establishing minimum requirements for HIE, including rates of e-prescribing and electronic lab orders, over time.
- (3) Consistent with its proposal approved during certification, Contractor will leverage HIT tools to transform from a volume-based to a value-based delivery system. In order to do so, Contractor should initially identify their current capacity and develop and implement a plan for improvement (including goals/milestones, etc.) in the following areas:
 - (a) Analytics that are regularly and timely used in reporting to its provider network (e.g., to assess provider performance, effectiveness and cost-efficiency of treatment, etc.).
 - (b) Quality Reporting (to facilitate quality improvement within the CCO as well as to report the data on quality of care that will allow the OHA to monitor the CCO's performance).
 - (c) Patient engagement through HIT (using existing tools such as e-mail).
 - (d) Analysis of quality of collection of race, ethnicity and language data, and subsequent analysis of clinical and non-clinical data to identify and track progress on elimination of health care access, quality and outcome disparities by these and other demographics.
 - (e) Other HIT (e.g., telehealth, mobile devices).

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.

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.

APPENDIX C – Accountability Questionnaire

This questionnaire consists of two sections, corresponding to the section of Chapter 7 of the CCO Implementation Proposal:

- Section 1:** Accountability Standards
- Section 2:** Quality Improvement Program
- Section 3:** Framework Scope of Work

For background and further information, see Chapter 7 of the CCO Implementation Proposal, “Accountability.”

Section 1 – Accountability Standards

C.1.1. Background information

Accountability for each aspect of the Triple Aim—better health, better care and lower costs—is a central tenet of health system transformation. As required by HB 3650, CCOs will be held accountable for their performance on outcomes, quality, health equity and efficiency measures identified by OHA through a robust public process in collaboration with culturally diverse stakeholders. CCO accountability metrics will function both as an assurance that CCOs are providing quality care for all of their members and as an incentive to encourage CCOs to transform care delivery in alignment with the goals of HB 3650.

OHA will distinguish CCO **accountability measures** (including both core and transformational measures) from **transparency measures** intended to promote community and consumer engagement and to enable evaluation of health systems transformation. The performance expectations outlined below (meeting minimum standards or improving on past performance) will apply to accountability metrics only. Metrics for transparency are intended to be calculated by OHA, rather than CCOs, and will be publicly reported but will not affect CCOs’ contract status or eligibility for incentives.

Accountability measures for CCOs will be phased in over time to allow CCOs to develop the necessary organizational infrastructure and enable OHA to incorporate CCO data into performance standards. In year 1, CCOs accountability will be for reporting only. In years 2 and 3, CCOs will be accountable for meeting minimum standards on core accountability measures and improving on their past performance for transformational accountability measures. Quality incentives for exceptional performance may be offered but not in the first year. Regardless of start date, all CCOs must meet minimum accountability standards by January 2014. CCOs that begin operation less than a year before that date will have a shorter reporting-only period and CCOs that start on or after January 2014 will have no phase-in period at all. While annual reporting will serve as the basis for holding CCOs accountable to contractual expectations, OHA will assess performance more frequently (e.g. quarterly or semi-annually) on an informal basis to facilitate timely feedback, mid-course corrections, and rapid improvement.

Proposed core and transformational accountability measures are shown in the below Table, along with the domain(s) and, where applicable, alignment with national quality measure sets. Potential transparency measures are shown as well. The next stage of metrics development will be for OHA to establish a technical group of culturally diverse internal and external experts to build measure specifications, including data sources, and to finalize a reporting schedule. This stage of the work will be completed by May 2012. Further work, such as establishing benchmarks for core measures and annually reviewing CCO accountability metrics for appropriateness and effectiveness, will also involve the technical workgroup. It is possible that CMS may request the inclusion of additional measures from its Adult Medicaid and CHIPRA core measure sets as CCO accountability measures.

Appendix C - Initial Proposed CCO Accountability Metrics (transparency metrics also listed)

CCO Accountability Measures – tied to contractual accountability & incentives		Transparency Measures – Collected/reported by OHA for public reporting, evaluation, etc.
Core Measures	Transformational Measures	
<p>1. Experience of Care*^ – Key domains TBD from member experience survey (version TBD and may alternate by year) <i>Domain(s): Member experience & activation</i> <i>Data type: Survey (collected by OHA)</i> <i>Also part of: Medicaid Adult Core, CHIPRA, Medicare ACOs, Medicare Part C, OR PCPCH, others</i></p> <p>2. Rate of tobacco use among CCO enrollees*^ <i>Domain(s): Prevention, outpatient physical, overall health status, cost control</i> <i>Data type: Survey</i> <i>Also part of: Nat'l Quality Strategy</i></p> <p>3. Access – Outpatient and ED utilization per member-month*^ <i>Domain(s): Access, community engagement</i> <i>Data type: Claims/encounter</i> <i>Also part of: CHIPRA Core, NCQA HEDIS</i></p> <p>4. BMI assessment & follow-up plan*^ / Weight assessment and counseling for children and adolescents <i>Domain(s): Prevention, outpatient physical</i> <i>Data type: Medical record</i> <i>Also part of: Medicare ACOs, OR PCPCH, CHIPRA</i></p> <p>5. Screening for clinical depression and follow-up plan^ <i>Domain(s): Mental health</i> <i>Data type: medical record</i> <i>Also part of: Adult Medicaid Core, Medicare ACOs</i></p> <p>6. Alcohol misuse - Screening, brief intervention, referral for treatment (SBIRT)^ <i>Domain(s): Addictions</i> <i>Data type: medical record</i> <i>Also part of: OR PCPCH</i></p>	<p>1. Rate of early childhood caries <i>Domain(s): Oral health</i> <i>Data type: Medical record</i> <i>Also part of: HP 2020</i></p> <p>2. Wrap-around care for children – TBD (% Children who receive a mental health assessment within 30 days of DHS custody or other wraparound initiative measure) <i>Domain(s): Care coordination, mental health</i> <i>Data type: TBD</i> <i>Also part of: TBD</i></p> <p>3. Effective contraceptive use - % reproductive age women who do not desire pregnancy using an effective method <i>Domain(s): Women's health, prevention</i> <i>Data type: Survey</i> <i>Also part of:</i></p> <p>4. Planning for end-of-life care: % members over 65 with a POLST form or advanced care plan or surrogate decision maker documented /on file (or documented that these were declined) <i>Domain(s): End-of-life care, care coordination</i> <i>Data type: Administrative or medical record</i> <i>Also part of: Pending</i></p> <p>5. Health and functional status – (1) % members who report the same or better mental and physical health status than 1 year ago*; (2) % members with Medicaid LTC benefit with improvement or stabilization in functional status <i>Domain(s): overall health outcomes</i> <i>Data type: Survey</i> <i>Also part of: Medicare ACOs, MA star ratings(1), SNP(2)</i></p> <p>6. ED visits – Potentially avoidable</p>	<p>CMS Adult Core Measures including:</p> <ul style="list-style-type: none"> Flu shots for adults 50-64 Breast & cervical cancer screening Chlamydia screening Elective delivery & antenatal steroids, prenatal and post-partum care Annual HIV visits Controlling high BP, comprehensive diabetes care Antidepressant and antipsychotic medication management or adherence Annual monitoring and for patients on persistent medications Transition of care record <p>CHIPRA Core Measures including:</p> <ul style="list-style-type: none"> Childhood & adolescent immunizations Developmental screening Well child visits Appropriate treatment for children with pharyngitis and otitis media Annual HbA1C testing Utilization of dental, ED care (including ED visits for asthma) Pediatric CLABSI Follow up for children prescribed ADHD medications <p>SAMSHA National Outcome Measures including:</p> <ul style="list-style-type: none"> Improvement in housing (adults) Improvement in employment (adults) Improvement in school attendance (youth) Decrease in criminal justice involvement (youth) <p>Others TBD, for example:</p>

CCO Accountability Measures – tied to contractual accountability & incentives		Transparency Measures – Collected/reported by OHA for public reporting, evaluation, etc.
Core Measures	Transformational Measures	
<p>7. Initiation & engagement in of alcohol and drug treatment[^] <i>Domain(s): Addictions</i> <i>Data type: Claims/encounter</i> <i>Also part of: Medicaid Adult Core, HEDIS, Meaningful Use, OR PCPCH</i></p> <p>8. Low birth weight or adequacy of prenatal care <i>Domain(s): Overall health status, MCH</i> <i>Data type: Claims/encounter</i> <i>Also part of: CHIPRA</i></p> <p>9. Primary-care sensitive hospital admissions (PQIs) for chronic conditions like diabetes, asthma, CHF, and COPD*[^] <i>Domain(s): Outpatient physical, prevention, cost control</i> <i>Data type: Encounter/hospital discharge</i> <i>Also part of: Adult Medicaid Core, Medicare ACOs</i></p> <p>10. Healthcare-acquired conditions – TBD <i>Domain(s): Inpatient care</i> <i>Data type: Clinical</i> <i>Also part of: CDC and OR HAI reporting, Medicare value-based purchasing, CHIPRA</i></p> <p>11. Follow-up after hospitalization[^] - % of members with follow-up visit within 7 days after hospitalization for mental illness <i>Domain(s): Care coordination</i> <i>Data type: Claims/encounter</i> <i>Also part of: Adult Medicaid Core</i></p> <p>12. Readmission rates: (1) Plan all-cause readmissions*[^]; (2) readmissions to psychiatric care[^] <i>Domain(s): Care coordination, cost control</i> <i>Data type: Claims/encounter</i> <i>Also part of: Adult Medicaid Core, Medicare ACOs</i></p> <p>13. High needs care coordination – TBD (e.g. % of members identified</p>	<p>or other categorization TBD (*[^]) <i>Domain(s): Outpatient physical, care coordination, cost control</i> <i>Data type: Claims/encounter</i> <i>Also part of: TBD</i></p> <p>7. Access - % of primary care providers who report no difficulty obtaining specialty care (including behavioral health services) for members <i>Domain(s): Access, coordination and integration</i> <i>Data type: Survey</i> <i>Also part of: Unknown</i></p> <p>8. Improvement on disparities in health status or quality of health care identified by CCO in community needs assessment <i>Domain(s): Equity, cost control, potentially others</i> <i>Data type: mixed</i> <i>Also part of: Unknown</i></p> <p>9. Community Orientation - TBD <i>Domain(s): TBD</i> <i>Data type: TBD</i> <i>Also part of: TBD</i></p> <p>10. Timely transmission of transition record - % of patients discharged from any inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or health care professional within 24 hours <i>Domain(s): Care coordination</i> <i>Data type: Attestation</i> <i>Also part of: Adult Medicaid Core</i></p>	<ul style="list-style-type: none"> · Time from enrollment to first encounter and type of first encounter (urgent or non-urgent, physical, mental, etc.) · Initiation and engagement of mental health treatment

CCO Accountability Measures – tied to contractual accountability & incentives		Transparency Measures – Collected/reported by OHA for public reporting, evaluation, etc.
Core Measures	Transformational Measures	
as high need assigned to intensive care coordination) <i>Domain(s): Care coordination</i> <i>Data type: TBD</i> <i>Also part of: TBD</i>		
14. Medication management –TBD <i>Domain(s): Care coordination</i> <i>Data type: TBD</i> <i>Also part of: TBD</i>		
15. MLR - % of global budget spent on health care and services <i>Domain(s): Efficiency, cost control</i> <i>Data type: Administrative</i> <i>Also part of: Unknown</i>		
CCO-LTC System Joint Accountability Measures		
1. Care planning - % of members with Medicaid-funded LTC benefits who have a care plan in place. <i>Domain(s): Care coordination</i> <i>Data type: Administrative</i> <i>Also part of: Pending</i>	1. Transitions of care - % of LTC patients discharged from any inpatient facility to home or any other site of care for whom a transition record was transmitted to the care manager or AAA/APD within 1 business day <i>Domain(s): Care coordination</i> <i>Data type: Administrative</i> <i>Also part of: Unknown</i>	

* Report separately for members with severe and persistent mental illness

^ Report separately for individuals with Medicaid-funded Long-Term Care (LTC) benefit

Duals / Medicare 3-way Contract Accountability Measures – TBD pending negotiation with CMS

- Additional measures may apply related to quality and experience, outcomes, etc. for dually eligible individuals
- These measures will be determined in consultation with CMS by June 2012.
- Rewards for strong performance on these measures would come in part from the incentives that CMS has specified as part of the state demonstration to integrate care for dually eligible individuals, possibly in the form of a quality withhold.

Note: Depending on the particular metric, reports and data may flow from CCOs to OHA or the reverse. For example, it may be advantageous for OHA to collect member experience data on behalf of CCOs just as the agency does now for MCOs. Likewise, metrics developed from claims data can come from the OHA All-Payer All-Claims (APAC) database rather than be individually collected from CCOs.

Shared accountability for long-term care: Medicaid-funded LTC services are legislatively excluded from CCO budgets and will continue to be paid for directly by the Department of Human Services (DHS). But in order to reduce cost shifting and ensure shared responsibility for delivering high quality, person-centered care, CCOs and the LTC system will need to coordinate care and share accountability. In conjunction with the state demonstration to integrate care for dual eligibles, a set of CCO-LTC joint accountability measures will be identified by June 2012 reflecting leverage areas where the activities of one system have significant impacts on the costs and outcomes realized in the other system. A selection

of these measures will be tied to future incentive payments for CCOs (and for LTC providers, depending on available funding).

- C.1.1.a.** Describe any quality measurement and reporting systems that the Applicant has in place or will implement in the first year of operation.
- C.1.1.b.** Will the Applicant participate in any external quality measurement and reporting programs (e.g. HEDIS reporting related to NCQA accreditation, federal reporting for Medicare Advantage lines of business)?
- C.1.1.c.** Explain the Applicant's internal quality standards or performance expectations to which providers and contractors are held.
- C.1.1.d.** Describe the mechanisms that the Applicant has for sharing performance information with providers and contractors for quality improvement.
- C.1.1.e.** Describe the mechanisms that the Applicant has for sharing performance information in a culturally and linguistically appropriate manner with members.
- C.1.1.f.** Describe any plans to use quality measures and/or reporting in connection with provider and contractor incentives or any alternative payment mechanisms.
- C.1.1.g.** Describe the Applicant's capacity to collect and report to OHA the accountability quality measures listed in the Table, if it is determined that those should be reported by CCOs. (Some may be collected by OHA.) Note: since measure specifications are not provided, capacity can be described in general terms based on the data type shown. Include information about the Applicant's capacity to report on measures that are not based on claims data.
- C.1.1.h.** Describe the Applicant's plans to participate in the All Payer All Claims data reporting system required by ORS 442.464 – 442.466 and ORS 414.625

Section 2 – Quality Improvement Program

C.2.1. Quality Assurance and Performance Improvement (QAPI)

As in the past, Oregon will continue to develop and maintain a Quality Strategy to assess and improve the quality of CCO services and to ensure compliance with established standards. CCO accountability measures and related incentives will be core elements of the state's Quality Strategy. Pending negotiations with CMS, this will be a joint strategy/performance improvement plan for all Medicaid populations, including dual eligibles.

Oregon will continue its robust monitoring of CCO system performance and will continue to assure that established standards for quality assessment and improvement are met. Many oversight mechanisms used today will continue in the future. The transition from managed physical and mental health care organizations (and dental care organizations, over time) to CCOs will mean a greater focus on person-centered care, prevention and continuous quality improvement.

- C.2.1.a.** Describe the Applicant's Quality Improvement (QI) program.
- C.2.1.b.** Describe the Quality Committee structure and accountability including how it reflects the diverse member and practitioner community within the proposed service area.

