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March 31, 2012

RFA 3402

Addendum #4

1. This is Addendum # 4 to Request for Application (RFA) 3402, Coordinated Care Organizations (CCOs).

2. RFA #3402 is hereby amended to provide answers to questions received by OHA via: the official question and answer period which closed on March 27, 2012, the Webinars conducted by OHA on March 22, 2012 (not including answers provided in addendum 2 to this RFA) and on March 27, 2012. The following are OHA's official answers:

General Application Questions

Question 1. Does the 50-page limit include restating the questions?

Answer 1. It is not necessary to restate the questions. Instead, simply refer to the appropriate section of the Application when responding with each answer.

Question 2. Does Attachment 2 need an independent cover letter from applicant cover letter?

Answer 2. No, Attachment 2 is part of the submission of materials included with the technical application.

Question 3. Since these CCOs are just forming, establishing relationships and getting organized, how specific does the CCO need to be when answering the questions in the RFA?

Answer 3. In general, we would like you to be a specific as you can be. We are going to require as a condition of the Contract that the CCO demonstrates that it has formed a genuine, viable organization that has all the necessary parts to enroll Members, provide coordinated and integrated health services, provide sound fiscal management, bear risk and so forth. So the Application should provide as much information as available, and Applicant should complete the additional information by the time of the Readiness Review. We understand that this is an evolutionary process, and during the process you can add information. Be as specific as you can be, but not having all of the specific relationships formed is not necessarily an absolute requirement; except that as we go through the Readiness Review, there will have to be answers to questions about access and it will need to be clear that the delivery system relationships are in place to provide the full set of benefits to Members.

Question 4. Some questions in the RFA are duplicative. Can answers to some questions be combined?

Answer 4. In order to avoid duplicate answers the Applicant may refer back to the answer in another section of the Application as long as it is clear that all required information is provided.

Question 5. In light of the page limitations and the readiness review, will a clarifying list be compiled of those documents that may be provided at a readiness review as opposed to be counted as part of the page limit?

Answer 5. If such a list is developed it will be provided as an addendum to the RFA.

Question 6. Who needs to fill out the Application?

Answer 6. The Applicant is responsible for the contents of the Application.

Question 7. In regards to the page limitations, will clarity be given to what qualifies as supporting documents, tables, and data not subject to page limits as stated in Section 5.2.5?

Answer 7. The intention is that the page limits apply to narrative; so supporting documents, tables and data would not be subject to page limits.

Question 8. Overall, the application is very long and will not be conducive to completion within the very short time frames envisioned. Our organizations have developed programs to improve the care and well being of our populations for many years. We are dedicated to finding better ways to integrate all aspects of care. The transformation process will take time. The request asks for descriptions of programs that will take months to develop after becoming a CCO. As these organizations are just forming, it would be presumptuous of us to describe fully-formed plans at this stage. We had understood from previous communication with all of you that the CCO process was to be a community driven and bottom up process with a drive towards innovation.

Answer 8. The RFA recognizes that the development of CCOs will occur over time. In light of the short time frames, Applicants are asked to describe their strategies and plans for meeting transformation requirements. The Readiness Review process is another opportunity for Applicants to continue to develop their delivery systems after the application is submitted. The transformational elements of contracts (Appendix H) provide opportunities for Applicants to identify how it will reach transformation goals.

Question 9. This application speaks of a very top down approach and leaves very little room for innovation. One of our members commented that this application "beats every bit of innovation out of the plan." The application assumes that a single organization will have all of the risk reserves and will provide all of the services. And there seems to be no place for the "network of organizations" that were specifically included in HB 3650. At least at the outset, networks of providers will be necessary in the transition period.

Answer 9. The RFA recognizes that the development of CCOs will occur over time. In light of the short time frames, Applicants are asked to describe their strategies and plans for meeting transformation requirements. The Readiness Review process is another opportunity for Applicants to continue to develop their delivery systems after the application is submitted. The transformational elements of contracts (Appendix H) provide opportunities for Applicants to identify how it will reach transformation goals.

Question 10. Can you explain section 6.6.6 around antitrust?

Answer 10. ORS 646.735(2), as amended by Section 22 of 2012 Senate Bill 1580, provides: "The Director of the Oregon Health Authority or the director's designee shall engage in appropriate state supervision necessary to promote state action immunity under state and federal antitrust laws, and may inspect or request additional documentation to verify that the Oregon Integrated and Coordinated Health Care Delivery System established under ORS 414.620 is implemented in accordance with the legislative intent expressed in ORS 414.018." Temporary OAR 410-141-3010(3)(e) provides: "The RFA will request information from Applicants in order to allow the Authority to engage in appropriate state supervision necessary to promote state action immunity under state and federal antitrust laws." Section 6.6.6 of the RFA implements these provisions.

Question 11. Do you consider Letters of Intent the same as a Memorandum of Understanding (MOU)?