- C.2.1.c.** Describe how the Quality plan is reviewed and developed over time.
- C.2.1.d.** Describe how all Applicant’s practitioners, culturally diverse community-based organizations and members can be involved and informed in the planning, design and implementation of the QI program.
- C.2.1.e.** Describe how the QI program specifically addresses health care and health outcome inequities, care coordination and transitions between care settings.
- C.2.1.f.** Describe how regular monitoring of provider’s compliance and corrective action will be completed.
- C.2.1.g.** Describe how the Applicant addresses QI in relation to:
 - Customer satisfaction: clinical, facility, cultural appropriateness
 - Fraud and Abuse/Member protections
 - Treatment planning protocol review/revision/dissemination and use with evidence based guidelines

C.2.2. Clinical Advisory Panel

An Applicant is encouraged but not required to establish a Clinical Advisory Panel (CAP) as a means of assuring best clinical practices.

- C.2.2.a.** If a CAP is established, is a representative of the CAP included on the governing board.
- C.2.2.b.** If a CAP is not established, describe how its governance and organizational structure will achieve best clinical practices.
- C.2.2.c.** Describe how the Applicant has implemented a utilization management system that matches services to member needs, in consideration of individual care plans, including safeguards against underutilization or inappropriate denial of covered services. How will these outcomes be used in relationship to the QI Program.

C.2.3. Continuity of Care/Outcomes/Quality Measures/Costs

- C.2.3.a.** Please describe policies, processes, practices and procedures you have in place that serve to improve member outcomes, including evidence-based best practices, emerging best practices, and innovative strategies in all areas of health care transformation, including patient engagement and activation.
- C.2.3.b.** Also describe key quality measures in place that are consistent with existing state and national quality measures, and will be used to determine progress towards improved outcomes such as benchmarks, evaluation results, decreases and/or elimination of health disparities, customer satisfaction, patient-centered primary care homes, the involvement of local governments in governance and service delivery.
- C.2.3.c.** Please describe your experience and plan to emphasize and implement wellness and health improvement activities and practices within your organization for members and staff, including partners and contracts in place to strengthen this aspect of health care.

- C.2.3.d.** Outline your experience, staffing, policies, procedures, and capacity to collect the necessary electronic and other data that will be required for meeting regular performance benchmarks to evaluate the value of health services delivered by your CCO. CCO accountability metrics serve to ensure quality care is provided and to serve as an incentive to improve care and the delivery of services.
- C.2.3.e.** What other strategies will you implement to improve patient care outcomes, decrease duplication of services, and make costs more efficient?
- C.2.3.f.** Describe your policies and procedures to ensure a continuity of care system for the coordination of care and the arrangement, tracking and documentation of all referrals and prior authorization.

Section 3 – 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 - Quality and Performance Outcomes and Accountability

1. Quality and Performance Outcomes

Accountability for each aspect of the Triple Aim—better health, better care and lower costs—is a central tenet of health system transformation. As required by Health Systems Transformation, CCO is held accountable for its performance on outcomes, quality, and efficiency measures incorporated into this Contract. CCO accountability metrics will function both as an assurance that Contractor is providing quality care for all of its members and as an incentive to encourage Contractor to transform care delivery in alignment with the goals of Health Systems Transformation. Further, members and the public deserve to know about the quality and efficiency of their health care so metrics of outcomes, quality and efficiency will be publicly reported. Health care transparency provides consumers with the information necessary to make informed choices and allows the community to monitor the performance of their community CCO.

Contractor implements data reporting systems necessary to timely submit claims data to the All Payer All Claims data system in accordance with ORS 414.625, and the requirements of ORS 442.464 to 442.466.

2. Quality Assurance and Improvement

Contractor implements, based on its proposal approved during certification, quality assurance and improvement measures demonstrating the methods and means by which Contractor will carry out planned or established mechanisms for:

- a. Establishing a complaint, grievance and appeals resolution process, including how that process will be for communicated to members and providers;
- b. Establishing and supporting an internal quality improvement committee that develops and operates under an annual quality strategy and work plan with feedback loops;
- c. Implementing an internal utilization review oversight committee that monitors utilization against practice guidelines and treatment planning protocols/policies.

3. Measurement and reporting requirements

Contractor implements, based on its proposal approved during certification, plans to develop the necessary organizational infrastructure to address performance standards established for this Contract.

- a. In the first year, accountability will be for reporting only.
- b. In future years, Contractor will be accountable for meeting specified performance benchmarks (see accountability standards below), specifically: to meet or exceed minimum performance expectations set for core measures and to improve on past year performance for transformational measures (see below for description of care and transformational categories).
- c. Initially, “reporting year” will be based on the effective date of each the contract; that is, year 1 a contract that starts operation in July 2012 runs through June 2013 and year 1 for a Contractor that is certified in October 2012 will run through September 2013. However, Contractor must meet performance benchmarks by January 2014. (Contracts that begin operation less than a year before that date will have a shorter reporting-only accountability period and Contracts that start on or after January 2014 will have no phase-in period at all.)
- d. Performance relative to targets will affect Contractor’s eligibility for financial and non-financial rewards. Contractor’s performance with respect to minimum expectations will be assessed as part of OHA monitoring and oversight. Initially, monitoring and oversight will be aimed at root cause analysis and assisting Contractor in developing improvement strategies; continued subpar performance will lead to progressive remediation established in the Contract, including increased frequency of monitoring, corrective action plans, enrollment restrictions, financial and non-financial sanctions, and ultimately, non-renewal of contracts.
- e. OHA will convene a Metrics and Scoring Committee to assist in building measure specifications and establishing performance targets for year 2 forward. The Committee will also advise OHA annually on adopting, retiring, or re-categorizing Contractors performance measures, based on evaluation of the metrics’ appropriateness and effectiveness.
- f. Annual reporting will serve as the basis for holding Contractor accountable to contractual expectations; however, OHA will assess performance more frequently (e.g. quarterly or semi-annually) on an informal basis to facilitate timely feedback, mid-course corrections, and rapid improvement recommendations to Contractor. The parties will document any changes agreed to during these informal procedures.
- g. The performance measures reporting requirements measure the quality of health care and services during a time period in which Contractor was providing Capitated Services. The performance measures reporting requirements expressly survive the expiration, termination or amendment of this Contract, even if Contract expiration, termination or amendment results in a

termination, modification or reduction of the Contract or the Contractor's enrollment or service area, since performance measures services are rendered when the Contractor is providing Capitated Services under this Contract.

- h.** It is possible that CMS may request the inclusion of additional measures from its Adult Medicaid and CHIPRA core measure sets as CCO accountability measures.

4. Specific areas of CCO accountability metrics

Contractor will be accountable for both core and transformational measures of quality and outcomes:

- a.** Core measures will be triple-aim oriented measures that gauge Contractor performance against key expectations for care coordination, consumer satisfaction, quality and outcomes. The measures will be uniform across CCOs and will encompass the range of services included in CCO global budgets (e.g. behavioral health, hospital care, women's health, etc.).
- b.** Transformational metrics will assess Contractor progress toward the broad goals of health systems transformation and will therefore require systems transitions and experimentation in effective use. This subset may include newer kinds of indicators (for which CCOs have less measurement experience) or indicators that entail collaboration with other care partners.
- c.** Accountability metrics that are applicable in Year 1 of this Contract can be found at in the above draft table.

REVIEW the MANDATORY CONTRACT LANGUAGE IN Exhibit B, Part 9 of 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.

APPENDIX D – Financial Reporting and Solvency Questionnaire

This Appendix consists of the following sections:

- Section 1:** Financial Organization
- Section 2:** Demonstration of Financial Solvency
- Section 3:** Demonstration of Ability to Achieve the Financial Goals
- Section 4:** Framework Scope of Work

For background and further information, see Chapter 8 of the CCO Implementation Proposal, “Financial Reporting Requirements to Ensure Against Risk of Insolvency.”

Section 1 - Financial Organization

D.1.1. Corporate Organization and Structure

- D.1.1.a.** Provide a certified copy of the applicant’s articles of incorporation as filed with the Oregon Secretary of State.
- D.1.1.b.** Provide listing of ownership or sponsorship, including the percentage control each owner has over the organization.
- D.1.1.c.** Provide a description of any licenses the corporation possesses.
- D.1.1.d.** If applicant is a current MCO, describe any organization changes that will occur to conduct operations as a CCO. Please delineate between current MCO service areas and proposed CCO service areas.
- D.1.1.e.** Provide a list of other contracts the applicant holds, including Oregon Medical Insurance Pool, Healthy Kids/Kids Connect, PEBB, OEBC, CMS.
- D.1.1.f.** Provide a description of any administrative service or management contracts with other parties where the applicant is the provider of the services under the contract. Affiliated contracts are excluded in this item and should be included under item D.1.2.b.

D.1.2. Corporate Affiliations, Transactions, Arrangements

- D.1.2.a.** Provide a chart or listing presenting the identities of and interrelationships between the parent, the applicant, affiliated insurers and reporting entities, and other affiliates. For each, identify the corporate structure, two –character state abbreviation of the state of domicile, Federal Employer’s Identification Number and NAIC cocode for insurers, Schedule Y of the NAIC Annual Statement Blank—Health is acceptable.

When interrelationships are a 50/50% ownership, footnote any voting rights preferences that one of the entities may have.

- D.1.2.b.** Provide a description of any expense arrangements with a parent or affiliate organization. Provide detail of the amounts paid under such arrangements for the last two years. Provide

footnotes to the operational budget when budgeted amounts include payments to affiliates for services under such agreements.

D.1.3. Demonstrated Experience

Applicants must describe their demonstrated experience and capacity for:

- Managing financial risk and establishing financial reserves
- Meeting the following minimum financial requirements:
 - Maintaining restricted reserves of \$250,000 plus an amount equal to 50 percent of the entity's total actual or projected liabilities above \$250,000.
 - Maintaining a net worth in an amount equal to at least five percent of the average combined revenue in the prior two quarters of the participating health care entities.

Section 2: Demonstration of Financial Solvency

The following standard applies as of the CCO's Medicaid effective date and/or the the CCO's dual eligible effective date:

THE APPLICANT SHALL PROVIDE EVIDENCE OF SOLVENCY, INCORPORATE SPECIFIC PROVISIONS AGAINST INSOLVENCY, COMMENSURATE WITH ENROLLMENT (BOTH MEDICAID AND MEDICARE) AND LEVEL OF RISK ASSUMED; DEMONSTRATE FINANCIAL MANAGEMENT ABILITY; AND GENERATE PERIODIC FINANCIAL REPORTS AND MAKE THEM AVAILABLE TO OHA FOR REVIEW BY DCBS AND OHA.

The specific measurements enumerated below are not intended to be considered in isolation from each other or to be comprehensive. When considered as a whole (and with additional information, as appropriate), they provide a basis for demonstrating general financial solvency and identifying changes to be addressed. The standards in (i) apply to a current MCO converting to a CCO and to a newly formed CCO; (ii) apply to existing insurers and newly formed insurers.

D.2.1. Measurement Standard—Applies to MCOs converting to CCO and newly formed CCO

To identify if an entity can demonstrate the necessary financial solvency and ability to manage a plan financially, an entity must show that sufficient financial resources are available to provide the needed developmental and operational capital and that an adequate staffing plan is in place to operate the plan effectively.

Financial Solvency Minimum Standard

- D.2.1.a.** Applicant shall establish and maintain restricted reserve funds per OAR . The restricted reserves must be in place before terminating the Applicant's current MCO contract to beginning operations as a CCO (restricted reserves previously held by an MCO may, with consent of OHA, be transferred to the CCO), and
- D.2.1.b.** Applicant shall maintain, at all times, a level of net worth that will provide for adequate operating capital, per OAR. A minimum acceptable level of net worth is defined as net worth that is greater than or equal to {This needs to be written after we settle on language for the Rule. If the Applicant has a net worth less than the calculated minimum requirement, the

Applicant’s net worth must be increased to an amount greater than or equal to the minimum requirement prior to the award of a contract under this RFA.

D.2.1.c. An applicant must also have sufficient working capital above the minimum in order to maintain the minimum net worth requirement at all times.

Required Response

D.2.1.d. Provide current financial statements of the applicant entity that demonstrates that the applicant currently possess funds equal to the financial solvency minimum standard. The financial statements should be prepared using Statutory Accounting Procedures as described in OAR using the format set forth in EXHIBIT. In addition, provide the most recent audited financial statements of the applicant entity, if available (GAAP basis is acceptable). If capitalization of the applicant has not yet occurred, please describe when start-up capitalization will occur and prepare the required financial statements on a “pro forma” basis. Additionally, provide contractual verification of all owners of entity, stipulating the degree to which each owner's resources are available to cover the entity's developmental costs and potential operational losses. If any other entity (such as an affiliate, a state or local government agency, or a reinsurer, but not including contracting providers) will guarantee the CCO’s ultimate financial risk, in full or in part, please furnish a copy of the guarantee documents.

D.2.1.e. Provide a monthly developmental budget delineating all expenses prior to beginning operation using the table below as a model. Replace “Month 1” with the month’s name in which you anticipate starting business as a CCO in the proposed initial service area.

If the resources required to develop the CCO business are less than 10% of the applying entity’s current net worth, you may provide written assurances that current operating funds will be sufficient to cover the developmental expenses.

	Mo. 1	Mo. 2	Mo. 3	Mo. 4	Mo. 5	Mo. 6	Mo. 7	Mo. 8	Mo. 9	Mo. 10	Mo. 11	Mo. 12	YTD
CAPITAL SOURCES:													
Source 1:													
Source 2:													
Source 3:													
Other sources													
Total Capital													
DEVELOPMENTAL EXPENSES:													
Research & Planning													
Actuarial													
Consulting													
Legal													
Accounting													
Business Plan													

	Mo. 1	Mo. 2	Mo. 3	Mo. 4	Mo. 5	Mo. 6	Mo. 7	Mo. 8	Mo. 9	Mo. 10	Mo. 11	Mo. 12	YTD
Formation													
Liability Insurance													
Setup of Systems													
Administrative Services													
Setup of Reserves													
Total Developmental Expenses													

D.2.1.f. Provide a monthly operational budget covering the initial two years of operation using the table below as a model. Replace “Month 1” with the month’s name in which you anticipate starting business as a CCO in the proposed initial service area.

The budget should factor in projected utilization levels by key categories of service, and projected expenditures reflecting health systems transformation responsibilities required by HB 3650 and any alternative payment methodologies implemented. A separate worksheet presenting this detail may be used, but the financial results should be included in the operational budget.

If the resources required to fund provision of services to the expansion members (will the meaning of “expansion members” need explanation) are anticipated to be less than or equal to a 10% increase of the applicant’s current health services expenses, you may provide written assurances that your current operating funds will be sufficient to cover the increase in operating expenses. Be sure to examine the per member per month increase difference between the transformation/demonstration/::members and your current MCO members (if any).

Operational Expenses	Mo. 1	Mo. 2	Mo. 3	Mo. 4	Mo. 5	Mo. 6	Mo. 7	Mo. 8	Mo. 9	Mo. 10	Mo. 11	Mo. 12	YTD
Revenue													
Premiums													
Fee-For-Service													
Other													
Total Revenue													
Total Medical/Hospital/Health expenses													
Reinsurance													
Administrative Expenses													
Compensation													
Marketing													

Liability Insurance													
Legal and professional													
Claims processing													
Office expenses													
Utilities													
Other expenses													
Total Administrative Expenses													
Total Expenses													
Budget Surplus/Deficit													

D.2.1.g. Provide a monthly staffing plan for the last three months of the CCO developmental or planning budget and the initial three years of the CCO operational budget using the table below as a model. Express the staffing requirements in Full-Time-Equivalents (FTEs).

If the staffing resources required to provide services to the transitional/demonstration members are anticipated to be less than or equal to a 10% increase of current staffing, you may furnish written assurances that your current staffing level will be sufficient to cover providing services to the anticipated increase in members and effectively administering the CCO.

	Mo. 1	Mo. 2	Mo. 3	Mo. 4	Mo. 5	Mo. 6	Mo. 7	Mo. 8	Mo. 9	Mo. 10	Mo. 11	Mo. 12
Director												
Office Manager												
Health Plan Specialist												
Enrollment Services												
Claims Processors												
Member Services												
Accounting Services												
Secretarial and Receptionist												
Other												
Total staffing in FTEs												

D.2.1.h. Provide pro forma balance sheet, income statement (p&l) and cash flow schedules reflecting anticipated assets, capital, revenue, expense, and cash flow. The pro forma financial

statements should reflect corporate-wide activity. The amounts/expenses included in the monthly developmental, operational and staffing budgets from b., c., and d. above should be included in and reconcile to the projected pro forma financial statements. The pro forma projections are to include projection of risk-based capital as calculated using the NAIC risk-based capital forecasting package. Provide an analysis of the capital requirements to cover the expenses of developing and operating the start-up entity or expansion, and the first five years of operations, including documentation of capital sources. This analysis should supplement the monthly projections under b., c. and d. above to form an overall account of the projected required capital for the CCO's development and first five years of operation

D.2.2. Measurement Standard

Demonstration of financial solvency is satisfied if the applicant CCO possess an Oregon Certificate of Authority issued by DCBS with the authorization class of health or health care services.

Required Response

- D.2.2.a.** The certificate of authority must be issued to the corporate legal entity that is applying for the CCO contract. Provide a copy of the certificate of authority issued by DCBS. Provide the insurer's NAIC code and if a member of a holding company system, the name of the holding company system and the NAIC group number. OHA and DCBS will utilize the insurer's most recent financial statements on file with DCBS to verify financial condition for purposes of the application process.
- D.2.2.b.** Provide monthly developmental budget delineating any additional expenses the insurer will incur to fulfill its obligations as a CCO. See required response item 1(b) above for instructions.
- D.2.2.c.** Provide monthly operational expenses the insurer will incur to fulfill its obligations as a CCO. See required response item 1(c) above for instructions.
- D.2.2.d.** Provide monthly staffing plan related to fulfillment of the insurer's CCO operations. See required response item 1(d) above for instructions.
- D.2.2.e.** Provide pro forma financial statements as outlined in 1(e) above. The pro forma financial statements should reflect corporate-wide activity.

Section 3 - Demonstration of Ability to Achieve the Financial Goals

D.3.1. General Questions Relating to Financial Management

- D.3.1.a.** Describe how the Applicant uses best practices in the management of finances, contracts, claims processing, payment functions and provider network administration.
- D.3.1.b.** Provide information relating to assets and financial and risk management capabilities, including:

- Access to capital and ability to generate capital growth to fulfill restricted reserve and net worth requirements
- Risk management measures
- Delegated risk; risk sharing arrangements. Provide copy of risk-sharing contract, or term sheets for such arrangements. Describe the extent to which these arrangements reduce the risk borne by the CCO.
- Reinsurance and stop loss. Provide a copy of the reinsurance policy or terms sheet. Describe the extent to which the reinsurance or stop loss policy will reduce the risk borne by the CCO.
- Development of adequate Incurred but not reported (IBNR) and unpaid claims reserves given the CCOs expected enrollment level and its mix of covered lives/rate category. This actuarial determination should reflect health systems responsibilities required by HB 3650 as well as the effects of alternative payment methodologies implemented by the CCO in its payments to hospitals, physician groups, or other providers and risk-sharing arrangements.
 - Claims payment
 - Participation in the All Payer All Claims reporting program
 - Internal auditing and financial performance monitoring
 - Administrative cost allocation across books of business (including Medicaid, Medicare, and commercial). Describe in detail any cost allocation arrangements with affiliates.

D.3.2. Questions Relating to Licensed Health Carrier Status

D.3.2.a. If Applicant is not a Licensed Health Carrier, submit the following financial information consistent with that required for insurers, including the use of statutory accounting principles (SAP), on a pro forma basis as of the requested effective date of Applicant's Medicaid contract:

- Statement of financial position using the annual statement form developed by the National Association of Insurance Commissioners (NAIC), including all applicable schedules;
- Annual actuarial certification of unpaid claim reserves,
- Annual calculation of risk-based capital;
- Holding company information consistent with that required for insurers.

D.3.2.b. Will any other entity (such as an Affiliate, a state or local government agency, or a reinsurer, but not including contracting providers) guarantee the CCO's ultimate financial risk, in full or in part? If so, furnish a copy of the guarantee documents.

D.3.2.c. Will the Applicant enter into contracts with hospitals, physician groups, or other providers to share in the financial risk (and rewards) associated with the difference between targeted or projected expenditures and actual expenditures, or other provider risk-sharing arrangements? If so, furnish a copy of the risk-sharing contract documents, or if contract

documents are not yet available then the term sheets for such arrangements. To what extent will these arrangements reduce the risk borne by the CCO itself?

- D.3.2.d.** Will the Applicant purchase reinsurance to cap its risk exposure on either a case-by-case or aggregate basis? If so, furnish a copy of the reinsurance policy. How will this reinsurance limit the financial risk of the CCO?
- D.3.2.e.** Provide an actuarial determination that the CCO will have an adequate amount of liquid assets to satisfy claims liability based on the CCO's expected enrollment level and its mix of covered lives based on rate category. This actuarial determination should reflect health systems responsibilities required by HB 3650 as well as the effects of alternative payment methodologies implemented by the CCO in its payments to hospitals, physician groups, or other providers.
- D.3.2.f.** What medical loss ratio (computed as required under the Affordable Care Act) does the CCO expect to achieve in its first year? In years two through five?
- D.3.2.g.** Describe the projected annual operating budget for the first three years of the CCO's operations, including projected revenue and investments, projected utilization levels by key categories of service, and projected expenditures reflecting health systems transformation responsibilities required by HB 3650 and any alternative payment methodologies implemented.
- D.3.2.h.** Outline, by category, administrative expenses relating to provision of services under its CCO contract, following the NAIC annual statement form's schedule of expenses by expense category. This expense schedule must delineate CCO expenses for all enrolled populations - those incurred under its CCO contract as well as contracts for other populations including Medicare, PEBB, OEBC, and other commercial insurance.
- D.3.2.i.** Provide information about expense arrangements with a parent or affiliate organization and detail amounts paid for such service arrangements in the form of the schedules and note disclosures required by the NAIC annual statement form.

Section 4 – 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

Financial Reporting Requirements to Ensure Against Risk of Insolvency

1. Contractor will submit financial information required under this Section to the Department of Consumer and Business Services. The following section provides an overview of proposed requirements related to the above items and addresses additional information on organizational structure, corporate status and structure, existing contracts and books of business, and risk management capacities that CCOs shall report.
2. CCOs must submit financial information to DCBS consistent with that required for insurers, including the use of statutory accounting principles (SAP) and financial information reported on a corporate-wide basis. Application of these principles would allow for standardization of accountability and solvency assurances across health plans enrolling Medicaid, Medicare, and commercial populations and will address the CMS's interest in having organizations that enroll Medicare beneficiaries regulated by the state's Insurance Division.
3. The filing requirements include: quarterly and annual statements of financial position using the form developed by the National Association of Insurance Commissioners (NAIC); annual actuarial certification of unpaid claim reserves; annual calculation of risk-based capital; quarterly management discussion and analysis (plain-language narrative of financial statements; annual audited financial statements; annual holding company registration statement (which includes description of any management, service or cost-sharing arrangements and an annual consolidated audited financial statement). Contractor is subject to periodic on-site financial examinations consistent with those performed on insurers. Contractor will pay the costs of such examination.
4. Contractor understands that, to the extent permissible under law, financial information collected as required by HB 3650 should be transparent and made available online. This kind of transparency will enable the community to evaluate Contractor's financial condition and increase confidence in the effectiveness of its governance. A high level of transparency will also enable the Contractor board to take early corrective actions. It is critical that Contractor provide understandable, comprehensive and reliable information about their financial status and performance.
5. Contractor should provide detailed information about how it is legally organized. Emphasis should be given to how the entity will guarantee the Contractor's ultimate financial under the Contract.
6. If Contractor is an MCO that plans to convert to a CCO, the Contractor should provide detailed information on how this will be accomplished, including but not limited to assets that will be transferred, how operating systems will be transferred or used by the new entity, disposition of the current MCO restricted reserve account.
7. Contractor understands that information from the NAIC financial reports will be used by financial analysts from DCBS and OHA, including OHA's Actuarial Services Unit, to track the financial solvency of Contractor as it gains (or loses) enrollment over time. Contractor should describe its plan for risk sharing arrangements. Such arrangements include but not limited to reinsurance, stop loss coverage, capitation arrangements and risk sharing arrangements. Contractor will need to demonstrate in its pro forma projections how these initiatives reduce the CCO's risks undertaken by this Contract. Adequate reinsurance and risk sharing arrangements have the effect of lowering a CCO's liabilities, but will not exempt the CCO from maintaining the minimum capital and surplus required by OAR 410-141-3340 through 410-141-3395.
8. Contractor must describe an annual operating budget including projected revenue and investments, projected utilization levels by key categories of service, and projected expenditures reflecting any alternative payment methodologies implemented. The operating budget should reflect CCO expenses for all of its populations - those incurred under its CCO contract as well as contracts for other populations including Medicare, PEBB, OEBC, and other commercial insurance. This operating budget will serve both to indicate the financial soundness of the Contractor to demonstrate that the Contractor has developed its budget to reflect the requirements and objectives of health systems transformation.

- a.** Contractor demonstrates to OHA through proof of financial responsibility, in accordance with OAR 410-141-0340, 42 CFR 438.106, 42 CFR 438.116 and Exhibit H, that it is able to perform the Work required under the Core Contract efficiently, effectively and economically and is able to comply with the requirements of this Contract.
- b.** If Contractor expects to change any elements of the Solvency Plan or solvency protection arrangements, Contractor provides written advance notice to OHA, at least 90 calendar days before the proposed effective date of change. Such changes are subject to written approval from OHA.
- c.** Contractor notifies OHA of its intent to update or change its data transaction systems that interface with OHA's data systems or transactions not later than 30 days before making such update or change in order to allow appropriate compatibility testing of any data interfaces with OHA, if necessary; and
- d.** Failure to comply with financial responsibility documentation requirements, including solvency protection specified pursuant to the requirements of applicable administrative rules and this Contract shall be grounds for termination or sanction under this Contract, at OHA's sole discretion.
- e.** Failure to maintain adequate financial solvency, including solvency protections specified pursuant to the requirements of administrative rules and this Contract, shall be grounds for termination, reduction in Service Area or Enrollment, or sanction under this Contract, at OHA's sole discretion.
- f.** In the event that insolvency occurs, Contractor remains responsible for providing Covered Services for Members through the end of the period for which it has been paid and for its hospitalized Members until discharge.
- g.** Contractor understands and agrees that in no circumstances will a Member be held liable for any payments for any of the following:
 - (1)** The Contractor's or Subcontractors' debt due to Contractor's or Subcontractors' insolvency;
 - (2)** Capitated Services authorized or required to be provided under this Contract to the Member, for which:
 - (a)** The State does not pay the Contractor; or
 - (b)** The Contractor does not pay a Provider or Subcontractor that furnishes the services under a contractual, referral, or other arrangement; or
 - (3)** Payments for Covered Services furnished under a contract, referral or other arrangement with Contractors, to the extent that those payments are in excess of the amount that the Member would owe if the Contractor provided the services directly.

- h.** Contractor may operate a Practitioner Incentive Plan only if no specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit Medically Appropriate Covered Services furnished to an individual Member. Contractor discloses to OHA information about Practitioner Incentive Plans (PIP), which is defined to mean “any compensation to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to a Member.” These Contract requirements implement federal law and regulations to protect Members against improper clinical decisions made under the influence of strong financial incentives.
- i.** If at any time OHA believes that Contractor has incorrectly computed the amounts related to these requirements, or that the coverage or protection amounts obtained by Contractor are insufficient to meet these requirements, OHA may notify Contractor of changes it requires. Within 30 days of any notice by OHA under this section, Contractor either makes the required changes or requests an Administrative Review as defined in OAR 410-120-1580(4)-(5). In the event an Administrative Review is requested and pending disposition of that review, OHA may require that Contractor take such actions as will assure financial responsibility and solvency or PIP stop-loss protections as may be determined necessary.
- j.** Contractor shall not seek recourse against OHA for Covered Services provided during the period for which CCO Payments were made by OHA to Contractor even in the event Contractor becomes insolvent.

APPENDIX E – Dual Eligibles Questionnaire

This Appendix consists of the following sections:

- Section 1:** Background Information
- Section 2:** Participation in the Demonstration (Pending CMS approvals)
- Section 3:** Proposed Scope of Work

Section 1 - Background Information – Inclusion of Dually Eligible Individuals in CCOs

HB 3650 indicates that “Subject to the Oregon Health Authority obtaining any necessary authorization from the Centers for Medicare and Medicaid Services... coordinated care organizations that meet the criteria [for CCOs]...are responsible for providing covered Medicare and Medicaid services, other than Medicaid-funded long term care services, to members who are dually eligible for Medicare and Medicaid in addition to medical assistance recipients.”²

The OHA is preparing a formal proposal to CMS for a demonstration to integrate care for individuals dually eligible for Medicare and Medicaid. CMS has offered all states the previously unavailable opportunity to pursue three-way contracts between health plans, the state, and CMS for blended Medicare and Medicaid payments to plans, set at a level to target savings that can be shared. CCOs will be required to participate in the three-way contracts, contingent on OHA and CMS reaching mutually agreeable terms, after OHA consultation with Oregon health plans.

Oregon’s proposal to CMS will be released for a 30-day public comment period in early March 2012 and will be submitted to CMS following that public comment period, with a current target date of mid-April. Following the submission of the proposal to CMS, CMS will have their own 30 day public comment period. During and following the CMS public comment period, CMS and Oregon will negotiate the requirements and payment rates for plans participating in the demonstration and will sign a memorandum of understanding (MOU), with a current target date of mid- to late-June. The timeline of the CMS process means that plans will be initially certified to become CCOs by OHA, and then the certification of plans to participate in the CMS demonstration/three-way contracts will take place later. The target date for CCOs to begin providing Medicare services to dually eligible individuals is January 1, 2013.

OHA has been working closely with CMS throughout the development of the CCO proposal to ensure that the general CCO structure will be acceptable for the demonstration and three-way contracts. However, since the final details of the demonstration requirements have not been finalized at this time, in order to participate in the three-way contracts and offer Medicare benefits as required by HB 3650, plans will be asked to provide additional information as part of the CMS certification process and will need to meet additional requirements. CMS recently released guidance with key information related to the demonstration for organizations that may wish to participate. The guidance is available on the CMS website at: <https://www.cms.gov/medicare-medicaid-coordination/downloads/FINALCMSCapitatedFinancialAlignmentModelplanguidance.pdf>

The CMS guidance linked above outlines some of the key areas of plan requirements that will be negotiated between CMS and the state. In particular, areas where there are likely to be additional requirements for CCOs related to the inclusion of dually eligible individuals for Medicare include:

- An integrated Medicare and Medicaid benefit package
- Integrated Medicare and Medicaid appeals process for dually eligible individuals
- Integrated beneficiary materials

² HB 3650, Section 7.