Answer 11. No. These are two different forms of Agreement. The Letter of Intent template is included in the RFA and provides a mechanism for Entities to formally announce their intention to submit an application to become a CCO. MOUs, in this context, are agreements between CCOs and other community organizations that describe how they will work together to deliver services to Medicaid Members.

Question 12. Can you speak to requested waiver Indian health organizations? Pending that, can you speak to any considerations for Tribes?

Answer 12. The RFA requires successful CCO applicants to collaborate with the Tribes and Urban Indian Health Care organizations. Please refer to Appendix B, Section 2 as an example.

Letter of Intent Questions

Question 13. Will you publish who has submitted a Letter of Intent next week?

Answer 13. Yes, on approximately April 3, 2012, the Letters of Intent will be published along with a matrix that includes service area.

Question 14. What flexibility will be allowed with the Application timelines submitted in the Letter of Intent being that some communities are just now beginning discussions –- i.e.: can you submit as second wave and change to first wave or vice versa?

Answer 14. With respect to the Contract start date, the Letter of Intent requests the Applicant to state its intent, but if the applicant wishes to change the intended start date this may be done in writing subsequently.

Question 15. When a Letter of Intent is submitted, can it be expanded at a later date? That is, if a plan submits a Letter of Intent, should they overestimate service area with the knowledge the service area may shrink, or is there opportunity to expand service area?

Answer 15. As with the date that the Contract will begin, the Applicant can submit an amended Letter of Intent changing the proposed service area –as long as that is done in writing, as described in 4.2.3 of the RFA. Further discussions will occur during the negotiation part of the certification process. Once Applicant is certified, changes to service area will be made in accordance with Contract.

Question 16. Do we need a secure portal account to gain access to Letter of Intents and Applications you plan to post?

Answer 16. Yes, you will need a secure portal account to submit a Letter of Intent and Applications. We are going to post the Letters of Intent and non-confidential portions of the Applications for general public viewing, which will not require a secure portal account.

Question 17. I thought it was said at the last webinar that we could include with our Letter of Intent a short statement or letter describing our goals/aspirations for becoming a CCO. What I see in the documented answers is that this could be included with the RFA but that we need to stick to the format requested for the Letter of Intent. May we add a one page statement to our Letter of Intent that indicates a bit about our goals and plans?

Answer 17. Such a statement can be included, but it is not required. We prefer you limit the information you provide to that which is requested in the Letter of Intent.

Question 18. What is the deadline for changes to the Letter of Intent?

Answer 18. Two weeks prior to the submittal of the Technical Application.

Question 19. Is it correct that Letters of Intent and Applications will be posted for public viewing - no secure portal account required? Also, when (approximately) do you plan to post them?

Answer 19. Yes, they will be posted for public viewing. The Letters of Intent will be posted on approximately April 3, 2012 and Technical Applications will be posted after the Technical Applications are received.

Question 20. Do we need to register on the portal to submit our Letters of Intent and RFA. The RFA states: The OHA web portal is the exclusive method for submitting written questions and requests for clarification (Section 4.4), the Letter of Intent to Apply (Section 4.2.3), and the Application itself.

Answer 20. Please see Addendum #3 to the RFA. Letters of Intent will be accepted via email to the SPC at: RFA.FormalQuestions@state.or.us and Technical and Financial Application must be submitted through the web portal.

Question 21. When you said you have not received any Applications as of this date, does that include Letters of Intent?

Answer 21. As of March 30, 2012 there have been Letters of Intent received from 7 organizations.

Question 22. If an out of state entity wishes to apply to be a CCO, and does not yet have an Oregon office, what address should the entity use for its "Oregon headquarters" in the letter of intent? For example, could the entity use its out of state address? Or the address of an agent such as a law firm?

Answer 22. It is required that the Letters of Intent identify a person as the legal representative of the organization applying to be a CCO. The address of this legal representative may be used in the Letter of Intent, but an Oregon office address for the CCO will be required before certification.

Question 23. How do we register to be able to send a Letter of Intent?

Answer 23. Go to http://cco.health.oregon.gov, and click on the Request for Applications page. There will be a registration link to the left side of the page.

Question 24. Since the Letter of Intent is to be submitted as a PDF document on the portal, is the name of the authorized representative, followed by the words "Electronically signed by CEO on (date)" adequate to satisfy the electronic signature requirement?

Answer 24. Yes.

OHA CCO Portal Questions

Question 25. Once I have applied for CCO account on portal site, how soon should I expect to hear back from cco.portal@state.or.us?

Answer 25. One business day.

Question 26. Does registration on the OHA portal require registration with ORPIN? Could you walk through that process?

Answer 26. It is not necessary at the time of Application to register with ORPIN. We do expect though that at the time we execute the Contract the Applicant will have registered with ORPIN so that we can post the necessary reporting information on the website.

Public Posting of Letters of Intent and Responses to RFA Questions

Question 27. Will the RFAs be posted on OHA's website? If so, will that be before May 14?

Answer 27. See Section 4.5 of the RFA, the Technical Applications will be posted as they are received. Attachment 3 of the RFA shows the due dates for the Technical Applications, depending, in part, on which "wave" the Applicant is using. Postings will be after the due date of the Technical Application.