- Integrated quality assurance/performance improvement requirements incorporating Medicare priorities and standards
- Model of care requirements
- Quality reporting and incentive program

Section 2 - Participation in the Demonstration (Pending CMS approvals)

The CMS guidance also provides an overview of key CMS deadlines that plans **must meet** in order to participate in the demonstration/three-way contracts and offer Medicare benefits, as required by HB 3650. The CMS guidance also includes instructions and links related to the first two deadlines below. While the CMS certification process will follow after the OHA process, many of these deadlines will occur prior to that CMS certification:

- April 2, 2012 – Final date for submission to CMS of Notice of Intent to Apply to offer demonstration plans
- April 9, 2012 – Final date for submission of CMS User ID connectivity form
- April 30, 2012 – Part D formulary submissions due to CMS for organizations that have not submitted a formulary for CY 2013 for a non-demonstration plan
- May 7, 2012 – Part D Medication Therapy Management Program submission due to CMS
- May 14, 2012 – Part D formulary submissions due to CMS for organizations that have already submitted a non-demonstration plan formulary for CY 2013 to CMS and intend to use that previously submitted formulary for their demonstration plans
- June 4, 2012 - Proposed plan benefit package submissions (including all Medicare and Medicaid benefits) due to CMS
- June 8, 2012 – Additional required Part D information submissions due to CMS

E.2.1. Has the applicant submitted the required CMS Notice of Intent to Apply prior to the April 2nd deadline? Provide a copy.

E.2.2. Has the Applicant submitted the required CMS User ID connectivity form? Provide a copy.

Formulary development is an extensive body of work, particularly for plans which have not previously offered a Part D plan. CMS has encouraged plans to start the work of developing their formulary and meeting other Part D requirements as soon as possible in order to meet the deadlines above. CMS has indicated that they will provide training to interested organizations on the Medicare Part D requirements and has provided an email address for any questions: CMSMMCOcapsmodel@cms.hhs.gov.

E.2.3. How does the applicant intend to meet the CMS Part D requirements, including the formulary requirement? Has the applicant previously offered a Part D benefit? If Applicant has not previously been offered a Part D benefit, does the Applicant intend to contract with a Pharmacy Benefits Manager or will they develop their own formulary and meet other Part D requirements without this type of assistance?

Applicants are not required to have prior experience as a Medicare Advantage (MA) plan (or as a Special Needs Plan in particular) in order to participate in the CMS demonstration.

E.2.4. Does Applicant or any Affiliate of Applicant currently have a contract with CMS to serve Medicare beneficiaries? If so, describe if it is:

- PACE program
- Special Needs Plan, including what type (dual eligible, chronic condition, institutional)
- Other Medicare Advantage

- E.2.5.** Describe the length of time and contract history with CMS or its intermediaries for any Medicare line of business for Applicant or any Affiliate of Applicant.
- E.2.6.** Is the Applicant or any Affiliate of Applicant a MA plan or applying to become one for 2013? If yes, the Applicant will submit with its CCO Application a copy of the entire MA application of Applicant or the Affiliate for 2013.

Section 3 – 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.

Please submit a proposed scope of work to serve as the foundation for the part of the Contract governing Work within the scope of this questionnaire. See RFA Section 3.2 for further information about Applicant's proposed scope of work.

APPENDIX F – Global Budget Questionnaire

This Appendix consists of the following sections:

- Section 1:** General Questions on Global Budgeting
- Exhibit 1:** Medicaid Program and Services for Inclusion in the CCO Global Budget
- Exhibit 2:** Instructions for Submitting Estimated Costs for Medicaid Services
- Exhibit 3:** Estimated Costs and Capitation Rates spreadsheet
- Exhibit 4:** Pro Forma Projections for the First Five Years

For background and further information, see Chapter 6 of the CCO Implementation Proposal, “Global Budget Methodology.” See Appendix E for information regarding the three-way contracts with CMS for blended Medicare and Medicaid funding for dually eligible individuals and the timeline on which that process will proceed.

1. Global Budget Methodology

CCO global budgets are designed to cover the broadest range of funded services for the most beneficiaries possible. The construction of global budgets start with the assumption that all Medicaid funding associated with a CCO’s enrolled population is included. Global budgets include services that are currently provided under Medicaid managed care in addition to Medicaid programs and services that have been provided outside of the managed care system. This inclusive approach enables CCOs to fully integrate and coordinate services and achieve economies of scale and scope. The global budget approach also allows CCOs maximum flexibility to dedicate resources towards the most efficient forms of care.

As funding allows, quality incentives will be incorporated into the global budget methodology to reward CCOs for improving health outcomes in order to increasingly pay for quality of care rather than quantity of care.

CCO global budgets will be comprised of two major components: capitated and non-capitated. The capitated portion will include funding for all services that can be disbursed to CCOs in a prospective per member per month payment. Initially, the capitated portion should include all services currently provided by physical health, behavioral health, and, by 2014 if not before, dental care organizations. The non-capitated portion of the global budget calculation will be for programs and services that are currently provided outside of managed care. The CCO will receive payment and be accountable for the provision of those services.

2. Populations Included in Global Budget Calculations

With very few exceptions, all Medicaid populations in Oregon are to be enrolled in CCOs and paid under the global budget methodology . OHA will enroll as many of the remaining eligible individuals (who are currently in fee-for-service) into a CCO as possible, with the exception of those specifically exempted by federal or State law.

3. Service/Program Inclusion and Alignment

One of the primary goals of the global budget concept is to allow CCOs flexibility to invest in care that may decrease costs and achieve better and more equitable outcomes. The more programs, services and funding streams that are included in CCO global budgets, the more flexibility and room for innovation exists for CCOs to provide comprehensive, culturally and linguistically appropriate, person-centered care. In addition, leaving necessary care outside of the global budget creates conflicting incentives

where the action of payers outside of the CCO, who have little reason to contribute to CCO efficiencies, may have undue impact on costs and outcomes within the CCO.

With respect to the remaining 13 percent of non-long-term care Medicaid expenditures, exceptions to service or program inclusion in the global budgets should be minimal. However, consideration could be given to CCO requests to postpone inclusion of one or more services or programs on the grounds that their inclusion would negatively impact health outcomes by reducing available funding, access or quality. CCOs are strongly encouraged to develop strategic partnerships within their community in order to successfully manage comprehensive global budgets.

In the case of services that are postponed or excluded from CCO global budgets, it is anticipated that CCOs will enter into shared accountability arrangements for the cost and health outcomes of these services in order to ensure that incentives are aligned in a manner that facilitates optimal coordination. Mental health drugs and long-term care services are excluded from CCO global budgets. As described in the Accountability questionnaire, these and other exclusions from CCO global budgets weaken incentives for coordinated care, which must be addressed.

4. Global Budget Development

The overall global budget strategy will hold CCOs accountable for costs but not enrollment growth. This strategy suggests an overall budgeting process that builds off of the current capitation rate methodology, but also includes a broader array of Medicaid services and/or programs. CCOs' 1st year global budgets will include two Medicaid components:

- A capitated portion that includes the per member per month payments for services currently provided through the OHP physical health plans, mental health organizations and, if included, dental care organizations; and,
- An add-on component to the capitated portion for the remaining Medicaid services or programs not currently included in capitation payments.

Additionally, CCO global budgets will also include Medicare funding to blend with their Medicaid funding to care for individuals eligible for both programs. After the development of an initial baseline of quality and outcome data, OHA will develop a quality incentive component to the global budget methodology to reward CCOs for improved health care outcomes and controlling costs.

5. Capitated Portion of the Global Budget Methodology

At least initially, the capitated portion CCO capitation rate setting would combine the information provided by organizations seeking CCO certification with a method similar to the lowest cost estimate approach OHA took in setting rates for the first year of the 2011-13 biennium. This approach provides a key role for plans in determining appropriate rates and potential efficiencies that can be realized under a transformed delivery system tailored to meet the needs of the community it serves.

More specifically, in order to establish rates, OHA will gather estimated costs that utilize the most reliable cost data from potential CCOs in order to produce a base cost while addressing actuarial soundness, CCO viability, and access to appropriate care. This cost data will indicate the lowest rate a CCO can accept in their "base region," based on current population, geographic coverage and benefit package (the "CCO Base Cost Template" referenced above). OHA will use the CCO Base Cost Template as the foundation for the CCO capitation rates. If CCOs propose to operate in geographic areas where they have little or no experience, state actuaries will use a population-based risk adjustment

methodology based on the currently used Chronic Illness and Disability Payment System (CDPS), to develop the rates in these new areas.

It is anticipated that initial CCO global budget amounts be established for one year, but that stakeholders and OHA will explore the possibility of establishing global budgets that could be enacted on a biennial or multi-year basis thereafter. For subsequent years, stakeholders have indicated support for continuing to adjust payments to CCOs based on member risk profiles under the current CDPS process. Stakeholders have encouraged OHA to investigate the possibility of including pharmacy data and expanded demographic data into CDPS.

CCO contractors will submit base costs to OHA on the schedule shown in Attachment 3. OHA's Actuarial Services Unit will be available for technical assistance and work closely with potential CCOs to help them prepare and submit their base cost estimates. If a potential CCO declines to provide a base cost template, OHPB does not recommend certifying a capitation rate for the CCO or issuing the CCO a contract.

The CCOs submitted rates will be reviewed by OHA's actuary and assessed for reasonableness based on documentation that the CCO is capable of:

- Attaining identified efficiencies without endangering its financial solvency
- Providing adequate access to services for its enrollees, and
- Meet all necessary federal standards, including but not limited to explanatory notes detailing planned actions, such as initiatives to increase efficiency.

OHA's Actuary will assess actuarial soundness at the CCO and region level, and will confer with the CCO regarding any questions or issues that need to be resolved. Additional calculations may be required to ensure that CCO rates in aggregate meet the 2011-13 legislatively approved budget.

6. Non-capitated or "supplemental" portion of the Global Budget Methodology

As previously stated, the OHPB recommended approach to global budgets starts with the assumption that all Medicaid funding associated with a CCO's enrolled population is included. The non-capitated portion of the global budget calculation will encompass programs and services that are currently provided outside of managed care. The CCO will now receive payment and be accountable for the provision of those services.

However, it may not be feasible or optimal to initially wrap all Medicaid services that have been traditionally outside of managed care capitation into a per member per month payment calculation. This may be the case when communities provide the state matching funds for certain Medicaid services. New financing arrangements between the state, CCO, and county will be needed to ensure the ability to match local funds is not compromised. In other cases, there may not be adequate experience to comfortably base a per member per month calculation, at least initially.

As the CCO develops and more experience is gained with the global budget, the breadth of funding incorporated into the capitated portion of the global budgets may expand.

7. Quality Incentive Payments

CCO global budget payments will be connected to quality metrics for both clinical processes and health outcomes. An incentive structure will be developed during in the first year of CCO operation by the

Metric and Scoring Committee. During the first year of operation, metrics will be utilized to ensure adequate CCO performance for all programs or funding streams in the global budget and to create a data baseline. After the initial period, metrics will be used to determine exceptional performers who would qualify for incentive rewards. Incentive design will include shared savings approaches so that do not penalized CCOs for successfully lowering costs.

Section 1 - General Questions Regarding Global Budgeting

- F.1.1.** Applicants must describe their demonstrated experience and capacity for operating within a fixed global budget.
- F.1.2.** Can the Applicant provide, on a full risk basis, all services currently provided by Medicaid physical health, mental health, and, by 2014 if not before, dental care MCO?
- F.1.3.** Will the Applicant have the necessary relationships, processes and systems in place to be able to provide the non-emergent medical transportation benefit to members by January 1, 2013?
- F.1.4.** When does the Applicant anticipate providing dental services on a full risk contract?
- F.1.5.** Can the Applicant provide, under full risk contract, all programs and services outlined in Exhibit 1?
- F.1.6.** Which programs and services can the Applicant provide in Exhibit 1?
- F.1.7.** What flexibility and room for innovation will Applicant need in order to invest in care that may decrease costs and achieve better outcomes?
- F.1.8.** Do you anticipate the need to subcontract a portion of the health care delivery system? If so, please describe.
- F.1.9.** Please submit lowest cost estimates, following the instructions in Exhibit 2, with a completed Base Cost Template (see Exhibit 3) using internal cost data that is representative of a minimum base population, for 1st year global budgets to include:
- F.1.10.** Per member per month payments for services currently **provided through the OHP physical health plans, mental health organizations and, if included, dental care organizations.**

Section 2 – 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.

Please submit a proposed scope of work to serve as the foundation for the part of the Contract governing Work within the scope of this questionnaire. See RFA Section 3.2 for further information about Applicant's proposed scope of work.

Exhibit 1 - Medicaid Program and Services for Inclusion in the CCO Global Budget

Program Area	Program/Service/Function	Notes	Timeline for Inclusion in Global Budgets		
			July 1, 2012	Jan. 1, 2013	Jan. 1, 2014
Physical health care	OHP physical health coverage for clients enrolled in managed care and FFS (includes emergency transport)	Currently paid through capitation; clients receiving coverage FFS would be moved into CCOs as well.	X		
Mental Health	OHP mental health coverage for clients enrolled in managed care and FFS	Currently paid through capitation; clients receiving coverage FFS would be moved into CCOs as well.	X		
Dual Eligible Specific	Payment of Medicare cost sharing (not including skilled nursing facilities) and Medicare Advantage premiums for dual eligibles	Basis of payment currently depends on whether or not a beneficiary is enrolled in a Medicare Advantage plan, Medicaid physical health managed care plan.	X		
Addictions	OHP addiction health coverage for clients enrolled in managed care and FFS	Currently paid through capitation; clients receiving coverage FFS would be moved into CCOs as well.	X		
Additional Enrollees	Breast and Cervical Cancer Medical (BCCM) (not inclusive of screening)	Clients currently receive care on a FFS basis, but would benefit from coordinated care. Benefits mirror those currently paid through capitation.	X		
Additional Enrollees	Eligible clients with third party insurance	Approach under development	X		

Program Area	Program/Service/Function	Notes	Timeline for Inclusion in Global Budgets		
			July 1, 2012	Jan. 1, 2013	Jan. 1, 2014
Dual Eligible Specific	Cost-sharing for Medicare skilled nursing facility care (day 21-100)	Cost sharing for Medicare eligibles also eligible for a full Medicaid benefit and enrolled in a CCO will be included in blended capitation rates under CMS demonstration.	X		
Mental Health	Children's Statewide Wraparound Projects	Services and supports for children with complex behavioral health needs and their families. Paid in the capitation rate for 3 MHOs currently.	X		
Mental Health	Exceptional Needs Care Coordinators	Specialized case management service provided to clients identified as aged, blind or disabled who have complex medical needs. Currently paid through capitation	X		
Mental Health	Non-forensic intensive treatment services for children	Currently paid through capitation for managed care enrolled clients and FFS for eligible clients not enrolled in managed care.	x		
Physical health care	OHP Post Hospital Extended Care (for non-Medicare eligibles)	Currently in the capitation rate for those in managed care for the first 20 days of care.	X		
Addictions	Substance Abusing Pregnant Women and Substance Abusing Parents with Children under Age 18 (Targeted Case Management)	Program currently operates in a limited number of counties.	Optional in counties where currently operating	X	

Program Area	Program/Service/Function	Notes	Timeline for Inclusion in Global Budgets		
			July 1, 2012	Jan. 1, 2013	Jan. 1, 2014
Addictions	Youth residential alcohol and drug treatment (OHP carve out)	HB 3650 states that OHA shall 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 coordinated care organization but no later than July 1, 2013.	Optional	Optional until July 1, 2013	
Mental Health	Adult residential alcohol and drug treatment (OHP carve out)	HB 3650 states that OHA shall 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 coordinated care organization but no later than July 1, 2013.	Optional	Optional until July 1, 2013	
Targeted Case Management	Asthma - Healthy Homes (Targeted Case Management)	Program is only one year old and has only operated in one county, with one additional county likely to begin operation soon.	Optional in counties where currently operating	X	
Transportation	Non-Emergent Medical Transportation	Not currently in capitated rates, but inclusion necessary for coordination and access to care. Includes wheelchair van, taxi, stretcher car, bus passes and tickets, secured transportation.		X	

Program Area	Program/Service/Function	Notes	Timeline for Inclusion in Global Budgets		
			July 1, 2012	Jan. 1, 2013	Jan. 1, 2014
Mental Health	Adult Residential Mental Health Services	High-cost, low-frequency services linked to management of census at state hospitals. CCOs will need to manage utilization and develop alternative services such as access to housing with necessary supports for independent living.		X	
Targeted Case Management	HIV/AIDS Targeted Case Management	Overall services supported by Medicaid and CDC block grant funds.		X	
Targeted Case Management	Nurse Home Visiting program: Babies First! And CaCoon	Considering inclusion in second year of CCO operation or later in order to determine how to best integrate public health nurses into transformation.		X	
Targeted Case Management	Nurse Home Visiting program: Maternity Case Management (MCM)	Considering inclusion in second year of CCO operation or later in order to determine how to best integrate public health nurses into transformation.		X	
Dental	OHP dental coverage	HB 3650 states that dental care organizations may choose to operate until 7/1/14 or opt to become part of a CCO sooner.	Optional	Optional	Optional Until July 1, 2014
Additional Enrollees	Citizen Alien-Waived Emergency Medical (CAWEM) Prenatal	Program currently operates in a limited number of counties.	Optional	Optional	X

Exhibit 2 - Instructions for Submitting Estimated Costs for Medicaid Services

Step 1:

- 1 Select either "CCO including Dental" or "CCO not including Dental" by moving the cursor to the cell next to "Contract Type:"
A small arrow will appear, click on it to choose.
- 2 Enter the name of your CCO.
- 3 Select your region or regions by moving the cursor to the highlighted area next to "Region(s)".
A small arrow will appear, click on it to select your region or regions.
If your estimated rates are different among your regions, select only one region and then complete the template.
If your estimated rates apply to multiple regions, select all the applicable regions and then complete the template.
- 4 Enter your data period (base period) begin date in the format of 1/1/2009.
- 5 Enter your data period (base period) ending date in the format of 12/31/2009. Both need to be "dates", rather than "months".
- 6 For each of the counties listed, select "Yes" if it's applicable under the heading "Base Area".
Base Area is where you are providing coverage for Medicaid members, and where you have enrollment and cost data.
You will be entering enrollment and cost data as well as information for the base area only.
- 7 For each of the counties listed, select "Yes" if it's applicable under the heading "Expansion Area".
Expansion area is where you currently do not provide coverage. You do not need to enter any data for expansion area.
Rather, risk adjustment factors will be applied to derive capitation rates for the expansion area.

Step 2:

- 8 Enter enrollment data for your base area in the highlighted cells below each of the eligibility categories, region by region.
- 9 If you want to utilize enrollment data from FCHP plans currently in the region, select "No" under "Manual Input" and then select the FCHP plan or plans. The template will calculate and provide the enrollment data for you, for the data period you specified in "Step 1".
Remember, this tab only applies to the base area and it requires you to enter the total member months for your entire data period not just a monthly figure.

Step 3a:

- 10 If you will be covering new members in the upcoming contract period who are currently covered Fee For Service (FFS), you need enter projected average member months. You do so by entering the percentage of all the FFS members you will be covering in the highlighted cells.
If you enter 100%, you can see what the total number of FFS members are. Only enter 100% as your final penetration percentage if you will be covering all of them.
These are monthly figures, for the new contract period.

Step 3b:

11 Enter the projected member months you will be covering in the upcoming contract period in addition to the estimates in number "9" above. These member months need to be entered for both base area and expansion area.

You may have other options than manually inputting member months. For the base area, if applicable, you can choose "Use Data Period Penetration %" or "Manually Input Penetration %". If you choose "Use Data Period Penetration %", the same penetration % in "Step 2" will be used.

For the expansion area, instead of manually inputting member months, you can choose to "Manually Input Penetration %". These result in monthly figures, for the new contract period.

Step 4:

12 Enter the administrative allowance first. There will be three choices.

You may choose "%" of administrative allowance. For example, you can enter 0.08 for 8% admin load.

You may choose "PMPM" of administrative allowance. For example, you can enter 20 for \$20 admin PMPM.

You may also choose "N/A (Use Total Admin Cell Below)". In this case, use the highlighted cell in the bottom, and enter your projected total admin dollar expense amount for the upcoming contract period.

These figures are net of premium tax, and net of admin expenses for HRA and include admin allowances for mental health services, and dental services (if applicable).

Below are instructions for entering cost estimates in each of the 12 rate categories. Please follow the same instructions for each of the rate categories:

- 13 Enter paid-through-date in the format of 7/1/2010. Paid-through-date is the last date your data were pulled from a live claims system.
- 14 Under "Note Ref#", enter a number denoting a sequence or ID number for your notes. There are highlighted areas below.
You can enter your reference ID number and notes there.
- 15 Under "Data Period Claim Cost", enter total claims cost for the base period. Claims cost should reflect actual paid amounts, or sub-capitation amounts, and appropriately account for any related costs such as stop-loss-premium as well as stop-loss recoveries (negative amounts).
Amounts must include only those for Medicaid members.
Amounts must include only those related to services covered as defined in the state plan.
Amounts must exclude admin pass-through in the sub-capitation payments.
- 16 Under "Claims Reserve for Data Period Incurral (IBNR)", enter IBNR reserve amounts for future expenses incurred in the data period.
IBNR reserve amounts are required fields.
Only when there is a very long run out period (paid-through-date is long after data period), can this field be zero.
- 17 Under "Data Period Claim PMPM Cost", enter the base year PMPM estimates.
These should be consistent with the total of "Data Period Claim Cost" and "Claims Reserve for Data Period Incurral (IBNR)" divided by "Data Period Member Months".
- 18 Under "Annual Cost Trend", enter the underlying cost trend factor for a 12 month period. This is the unit service cost inflation factor.
Annual cost trends usually differ from inpatient to outpatient, physician, Rx, etc.
- 19 Under "Annual Utilization Trend", enter the utilization trend factor that reflects increases or decreases in frequency of treatment or services per 1,000 member months as well as shifts towards more expensive or less expensive service mixes.
- 20 Under "Adjustment to Cover FFS", leave the highlighted field blank until such numbers are available after discussions and collaborations with OHA/ASU.
- 21 Under "Other Adjustment #1", enter adjustment factors. These should be near 1.05 or 0.95.
In the note section, explain what the adjustments factors are for, and also briefly how you estimated them.
- 22 Under "Other Adjustment #2", enter adjustment factors. These should be near 1.05 or 0.95.
In the note section, explain what the adjustments factors are for, and also briefly how you estimated them.
- 23 Under "Other Adjustment #3", enter adjustment factors. These should be near 1.05 or 0.95.
In the note section, explain what the adjustments factors are for, and also briefly how you estimated them.
- 24 Enter mental health services administrative allowance % or PMPM in either of the cells. Only one field needs to be entered.
This is for the contract period and serves the purpose of parsing out MH admin from total admin.
This does not include the premium tax of 1%.
- 25 Enter mental health services administrative allowance % or PMPM in either of the cells. Only one field needs to be entered.
This is for the contract period and serves the purpose of parsing out dental admin from total admin.
This does not include the premium tax of 1%.
- 26 Repeat numbers "6" through "13" for other rate categories.

Combining Rate/Eligibility Categories

- 27 If member months for a particular rate category have been combined into another rate category, then you do not have to enter these two columns: "Data Period Claims Cost" and "Claims Reserve for Data Period Incurral (IBNR)".
However, you still have to enter the rest of the columns such as "Data Period Claim PMPM Cost", "Annual Cost Trend", and "Annual Utilization Tr and adjustment factors.
Please tell us what categories are combined in the reference note section.
Please check to make sure the combined rate categories have the same PMPM cost estimates and rates.

Exhibit 3 - Estimated Costs and Capitation Rates Spreadsheet

Step 1 - Enter Coordinated Care Organization (CCO) Information

Contract Type:	CCO including Dental	Plan:	Coordinated Care of Oregon
Region(s):			
Tri-County?	Tri-County		
LBMPY?	LBMPY		
JJD?	JJD		
Lane?	Lane		
Other?	Other		
Contract Time Period:	From:	7/1/2012	Thru: 6/30/2013
Data Time Period:	From:	2/1/2011	Thru: 3/31/2011
Years from Midpoint of Data Period to Midpoint of Contract Period:			1.8

		Coverage Area	
		Base	Expansion
Tri-County	Clackamas	Yes	--
	Multnomah	--	Yes
	Washington	--	--
LBMPY	Benton	Yes	--
	Linn	--	Yes
	Marion	--	--
	Polk	Yes	--
	Yamhill	--	Yes
JJD	Douglas	Yes	--
	Jackson	--	Yes
	Josephine	--	--
Lane	Lane	Yes	--

Other

Baker	Yes	--
Clatsop	--	Yes
Columbia	--	--
Coos	Yes	--
Crook	--	Yes
Curry	--	--
Deschutes	Yes	--
Gilliam	--	Yes
Grant	--	--
Harney	Yes	--
Hood River	--	Yes
Jefferson	--	--
Klamath	Yes	--
Lake	--	Yes
Lincoln	--	--
Malheur	Yes	--
Morrow	--	Yes
Sherman	--	--
Tillamook	Yes	--
Umatilla	--	Yes
Union	--	--
Wallowa	Yes	--
Wasco	--	Yes
Wheeler	--	--

Step 2 - Enter Data Period Enrollment for Base Area

Manual Input	or Take These Enrollment			
No	CareOregon	Cascade C	--	--

Region	County	Coverage	TANF	PLMA	CHILD 00-01	CHILD 01-05	CHILD 06-18	ABAD-MED	ABAD	OAA-MED	OAA	CAF	OHPFAM	OHPAC
Tri-County		N/A	3,000	2,900	-	-	2,800	1,000	1,800	-	1,000	300	100	-
		Data period enrollment	1,859	329	665	2,866	6,044	868	1,543	725	13	468	763	2,107
		(Eligibles)	3,567	782	1,584	6,501	12,635	1,922	2,920	2,522	46	1,539	1,394	3,210
		(Penetration %)	52%	42%	42%	44%	48%	45%	53%	29%	27%	30%	55%	66%
	Clackamas	Base	1,859	329	665	2,866	6,044	868	1,543	725	13	468	763	2,107
	Multnomah	Expansion	-	-	-	-	-	-	-	-	-	-	-	-
	Washingto	--	-	-	-	-	-	-	-	-	-	-	-	-
LBMPY		N/A	-	900	-	200	400	400	100	400	600	-	1,000	-
		Data period enrollment	135	51	89	465	791	29	109	15	3	52	71	248
		(Eligibles)	2,093	473	979	4,269	7,276	1,109	1,639	1,065	27	738	867	1,911
		(Penetration %)	6%	11%	9%	11%	11%	3%	7%	1%	11%	7%	8%	13%
	Benton	Base	4	-	1	7	4	-	4	-	-	3	-	2
	Linn	Expansion	-	-	-	-	-	-	-	-	-	-	-	-
	Marion	--	-	-	-	-	-	-	-	-	-	-	-	-
	Polk	--	-	-	-	-	-	-	-	-	-	-	-	-
	Yamhill	Base	131	51	88	458	787	29	106	15	3	49	71	246
JJD		N/A	300	400	-	1,000	700	700	900	900	600	700	100	500
		Data period enrollment	1,765	317	753	3,330	5,895	308	909	288	13	271	845	1,473
		(Eligibles)	3,345	923	1,568	6,244	10,908	1,694	2,641	1,700	40	1,005	1,549	3,138
		(Penetration %)	53%	34%	48%	53%	54%	18%	34%	17%	33%	27%	55%	47%
	Douglas	--	-	-	-	-	-	-	-	-	-	-	-	-
	Jackson	Base	1,765	317	753	3,330	5,895	308	909	288	13	271	845	1,473
	Josephine	--	-	-	-	-	-	-	-	-	-	-	-	-
Lane		N/A	-	700	-	-	1,000	-	800	900	100	500	200	-
		Data period enrollment	19	1	3	18	22	5	13	-	-	9	1	13
		(Eligibles)	4,899	1,293	2,046	8,389	15,195	3,389	5,552	2,757	72	2,335	2,237	5,904
		(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	Lane	Base	19	1	3	18	22	5	13	-	-	9	1	13

If you are combining a different set of enrollment numbers for each of the regions, manipulate the

CareOregon	Cascade C	--	--	--
1	1	1	1	1

CareOregon	Cascade C	--	--	--
1	1	1	1	1

CareOregon	Cascade C	--	--	--
1	1	1	1	1

CareOregon	Cascade C	--	--	--
1	1	1	1	1

Other

	N/A	70	50	30	190	50	50	50	60	110	-	-	10
Data period enrollment	-	-	-	-	-	-	-	-	-	-	-	-	-
(Eligibles)	-	-	-	-	-	-	-	-	-	-	-	-	-
(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

CareOregd	Cascade C	--	--	--
1	1	1	1	1

Baker	--	-	-	-	-	-	-	-	-	-	-	-	-
Clatsop	--	-	-	-	-	-	-	-	-	-	-	-	-
Columbia	--	-	-	-	-	-	-	-	-	-	-	-	-
Coos	--	-	-	-	-	-	-	-	-	-	-	-	-
Crook	--	-	-	-	-	-	-	-	-	-	-	-	-
Curry	--	-	-	-	-	-	-	-	-	-	-	-	-
Deschutes	--	-	-	-	-	-	-	-	-	-	-	-	-
Gilliam	--	-	-	-	-	-	-	-	-	-	-	-	-
Grant	--	-	-	-	-	-	-	-	-	-	-	-	-
Harney	--	-	-	-	-	-	-	-	-	-	-	-	-
Hood Rive	--	-	-	-	-	-	-	-	-	-	-	-	-
Jefferson	--	-	-	-	-	-	-	-	-	-	-	-	-
Klamath	--	-	-	-	-	-	-	-	-	-	-	-	-
Lake	--	-	-	-	-	-	-	-	-	-	-	-	-
Lincoln	--	-	-	-	-	-	-	-	-	-	-	-	-
Malheur	--	-	-	-	-	-	-	-	-	-	-	-	-
Morrow	--	-	-	-	-	-	-	-	-	-	-	-	-
Sherman	--	-	-	-	-	-	-	-	-	-	-	-	-
Tillamook	--	-	-	-	-	-	-	-	-	-	-	-	-
Umatilla	--	-	-	-	-	-	-	-	-	-	-	-	-
Union	--	-	-	-	-	-	-	-	-	-	-	-	-
Wallowa	--	-	-	-	-	-	-	-	-	-	-	-	-
Wasco	--	-	-	-	-	-	-	-	-	-	-	-	-
Wheeler	--	-	-	-	-	-	-	-	-	-	-	-	-

DRAFT

Step 3a - For the new contract period, enter member months for new members who are currently FFS

Note: Only enter 100% if all of those on FFS in the county will be enrolled into your CCO and only for your base counties or expansion counties

Region	County	Coverage		TANF	PLMA	CHILD 00-01	CHILD 01-05	CHILD 06-18	ABAD-MED	ABAD	OAA-MED	OAA	CAF	OHPFAM	OHPAC	
Tri-County			Jan 2012	303	270	-	388	885	1,697	1,342	344	15	-	63	465	
			July 2012 to June 2013	318	284	-	407	929	1,782	1,409	361	16	-	66	488	
Clackamas	Base	Penetration %		60%	100%	0%	80%	50%	70%	0%	0%	60%	0%	0%	20%	
			Jan 2012	114	142	-	306	395	434	-	-	6	-	-	-	54
			July 2012 to June 2013	120	149	-	321	415	456	-	-	6	-	-	-	57
Multnomah	Expansion	Penetration %		40%	40%	0%	10%	30%	70%	90%	10%	20%	0%	30%	60%	
			Jan 2012	189	129	-	82	490	1,263	1,342	344	9	-	-	63	411
			July 2012 to June 2013	198	135	-	86	514	1,326	1,409	361	9	-	-	66	431
Washington	--	Penetration %		80%	100%	10%	0%	20%	20%	30%	30%	20%	50%	0%	40%	
			Jan 2012	-	-	-	-	-	-	-	-	-	-	-	-	-
			July 2012 to June 2013	-	-	-	-	-	-	-	-	-	-	-	-	-
LBMPY			Jan 2012	280	168	208	1,534	886	566	175	235	10	163	9	82	
			July 2012 to June 2013	294	176	219	1,611	930	594	184	247	10	171	9	86	
Benton	Base	Penetration %		0%	50%	0%	10%	40%	60%	10%	0%	40%	0%	80%	70%	
			Jan 2012	-	18	-	9	63	59	14	-	2	-	-	9	26
			July 2012 to June 2013	-	19	-	9	66	61	15	-	2	-	-	9	27
Linn	Expansion	Penetration %		20%	30%	20%	0%	0%	0%	70%	40%	10%	80%	0%	60%	
			Jan 2012	21	22	7	-	-	-	161	168	0	163	-	-	56
			July 2012 to June 2013	22	23	7	-	-	-	169	176	0	171	-	-	59
Marion	--	Penetration %		90%	70%	20%	30%	0%	40%	10%	0%	40%	10%	0%	0%	
			Jan 2012	-	-	-	-	-	-	-	-	-	-	-	-	-
			July 2012 to June 2013	-	-	-	-	-	-	-	-	-	-	-	-	-
Polk	--	Penetration %		0%	70%	30%	90%	80%	0%	0%	0%	0%	40%	40%	40%	
			Jan 2012	-	-	-	-	-	-	-	-	-	-	-	-	-
			July 2012 to June 2013	-	-	-	-	-	-	-	-	-	-	-	-	-
Yamhill	Base	Penetration %		30%	70%	60%	100%	30%	100%	0%	10%	70%	0%	0%	0%	
			Jan 2012	260	127	201	1,525	823	507	-	68	8	-	-	-	-
			July 2012 to June 2013	273	134	211	1,601	864	533	-	71	8	-	-	-	-

JJD		Jan 2012	32	54	42	100	-	-	778	648	14	274	51	106
		July 2012 to June 2013	33	57	44	105	-	-	817	680	15	288	54	111
Douglas	--	Penetration %	90%	20%	80%	10%	10%	0%	80%	50%	0%	90%	60%	30%
		Jan 2012	-	-	-	-	-	-	-	-	-	-	-	-
		July 2012 to June 2013	-	-	-	-	-	-	-	-	-	-	-	-
Jackson	Base	Penetration %	20%	30%	70%	30%	0%	0%	90%	70%	90%	50%	50%	50%
		Jan 2012	32	54	42	100	-	-	778	648	14	274	51	106
		July 2012 to June 2013	33	57	44	105	-	-	817	680	15	288	54	111
Josephine	--	Penetration %	50%	40%	50%	0%	90%	90%	80%	20%	50%	100%	100%	80%
		Jan 2012	-	-	-	-	-	-	-	-	-	-	-	-
		July 2012 to June 2013	-	-	-	-	-	-	-	-	-	-	-	-
Lane		Jan 2012	-	27	85	-	-	-	960	1,072	-	834	-	-
		July 2012 to June 2013	-	29	89	-	-	-	1,008	1,126	-	875	-	-
Lane	Base	Penetration %	0%	10%	50%	0%	0%	0%	90%	70%	0%	100%	0%	0%
		Jan 2012	-	27	85	-	-	-	960	1,072	-	834	-	-
		July 2012 to June 2013	-	29	89	-	-	-	1,008	1,126	-	875	-	-

DRAFT

Other

		Jan 2012	-	-	-	-	-	-	-	-	-	-	-	-
		July 2012 to June 2013	-	-	-	-	-	-	-	-	-	-	-	-
Baker	--	Penetration %	80%	50%	70%	0%	0%	40%	20%	50%	20%	0%	30%	70%
		Jan 2012	-	-	-	-	-	-	-	-	-	-	-	-
		July 2012 to June 2013	-	-	-	-	-	-	-	-	-	-	-	-
Clatsop	--	Penetration %	20%	20%	40%	50%	0%	70%	0%	80%	0%	20%	20%	100%
		Jan 2012	-	-	-	-	-	-	-	-	-	-	-	-
		July 2012 to June 2013	-	-	-	-	-	-	-	-	-	-	-	-
Columbia	--	Penetration %	20%	0%	80%	90%	0%	0%	90%	10%	30%	10%	90%	0%
		Jan 2012	-	-	-	-	-	-	-	-	-	-	-	-
		July 2012 to June 2013	-	-	-	-	-	-	-	-	-	-	-	-
Coos	--	Penetration %	0%	80%	0%	0%	70%	70%	90%	100%	10%	30%	0%	0%
		Jan 2012	-	-	-	-	-	-	-	-	-	-	-	-
		July 2012 to June 2013	-	-	-	-	-	-	-	-	-	-	-	-
Crook	--	Penetration %	100%	90%	0%	50%	20%	0%	30%	90%	0%	10%	50%	0%
		Jan 2012	-	-	-	-	-	-	-	-	-	-	-	-
		July 2012 to June 2013	-	-	-	-	-	-	-	-	-	-	-	-
Curry	--	Penetration %	30%	80%	80%	10%	50%	30%	10%	100%	60%	20%	30%	70%
		Jan 2012	-	-	-	-	-	-	-	-	-	-	-	-
		July 2012 to June 2013	-	-	-	-	-	-	-	-	-	-	-	-
Deschutes	--	Penetration %	100%	70%	0%	40%	0%	80%	50%	90%	100%	40%	10%	0%
		Jan 2012	-	-	-	-	-	-	-	-	-	-	-	-
		July 2012 to June 2013	-	-	-	-	-	-	-	-	-	-	-	-
Gilliam	--	Penetration %	0%	0%	50%	0%	0%	70%	40%	90%	0%	10%	30%	90%
		Jan 2012	-	-	-	-	-	-	-	-	-	-	-	-
		July 2012 to June 2013	-	-	-	-	-	-	-	-	-	-	-	-
Grant	--	Penetration %	30%	10%	30%	30%	50%	70%	0%	0%	90%	0%	70%	80%
		Jan 2012	-	-	-	-	-	-	-	-	-	-	-	-
		July 2012 to June 2013	-	-	-	-	-	-	-	-	-	-	-	-

Harney	--	<i>Penetration %</i>	90%	40%	20%	40%	40%	90%	0%	0%	60%	80%	0%	0%
		Jan 2012	-	-	-	-	-	-	-	-	-	-	-	-
		July 2012 to June 2013	-	-	-	-	-	-	-	-	-	-	-	-
Hood River	--	<i>Penetration %</i>	20%	50%	100%	90%	40%	0%	0%	80%	0%	10%	0%	10%
		Jan 2012	-	-	-	-	-	-	-	-	-	-	-	-
		July 2012 to June 2013	-	-	-	-	-	-	-	-	-	-	-	-
Jefferson	--	<i>Penetration %</i>	80%	90%	10%	30%	60%	0%	50%	70%	30%	0%	70%	0%
		Jan 2012	-	-	-	-	-	-	-	-	-	-	-	-
		July 2012 to June 2013	-	-	-	-	-	-	-	-	-	-	-	-
Klamath	--	<i>Penetration %</i>	10%	30%	80%	0%	40%	20%	30%	0%	30%	0%	80%	80%
		Jan 2012	-	-	-	-	-	-	-	-	-	-	-	-
		July 2012 to June 2013	-	-	-	-	-	-	-	-	-	-	-	-
Lake	--	<i>Penetration %</i>	0%	10%	30%	100%	70%	90%	60%	0%	0%	60%	70%	0%
		Jan 2012	-	-	-	-	-	-	-	-	-	-	-	-
		July 2012 to June 2013	-	-	-	-	-	-	-	-	-	-	-	-
Lincoln	--	<i>Penetration %</i>	90%	10%	20%	80%	80%	0%	0%	30%	30%	20%	80%	30%
		Jan 2012	-	-	-	-	-	-	-	-	-	-	-	-
		July 2012 to June 2013	-	-	-	-	-	-	-	-	-	-	-	-
Malheur	--	<i>Penetration %</i>	0%	90%	80%	20%	0%	0%	30%	20%	100%	10%	20%	30%
		Jan 2012	-	-	-	-	-	-	-	-	-	-	-	-
		July 2012 to June 2013	-	-	-	-	-	-	-	-	-	-	-	-
Morrow	--	<i>Penetration %</i>	70%	30%	30%	50%	60%	50%	30%	70%	20%	30%	30%	50%
		Jan 2012	-	-	-	-	-	-	-	-	-	-	-	-
		July 2012 to June 2013	-	-	-	-	-	-	-	-	-	-	-	-
Sherman	--	<i>Penetration %</i>	10%	50%	100%	80%	0%	60%	70%	70%	60%	50%	50%	10%
		Jan 2012	-	-	-	-	-	-	-	-	-	-	-	-
		July 2012 to June 2013	-	-	-	-	-	-	-	-	-	-	-	-

Tillamook	--	Penetration %	20%	50%	60%	80%	90%	10%	30%	0%	50%	60%	90%	10%
		Jan 2012	-	-	-	-	-	-	-	-	-	-	-	-
		July 2012 to June 2013	-	-	-	-	-	-	-	-	-	-	-	-
Umatilla	--	Penetration %	50%	60%	60%	40%	70%	70%	20%	70%	40%	30%	40%	40%
		Jan 2012	-	-	-	-	-	-	-	-	-	-	-	-
		July 2012 to June 2013	-	-	-	-	-	-	-	-	-	-	-	-
Union	--	Penetration %	0%	90%	40%	0%	0%	0%	40%	40%	0%	0%	0%	60%
		Jan 2012	-	-	-	-	-	-	-	-	-	-	-	-
		July 2012 to June 2013	-	-	-	-	-	-	-	-	-	-	-	-
Wallowa	--	Penetration %	70%	90%	60%	0%	0%	20%	30%	60%	40%	90%	0%	90%
		Jan 2012	-	-	-	-	-	-	-	-	-	-	-	-
		July 2012 to June 2013	-	-	-	-	-	-	-	-	-	-	-	-
Wasco	--	Penetration %	10%	90%	30%	30%	60%	90%	0%	50%	90%	0%	30%	100%
		Jan 2012	-	-	-	-	-	-	-	-	-	-	-	-
		July 2012 to June 2013	-	-	-	-	-	-	-	-	-	-	-	-
Wheeler	--	Penetration %	0%	30%	0%	60%	40%	70%	70%	70%	0%	0%	50%	60%
		Jan 2012	-	-	-	-	-	-	-	-	-	-	-	-
		July 2012 to June 2013	-	-	-	-	-	-	-	-	-	-	-	-

DRAFT

Step 3b - For the new contract period, enter projected average monthly enrollment (excluding those currently on FFS)

		Base area Use data period penetration %											Expansion area Manually input enrollment					Penetration %										
Region	County	Coverage	TANF	PLMA	CHILD 00-01	CHILD 01-05	CHILD 06-18	ABAD-MED	ABAD	OAA-MED	OAA	CAF	OHPFAM	OHPAC	TANF	PLMA	CHILD 00-01	CHILD 01-05	CHILD 06-18	ABAD-MED	ABAD	OAA-MED	OAA	CAF	OHPFAM	OHPAC		
Tri-County		Contract period enrollment	2,933	2,118	1,589	4,632	7,327	2,506	2,603	2,360	312	887	1,769	2,127														
		(Eligibles)	19,594	3,865	9,401	39,434	67,164	10,385	18,098	14,526	710	6,299	10,629	16,802														
		(Penetration %)	15%	55%	17%	12%	11%	24%	14%	16%	44%	14%	26%	13%														
Clackamas	Base	Contract period enrollment	100	-	1,300	800	1,100	-	300	900	1,000	800	100	-	46%	40%	73%	45%	72%	61%	73%	55%	49%	23%	46%	19%		
		(Eligibles)	1,833	318	689	2,932	6,127	906	1,603	760	12	487	769	2,027														
		(Penetration %)	3,516	755	1,640	6,650	12,809	2,005	3,033	2,641	46	1,602	1,404	3,088														
Multnomah	Expansion	Contract period enrollment	1,100	1,800	900	1,700	1,200	1,600	1,000	1,600	300	400	1,000	100	78%	8%	58%	4%	69%	54%	34%	10%	57%	67%	74%	53%		
		(Eligibles)	1,100	1,800	900	1,700	1,200	1,600	1,000	1,600	300	400	1,000	100														
		(Penetration %)	11,751	1,985	4,913	20,351	34,341	6,250	11,456	8,385	532	3,157	3,725	10,609														
Washington	--	Contract period enrollment	100	400	-	2,000	1,700	200	500	-	-	200	1,400	600	1%	23%	11%	61%	5%	56%	66%	3%	33%	36%	78%	15%		
		(Eligibles)	-	-	-	-	-	-	-	-	-	-	-	-	-													
		(Penetration %)	4,328	1,125	2,848	12,433	20,014	2,130	3,609	3,499	132	1,540	1,622	3,105														
LBMPY		Contract period enrollment	1,937	850	491	481	805	730	2,015	1,715	503	1,855	71	1,142														
		(Eligibles)	10,733	2,148	5,465	23,559	39,845	5,177	9,128	5,559	146	3,790	4,178	8,273														
		(Penetration %)	18%	40%	9%	2%	2%	14%	22%	31%	345%	49%	2%	14%														
Benton	Base	Contract period enrollment	700	300	1,200	1,300	900	-	1,000	1,200	1,700	1,600	600	1,300	36%	5%	8%	11%	78%	6%	17%	53%	60%	61%	26%	14%		
		(Eligibles)	45	16	30	138	230	12	48	4	1	18	20	89														
		(Penetration %)	700	151	325	1,269	2,119	470	719	284	8	262	243	685														
Linn	Expansion	Contract period enrollment	1,800	800	400	-	-	700	1,900	1,700	500	1,800	-	900	42%	68%	58%	13%	38%	13%	79%	17%	37%	46%	35%	26%		
		(Eligibles)	1,800	800	400	-	-	700	1,900	1,700	500	1,800	-	900														
		(Penetration %)	2,114	415	872	3,697	6,486	1,048	2,120	1,107	32	720	840	1,750														
Marion	--	Contract period enrollment	1,100	1,500	100	-	600	1,900	-	1,200	1,100	-	400	-	59%	53%	80%	5%	71%	14%	78%	27%	70%	53%	46%	66%		
		(Eligibles)	-	-	-	-	-	-	-	-	-	-	-	-	-													
		(Penetration %)	5,334	1,079	3,129	13,366	22,377	2,405	4,391	2,767	79	1,784	2,049	3,841														
Polk	--	Contract period enrollment	-	100	1,300	-	1,800	500	1,500	1,000	200	1,800	-	800	40%	2%	12%	14%	35%	41%	13%	26%	23%	30%	27%	52%		
		(Eligibles)	-	-	-	-	-	-	-	-	-	-	-	-	-													
		(Penetration %)	1,161	189	461	2,087	3,570	574	891	577	11	506	431	812														
Yamhill	Base	Contract period enrollment	900	1,300	-	700	300	900	1,500	1,100	1,000	1,700	100	700	55%	24%	27%	66%	35%	65%	74%	24%	50%	56%	75%	63%		
		(Eligibles)	92	34	62	342	575	18	67	11	2	36	51	153														
		(Penetration %)	1,424	314	678	3,140	5,292	680	1,007	823	17	518	616	1,185														
JJD		Contract period enrollment	1,778	311	778	3,420	5,977	320	955	297	14	288	826	1,406														
		(Eligibles)	7,507	1,717	2,992	12,079	21,991	3,696	6,562	3,849	74	2,342	3,203	6,919														

	(Penetration %)	24%	18%	26%	28%	27%	9%	15%	8%	18%	12%	26%	20%															
Douglas	--	900	100	100	-	1,800	400	100	1,500	1,800	1,800	1,600	1,200		60%	80%	28%	61%	51%	23%	47%	60%	19%	72%	45%	65%		
	Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-	-															
	(Eligibles)	2,117	456	745	3,107	5,808	1,102	1,966	1,076	16	702	907	1,949															
	(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%															
Jackson	Base	500	1,600	100	1,600	1,100	1,700	1,300	200	500	1,500	-	2,000		47%	66%	2%	67%	47%	41%	71%	64%	31%	35%	18%	79%		
	Contract period enrollment	1,778	311	778	3,420	5,977	320	955	297	14	288	826	1,406															
	(Eligibles)	3,371	907	1,620	6,413	11,058	1,760	2,772	1,756	41	1,070	1,515	2,994															
	(Penetration %)	53%	34%	48%	53%	54%	18%	34%	17%	33%	27%	55%	47%															
Josephine	--	-	-	-	1,100	2,000	600	1,700	1,700	1,800	300	400	1,200		70%	45%	21%	28%	69%	9%	15%	22%	77%	70%	78%	6%		
	Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-	-															
	(Eligibles)	2,019	353	628	2,560	5,124	834	1,823	1,017	17	571	782	1,976															
	(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%															
Lane		20	1	3	18	23	5	14	-	-	10	1	13															
	Contract period enrollment	4,931	1,273	2,139	8,634	15,541	3,544	5,805	2,893	73	2,456	2,220	5,614															
	(Eligibles)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%															
	(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%															
Lane	Base	1,000	400	400	200	2,000	-	2,000	-	-	700	300	-		46%	19%	43%	63%	67%	77%	50%	64%	38%	37%	11%	55%		
	Contract period enrollment	20	1	3	18	23	5	14	-	-	10	1	13															
	(Eligibles)	4,931	1,273	2,139	8,634	15,541	3,544	5,805	2,893	73	2,456	2,220	5,614															
	(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%															
Other		-	-	-	-	-	-	-	-	-	-	-	-															
	Contract period enrollment	11,446	2,719	5,519	22,410	39,998	6,002	10,868	6,668	76	4,240	4,621	10,125															
	(Eligibles)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%															
	(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%															
Baker	--	50	10	20	90	50	50	40	80	10	90	70	40		39%	47%	4%	50%	77%	69%	52%	71%	61%	79%	26%	26%		
	Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-	-															
	(Eligibles)	256	59	115	463	809	160	251	171	1	139	130	285															
	(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%															
Clatsop	--	30	30	30	10	30	40	80	60	40	40	50	90		25%	7%	67%	77%	26%	15%	16%	12%	12%	59%	30%	55%		
	Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-	-															
	(Eligibles)	429	144	258	963	1,616	308	514	308	-	251	194	531															
	(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%															
Columbia	--	20	70	80	50	20	80	50	60	70	10	10	50		12%	44%	48%	9%	45%	62%	15%	35%	60%	32%	42%	42%		
	Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-	-															
	(Eligibles)	721	144	261	1,039	2,162	339	663	306	-	361	335	871															
	(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%															
Coos	--	70	20	70	10	60	90	60	60	60	30	50	30		15%	70%	54%	47%	46%	22%	32%	48%	37%	38%	14%	73%		
	Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-	-															
	(Eligibles)	1,204	239	445	1,758	3,266	783	1,590	883	6	513	483	1,274															
	(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%															
Crook	--	50	80	80	50	50	40	30	10	60	80	10	20		33%	33%	71%	67%	11%	12%	47%	75%	33%	6%	29%	18%		
	Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-	-															
	(Eligibles)	371	47	121	536	1,271	161	259	182	3	106	157	295															
	(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%															
Curry	--	10	60	70	20	50	-	10	70	50	50	30	60		41%	61%	13%	61%	55%	54%	4%	38%	38%	1%	16%	21%		
	Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-	-															
	(Eligibles)	161	49	76	249	471	203	261	244	1	85	86	213															

Summary of Step 3a and Step 3b - Contract Period Average Enrollment for Base and Expansion Areas

Region	County	Coverage	TANF	PLMA	CHILD 00-01	CHILD 01-05	CHILD 06-18	ABAD-MED	ABAD	OAA-MED	OAA	CAF	OHPFAM	OHPAC	
Tri-County			Contract period enrollment	3,251	2,402	1,589	5,039	8,256	4,287	4,012	2,721	328	887	1,835	2,615
			(Eligibles)	19,594	3,865	9,401	39,434	67,164	10,385	18,098	14,526	710	6,299	6,751	16,802
			(Penetration %)	17%	62%	17%	13%	12%	41%	22%	19%	46%	14%	27%	16%
Clackamas	Base		Contract period enrollment	1,953	466	689	3,253	6,542	1,362	1,603	760	19	487	769	2,084
			(Eligibles)	3,516	755	1,640	6,650	12,809	2,005	3,033	2,641	46	1,602	1,404	3,088
			(Penetration %)	56%	62%	42%	49%	51%	68%	53%	29%	41%	30%	55%	67%
Multnomah	Expansion		Contract period enrollment	1,298	1,935	900	1,786	1,714	2,926	2,409	1,961	309	400	1,066	531
			(Eligibles)	11,751	1,985	4,913	20,351	34,341	6,250	11,456	8,385	532	3,157	3,725	10,609
			(Penetration %)	11%	97%	18%	9%	5%	47%	21%	23%	58%	13%	29%	5%
Washington	--		Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-	
			(Eligibles)	4,328	1,125	2,848	12,433	20,014	2,130	3,609	3,499	132	1,540	1,622	3,105
			(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
LBMPY			Contract period enrollment	2,231	1,026	710	2,091	1,736	1,324	2,199	1,963	513	2,026	80	1,228
			(Eligibles)	10,733	2,148	5,465	23,559	39,845	5,177	9,128	5,559	146	3,790	4,178	8,273
			(Penetration %)	21%	48%	13%	9%	4%	26%	24%	35%	352%	53%	2%	15%
Benton	Base		Contract period enrollment	45	35	30	148	296	74	63	4	3	18	29	116
			(Eligibles)	700	151	325	1,269	2,119	470	719	284	8	262	243	685
			(Penetration %)	6%	23%	9%	12%	14%	16%	9%	1%	31%	7%	12%	17%
Linn	Expansion		Contract period enrollment	1,822	823	407	-	-	700	2,069	1,876	500	1,971	-	959
			(Eligibles)	2,114	415	872	3,697	6,486	1,048	2,120	1,107	32	720	840	1,750
			(Penetration %)	86%	198%	47%	0%	0%	67%	98%	169%	1589%	274%	0%	55%
Marion	--		Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-	
			(Eligibles)	5,334	1,079	3,129	13,366	22,377	2,405	4,391	2,767	79	1,784	2,049	3,841
			(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Polk	--		Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-	
			(Eligibles)	1,161	189	461	2,087	3,570	574	891	577	11	506	431	812
			(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Yamhill	Base		Contract period enrollment	364	167	273	1,944	1,440	550	67	83	10	36	51	153
			(Eligibles)	1,424	314	678	3,140	5,292	680	1,007	823	17	518	616	1,185
			(Penetration %)	26%	53%	40%	62%	27%	81%	7%	10%	59%	7%	8%	13%
JJD			Contract period enrollment	1,811	368	822	3,526	5,977	320	1,772	977	29	576	880	1,517
			(Eligibles)	7,507	1,717	2,992	12,079	21,991	3,696	6,562	3,849	74	2,342	3,203	6,919
			(Penetration %)	24%	21%	27%	29%	27%	9%	27%	25%	39%	25%	27%	22%
Douglas	--		Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-	
			(Eligibles)	2,117	456	745	3,107	5,808	1,102	1,966	1,076	16	702	907	1,949
			(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Jackson	Base		Contract period enrollment	1,811	368	822	3,526	5,977	320	1,772	977	29	576	880	1,517
			(Eligibles)	3,371	907	1,620	6,413	11,058	1,760	2,772	1,756	41	1,070	1,515	2,994
			(Penetration %)												

		(Penetration %)	54%	41%	51%	55%	54%	18%	64%	56%	69%	54%	58%	51%
Josephine	--	Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-	-
		(Eligibles)	2,019	353	628	2,560	5,124	834	1,823	1,017	17	571	782	1,976
		(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Lane		Contract period enrollment	20	30	92	18	23	5	1,022	1,126	-	885	1	13
		(Eligibles)	4,931	1,273	2,139	8,634	15,541	3,544	5,805	2,893	73	2,456	2,220	5,614
		(Penetration %)	0%	2%	4%	0%	0%	0%	18%	39%	0%	36%	0%	0%
Lane	Base	Contract period enrollment	20	30	92	18	23	5	1,022	1,126	-	885	1	13
		(Eligibles)	4,931	1,273	2,139	8,634	15,541	3,544	5,805	2,893	73	2,456	2,220	5,614
		(Penetration %)	0%	2%	4%	0%	0%	0%	18%	39%	0%	36%	0%	0%
Other		Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-	-
		(Eligibles)	11,446	2,719	5,519	22,410	39,998	6,002	10,868	6,668	76	4,240	4,621	10,125
		(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Baker	--	Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-	-
		(Eligibles)	256	59	115	463	809	160	251	171	1	139	130	285
		(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Clatsop	--	Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-	-
		(Eligibles)	429	144	258	963	1,616	308	514	308	-	251	194	531
		(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Columbia	--	Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-	-
		(Eligibles)	721	144	261	1,039	2,162	339	663	306	-	361	335	871
		(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Coos	--	Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-	-
		(Eligibles)	1,204	239	445	1,758	3,266	783	1,590	883	6	513	483	1,274
		(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Crook	--	Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-	-
		(Eligibles)	371	47	121	536	1,271	161	259	182	3	106	157	295
		(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Curry	--	Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-	-
		(Eligibles)	161	49	76	249	471	203	261	244	1	85	86	213
		(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Deschutes	--	Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-	-
		(Eligibles)	2,271	506	980	4,252	8,037	820	1,420	825	8	469	1,038	1,891
		(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Gilliam	--	Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-	-
		(Eligibles)	19	6	8	36	56	19	20	21	-	8	8	22
		(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Grant	--	Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-	-
		(Eligibles)	80	19	39	144	291	57	91	106	-	60	46	89
		(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Harney	--	Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-	-
		(Eligibles)	72	34	52	197	378	77	128	71	-	63	62	112
		(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Hood River	--	Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-		
			(Eligibles)	158	77	176	767	1,417	95	161	132	3	84	113	130
			(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Jefferson	--	Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-		
			(Eligibles)	491	121	221	990	1,687	137	344	167	7	172	116	308
			(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Klamath	--	Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-		
			(Eligibles)	1,253	315	561	2,152	3,968	615	1,263	531	8	495	439	1,105
			(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Lake	--	Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-		
			(Eligibles)	122	16	41	156	361	51	142	68	2	48	48	174
			(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Lincoln	--	Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-		
			(Eligibles)	817	163	339	1,353	2,344	472	840	523	7	264	362	969
			(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Malheur	--	Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-		
			(Eligibles)	561	136	364	1,496	2,383	318	514	409	1	159	172	273
			(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Morrow	--	Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-		
			(Eligibles)	188	53	114	468	774	77	124	74	6	51	34	67
			(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Sherman	--	Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-		
			(Eligibles)	19	2	8	33	61	7	30	11	0	25	3	13
			(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Tillamook	--	Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-		
			(Eligibles)	305	60	160	629	1,137	189	304	196	1	122	118	254
			(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Umatilla	--	Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-		
			(Eligibles)	1,114	316	744	2,898	4,602	569	1,029	778	18	414	312	511
			(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Union	--	Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-		
			(Eligibles)	452	102	195	811	1,230	221	379	252	1	148	156	295
			(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Wallowa	--	Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-		
			(Eligibles)	72	19	31	153	257	85	99	69	-	30	49	103
			(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Wasco	--	Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-		
			(Eligibles)	293	88	193	840	1,361	236	424	326	1	166	140	310
			(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Wheeler	--	Contract period enrollment	-	-	-	-	-	-	-	-	-	-	-		
			(Eligibles)	17	4	13	27	61	5	19	17	-	6	20	30
			(Penetration %)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Step 4 - Enter Data Period Cost and Admin for Base Area, and Adjustments and Trends

Rate Category	Claims Cost	IBNR Reserve	%		Admin PMPM*	Admin %	Jan 2012 Member Months			Proposed Cap Rate for Jul 2012 (Base Area)	Risk Conversion Factor (From Base Area to Expansion Area)	Proposed Cap Rate for Jul 2012 (Expansion Area)	Estimated Overall Cap Rate for Jul 2012	Jan 2012 Overall Cap Rate	% Change
			Admin Load*				Base Area	Expansion Area	Total						
Temporary Assistance to Needy Families - Adults	\$ -	\$ -	0.020		\$ 12.40	2.0%	3,993	2,971	6,965	\$ 742.15	2.00	\$ 1,484.30	\$ 1,058.76	\$ 515.98	-10.6%
Poverty Level Medical - Adults	\$ -	\$ -	0.020		\$ 12.40	2.0%	1,016	2,627	3,643	\$ 742.15	2.00	\$ 1,484.30	\$ 1,277.27	\$ 472.58	10.0%
Children 0-1 (CHIP, PLMC, TANF Children)	\$ -	\$ -	0.020		\$ 12.40	2.0%	1,815	1,245	3,060	\$ 742.15	2.00	\$ 1,484.30	\$ 1,044.17	\$ 648.53	11.0%
Children 1-5 (CHIP, PLMC, TANF Children)	\$ -	\$ -	0.020		\$ 12.40	2.0%	8,465	1,701	10,166	\$ 742.15	2.00	\$ 1,484.30	\$ 866.30	\$ 151.58	12.1%
Children 6-18 (CHIP, PLMC, TANF Children)	\$ -	\$ -	0.020		\$ 12.40	2.0%	13,598	1,632	15,230	\$ 742.15	2.00	\$ 1,484.30	\$ 821.70	\$ 143.02	8.4%
ABAD with Medicare	\$ -	\$ -	0.020		\$ 12.40	2.0%	2,201	3,453	5,654	\$ 742.15	2.00	\$ 1,484.30	\$ 1,195.41	\$ 278.92	7.6%
ABAD without Medicare	\$ -	\$ -	0.020		\$ 12.40	2.0%	4,311	4,265	8,576	\$ 742.15	2.00	\$ 1,484.30	\$ 1,111.24	\$ 1,428.51	5.0%
OAA with Medicare	\$ -	\$ -	0.020		\$ 12.40	2.0%	2,809	3,654	6,463	\$ 742.15	2.00	\$ 1,484.30	\$ 1,161.77	\$ 248.36	0.7%
OAA without Medicare	\$ -	\$ -	0.020		\$ 12.40	2.0%	57	771	828	\$ 742.15	2.00	\$ 1,484.30	\$ 1,433.10	\$ 1,087.38	10.4%
Foster Children (CAF)	\$ -	\$ -	0.020		\$ 12.40	2.0%	1,907	2,258	4,165	\$ 742.15	2.00	\$ 1,484.30	\$ 1,144.53	\$ 518.31	4.2%
OHP Standard - Families	\$ -	\$ -	0.020		\$ 12.40	2.0%	1,647	1,016	2,663	\$ 742.15	2.00	\$ 1,484.30	\$ 1,025.25	\$ 295.17	8.4%
OHP Standard - Adults and Couples	\$ -	\$ -	0.020		\$ 12.40	2.0%	3,697	1,419	5,116	\$ 742.15	2.00	\$ 1,484.30	\$ 948.00	\$ 523.75	5.0%
Total	\$ -	\$ -					45,516	27,013	72,529						
					Leave Blank (N/A) ==>		\$ 1,234,567.89								
					Total Admin Cost ==>		\$ 1,234,567.89								
Composite PMPM Rate										\$ 742.15		\$ 1,484.30	\$ 1,018.56	\$ 365.02	4.5%

Note: DRG hospital costs exclude pass-through payments for Hospital Reimbursement Adjustment and Graduate Medical Education

*: Excluding administrative allowance for HRA and GME.

Before completing the sections below, please enter the paid-through date beyond your data period (this is usually the last date your data were pulled)	
Paid-through Date	

Guidelines:

1. Estimates of costs and rates for contract period are based on current benefits, coverages, and reimbursement level (80% DRG)
2. Data Period claims costs, reserves, and member month information are based on actual data.
3. Data used in the proposal have gone through adequate review and validation.
4. Data used in the proposal are consistent with internal financial ledgers and financial statements.
5. Trend assumptions are based on analysis and projection of underlying cost and member month data.
6. All Medicaid related costs including sub-capitation payments, stop-loss premiums have been appropriately accounted for.
7. The proposed rates are sufficient and projected to have reasonable and acceptable medical loss ratios,
8. Third Party Liability amounts are to be reflected by an adjustment factor (<1.0) or appropriately accounted for in the claims cost.
9. Prescription drug rebate amounts are to be reflected by an adjustment factor (<1.0) or appropriately accounted for in the claims cost.
10. Only the Medicaid related costs, NOT Medicare costs are to be included for dual-eligible members.

DRAFT

Summary and Comparison to January 2012 Rates

Physical and Mental Health Combined (Does not include optional Dental Services)	Comparing Jul 2012 to Jan 2012								
	Base Area			Expanded Area			Overall		
	Jan 2012 Rate	Jul 2012 Rate	% Change	Jan 2012 Rate	Jul 2012 Rate	% Change	Jan 2012 Rate	Jul 2012 Rate	% Change
Temporary Assistance to Needy Families - Adults	\$ 527.99	\$ 527.99	0.0%	\$ 407.12	\$ 407.12	0.0%	\$ 515.98	\$ 515.98	0.0%
Poverty Level Medical - Adults	\$ 489.82	\$ 489.82	0.0%	\$ 311.66	\$ 311.66	0.0%	\$ 472.58	\$ 472.58	0.0%
Children 0-1 (CHIP, PLMC, TANF Children)	\$ 659.00	\$ 659.00	0.0%	\$ 537.21	\$ 537.21	0.0%	\$ 648.53	\$ 648.53	0.0%
Children 1-5 (CHIP, PLMC, TANF Children)	\$ 157.35	\$ 157.35	0.0%	\$ 87.89	\$ 87.89	0.0%	\$ 151.58	\$ 151.58	0.0%
Children 6-18 (CHIP, PLMC, TANF Children)	\$ 144.68	\$ 144.68	0.0%	\$ 125.16	\$ 125.16	0.0%	\$ 143.02	\$ 143.02	0.0%
ABAD with Medicare	\$ 294.59	\$ 294.59	0.0%	\$ 158.97	\$ 158.97	0.0%	\$ 278.92	\$ 278.92	0.0%
ABAD without Medicare	\$1,460.44	\$1,460.44	0.0%	\$1,181.13	\$1,181.13	0.0%	\$1,428.51	\$1,428.51	0.0%
OAA with Medicare	\$ 259.41	\$ 259.41	0.0%	\$ 120.17	\$ 120.17	0.0%	\$ 248.36	\$ 248.36	0.0%
OAA without Medicare	\$1,087.32	\$1,087.32	0.0%	\$1,089.19	\$1,089.19	0.0%	\$1,087.38	\$1,087.38	0.0%
Foster Children (CAF)	\$ 531.94	\$ 531.94	0.0%	\$ 405.97	\$ 405.97	0.0%	\$ 518.31	\$ 518.31	0.0%
OHP Standard - Families	\$ 288.26	\$ 288.26	0.0%	\$ 351.02	\$ 351.02	0.0%	\$ 295.17	\$ 295.17	0.0%
OHP Standard - Adults and Couples	\$ 511.28	\$ 511.28	0.0%	\$ 634.88	\$ 634.88	0.0%	\$ 523.75	\$ 523.75	0.0%
Composite PMPM Rate	\$ 367.98	\$ 367.98	0.0%	\$ 335.80	\$ 335.80	0.0%	\$ 365.02	\$ 365.02	0.0%

Physical Health Services Only	Comparing Jul 2012 to Jan 2012								
	Base Area			Expanded Area			Overall		
	Jan 2012 Rate	Jul 2012 Rate	% Change	Jan 2012 Rate	Jul 2012 Rate	% Change	Jan 2012 Rate	Jul 2012 Rate	% Change
Temporary Assistance to Needy Families - Adults	\$ 527.99	\$ 527.99	0.0%	\$ 407.12	\$ 407.12	0.0%	\$ 515.98	\$ 515.98	0.0%
Poverty Level Medical - Adults	\$ 489.82	\$ 489.82	0.0%	\$ 311.66	\$ 311.66	0.0%	\$ 472.58	\$ 472.58	0.0%
Children 0-1 (CHIP, PLMC, TANF Children)	\$ 659.00	\$ 659.00	0.0%	\$ 537.21	\$ 537.21	0.0%	\$ 648.53	\$ 648.53	0.0%
Children 1-5 (CHIP, PLMC, TANF Children)	\$ 157.35	\$ 157.35	0.0%	\$ 87.89	\$ 87.89	0.0%	\$ 151.58	\$ 151.58	0.0%
Children 6-18 (CHIP, PLMC, TANF Children)	\$ 144.68	\$ 144.68	0.0%	\$ 125.16	\$ 125.16	0.0%	\$ 143.02	\$ 143.02	0.0%
ABAD with Medicare	\$ 294.59	\$ 294.59	0.0%	\$ 158.97	\$ 158.97	0.0%	\$ 278.92	\$ 278.92	0.0%
ABAD without Medicare	\$1,460.44	\$1,460.44	0.0%	\$1,181.13	\$1,181.13	0.0%	\$1,428.51	\$1,428.51	0.0%
OAA with Medicare	\$ 259.41	\$ 259.41	0.0%	\$ 120.17	\$ 120.17	0.0%	\$ 248.36	\$ 248.36	0.0%
OAA without Medicare	\$1,087.32	\$1,087.32	0.0%	\$1,089.19	\$1,089.19	0.0%	\$1,087.38	\$1,087.38	0.0%
Foster Children (CAF)	\$ 531.94	\$ 531.94	0.0%	\$ 405.97	\$ 405.97	0.0%	\$ 518.31	\$ 518.31	0.0%
OHP Standard - Families	\$ 288.26	\$ 288.26	0.0%	\$ 351.02	\$ 351.02	0.0%	\$ 295.17	\$ 295.17	0.0%
OHP Standard - Adults and Couples	\$ 511.28	\$ 511.28	0.0%	\$ 634.88	\$ 634.88	0.0%	\$ 523.75	\$ 523.75	0.0%
Composite PMPM Rate	\$ 367.98	\$ 367.98	0.0%	\$ 335.80	\$ 335.80	0.0%	\$ 365.02	\$ 365.02	0.0%

Mental Health Services Only	Comparing Jul 2012 to Jan 2012								
	Base Area			Expanded Area			Overall		
	Jan 2012 Rate	Jul 2012 Rate	% Change	Jan 2012 Rate	Jul 2012 Rate	% Change	Jan 2012 Rate	Jul 2012 Rate	% Change
Temporary Assistance to Needy Families - Adults	\$ 527.99	\$ 527.99	0.0%	\$ 407.12	\$ 407.12	0.0%	\$ 515.98	\$ 515.98	0.0%
Poverty Level Medical - Adults	\$ 489.82	\$ 489.82	0.0%	\$ 311.66	\$ 311.66	0.0%	\$ 472.58	\$ 472.58	0.0%
Children 0-1 (CHIP, PLMC, TANF Children)	\$ 659.00	\$ 659.00	0.0%	\$ 537.21	\$ 537.21	0.0%	\$ 648.53	\$ 648.53	0.0%
Children 1-5 (CHIP, PLMC, TANF Children)	\$ 157.35	\$ 157.35	0.0%	\$ 87.89	\$ 87.89	0.0%	\$ 151.58	\$ 151.58	0.0%
Children 6-18 (CHIP, PLMC, TANF Children)	\$ 144.68	\$ 144.68	0.0%	\$ 125.16	\$ 125.16	0.0%	\$ 143.02	\$ 143.02	0.0%
ABAD with Medicare	\$ 294.59	\$ 294.59	0.0%	\$ 158.97	\$ 158.97	0.0%	\$ 278.92	\$ 278.92	0.0%
ABAD without Medicare	\$1,460.44	\$1,460.44	0.0%	\$1,181.13	\$1,181.13	0.0%	\$1,428.51	\$1,428.51	0.0%
OAA with Medicare	\$ 259.41	\$ 259.41	0.0%	\$ 120.17	\$ 120.17	0.0%	\$ 248.36	\$ 248.36	0.0%
OAA without Medicare	\$1,087.32	\$1,087.32	0.0%	\$1,089.19	\$1,089.19	0.0%	\$1,087.38	\$1,087.38	0.0%
Foster Children (CAF)	\$ 531.94	\$ 531.94	0.0%	\$ 405.97	\$ 405.97	0.0%	\$ 518.31	\$ 518.31	0.0%
OHP Standard - Families	\$ 288.26	\$ 288.26	0.0%	\$ 351.02	\$ 351.02	0.0%	\$ 295.17	\$ 295.17	0.0%
OHP Standard - Adults and Couples	\$ 511.28	\$ 511.28	0.0%	\$ 634.88	\$ 634.88	0.0%	\$ 523.75	\$ 523.75	0.0%
Composite PMPM Rate	\$ 367.98	\$ 367.98	0.0%	\$ 335.80	\$ 335.80	0.0%	\$ 365.02	\$ 365.02	0.0%

Dental Services (Optional) Only	Comparing Jul 2012 to Jan 2012								
	Base Area			Expanded Area			Overall		
	Jan 2012 Rate	Jul 2012 Rate	% Change	Jan 2012 Rate	Jul 2012 Rate	% Change	Jan 2012 Rate	Jul 2012 Rate	% Change
Temporary Assistance to Needy Families - Adults	\$ 527.99	\$ 527.99	0.0%	\$ 407.12	\$ 407.12	0.0%	\$ 515.98	\$ 515.98	0.0%
Poverty Level Medical - Adults	\$ 489.82	\$ 489.82	0.0%	\$ 311.66	\$ 311.66	0.0%	\$ 472.58	\$ 472.58	0.0%
Children 0-1 (CHIP, PLMC, TANF Children)	\$ 659.00	\$ 659.00	0.0%	\$ 537.21	\$ 537.21	0.0%	\$ 648.53	\$ 648.53	0.0%
Children 1-5 (CHIP, PLMC, TANF Children)	\$ 157.35	\$ 157.35	0.0%	\$ 87.89	\$ 87.89	0.0%	\$ 151.58	\$ 151.58	0.0%
Children 6-18 (CHIP, PLMC, TANF Children)	\$ 144.68	\$ 144.68	0.0%	\$ 125.16	\$ 125.16	0.0%	\$ 143.02	\$ 143.02	0.0%
ABAD with Medicare	\$ 294.59	\$ 294.59	0.0%	\$ 158.97	\$ 158.97	0.0%	\$ 278.92	\$ 278.92	0.0%
ABAD without Medicare	\$1,460.44	\$1,460.44	0.0%	\$1,181.13	\$1,181.13	0.0%	\$1,428.51	\$1,428.51	0.0%
OAA with Medicare	\$ 259.41	\$ 259.41	0.0%	\$ 120.17	\$ 120.17	0.0%	\$ 248.36	\$ 248.36	0.0%
OAA without Medicare	\$1,087.32	\$1,087.32	0.0%	\$1,089.19	\$1,089.19	0.0%	\$1,087.38	\$1,087.38	0.0%
Foster Children (CAF)	\$ 531.94	\$ 531.94	0.0%	\$ 405.97	\$ 405.97	0.0%	\$ 518.31	\$ 518.31	0.0%
OHP Standard - Families	\$ 288.26	\$ 288.26	0.0%	\$ 351.02	\$ 351.02	0.0%	\$ 295.17	\$ 295.17	0.0%
OHP Standard - Adults and Couples	\$ 511.28	\$ 511.28	0.0%	\$ 634.88	\$ 634.88	0.0%	\$ 523.75	\$ 523.75	0.0%
Composite PMPM Rate	\$ 367.98	\$ 367.98	0.0%	\$ 335.80	\$ 335.80	0.0%	\$ 365.02	\$ 365.02	0.0%

Exhibit 4 - Pro Forma Projections for the First Five Years

COORDINATED CARE ORGANIZATION: REQUEST FOR APPLICATION											
Name of Requestor:											
Pro Forma Projections for the First Five Years											
Utilization and Expenditure Projection											
	Year 1		Year 2		Year 3		Year 4		Year 5		
	Utilization	Expenditure	Utilization	Expenditure	Utilization	Expenditure	Utilization	Expenditure	Utilization	Expenditure	
Hospitalization											
1	In Patient Hospitalization										
2	Out Patient Hospitalization										
3	Emergency Room										
4	Non-Emergent Emergency Room										
Primary Care											
1	Primary Care Physician Related Services										
2	Patient Centered Primary Care Home										
3	Care Coordination										
Specialty Services											
1	Non Primary Care Physician Related Services										
Dual Populations											
1	Facility Based services										
2	Community based Services										
3	Care Coordination										
4	Transition Management										
5	Palliative Care										
6	Hospice										
** Units of measurement and definitions are still under consideration. Suggestions or comments are welcomed.**											

APPENDIX G – Core Contract

RFA# 3402

[See separate document]

DRAFT