Question 28. Where on the CCO website will the public information be accessible, i.e., who is participating and their submissions?

Answer 28. We will be adding a new web page to the web portal specifically for accepted Letters of Intent and Technical Applications.

Questions on RFA Review Process

Question 29. Who or what agency will be reviewing and approving the Applications?

Answer 29. The Applications will be reviewed by what we are calling a Technical Review committee which will include subject matter experts from OHA, DHS, and DCBS. This group will be making recommendations to a committee that will be appointed by Director of OHA and the Governor's office to make final approval.

Question 30. When reviewing the RFA-Cost Estimate will the review committee asks for clarifications of the submitter or will it be judged "as is".

Answer 30. We will ask for clarifications, when appropriate, if there is something that is not clear.

Rules Questions

Question 31. The full set of temporary rules appears to have been removed from the web site. Can you clarify?

Answer 31. The "preview" version of the draft temporary rules has been removed from the web portal. The web portal now includes the temporary rules that have been filed with the Secretary of State's office.

Question 32. Are the draft rules currently available at another website?

Answer 32. The temporary rules have been filed with the Secretary of State. There was a short time lag between the official filing with SOS and posting onto the OHA web portal.

Question 33. There are references in the Core Contract to OARs in the 410-141-2500 and following range. Those numbers were not included in the previously published temporary rules and do not appear to be part of existing rules. Can you clarify?

Answer 33. It appears that the citation is mistaken. In that case, the Core Contract is referring to excluded services, described in OAR 410-120-1200. We will make that correction, as well as checking other citations in the Contract before it is finalized.

Question 34. Where are the Rules posted?

Answer 34. They are posted on http://cco.health.oregon.gov and you click on the CCO Rules tab at the top of the page.

Question 35. The rules are similarly concerning. We understand that the rules provided to us are in draft form and may change, but it will be very difficult to do the application until we fully understand the rules. For example, the reserve requirements are very different from what was specifically included in SB1580 and the near doubling of reserve requirements will be a tremendous burden, especially on small plans. We are concerned that there are significant changes in the covered populations, with no annotation or comment. For example, our discovery of the inclusion of the ESRD population came only with a line-by-line comparison of the current and proposed rules. As the proposed rules did not have a "red line" version, this has put a tremendous burden on the applicants to do a line-by-line comparison.

Answer 35. Temporary rules have been filed and a copy of those rules are posted on the OHA CCO website for convenience.

In response to initial feedback on the "preview" draft rules, changes were made to the financial requirements.

Governance/Organizational Requirements Questions:

Question 36. Please clarify if you expect names for the governance board or just positions or titles? This would require the Community Advisory Council (CAC) to be formed prior to Application.

Answer 36. Names of the governance board or the Community Advisory Council will not be required at the time the Application is submitted, but names will be required by the time of Readiness Review.

At Application, describe the processes that are being used to develop the appropriate governance and council membership.

Question 37. Can you explain how a CCO in its first year can meet the requirement in the RFA at 6.3.1.b which requires a net worth of "five percent of the CCO's average annualized total revenue in the prior two quarters?"

Answer 37. If this is a CCO that is formed independent of an MCO that's been in operation for a period of time then that net worth requirement would have to be subject to an alternative demonstration of financial capabilities. In the case of CCO's that are formed from existing MCO or multiple MCO's then it would be the experience of the predecessor MCO's that would be used to develop the net worth calculation.

Question 38. Are CCO capital requirements being reviewed, or should we consider the current language final?

Answer 38. OHA made an adjustment between the draft RFA and Final RFA that was posted on the web site, and that relaxed the capital requirement. We received questions last week; we considered the capital requirements in terms of finding the right balance between assuring financial liability and avoiding unnecessary entry barriers. No changes to the current CCO capital requirements are anticipated.

Question 39. Must CCOs have the dollars in hand to satisfy capital requirements, or will pledges/letters from participating providers suffice?

Answer 39. Legal subordination agreements will be required if a CCO wishes to demonstrate that the required capital is available, to ensure financial solvency and to make certain that all providers participating in the network receive appropriate payment in the event there is a CCO financial failure.

Question 40. Will the articles of incorporation need to be submitted with the technical portion or can they be submitted later?

Answer 40. The articles of incorporation would be applicable to those organizations that actually are incorporated and in that case they would not have to be submitted with the technical portion, they could be submitted later. See Appendix E of the RFA which describes the particular requirements.

Question 41. Regarding the CCO advisory council, do you want the advisory council named and the application process that is used identified with the application, or just the describe and outline the process in the application and select the advisory council after the application is submitted?

Answer 41. The combination of names and how the CAC was selected will be necessary for OHA to confirm that the governance structure is consistent with the statute. If the CAC is not entirely constituted when the technical application is submitted, the Applicant can provide that information as it becomes available but not later than the time of the Readiness Review.

Benefits/Services/Providers Questions

Question 42. Are CCO Applicants aware of DMAP's Non-Emergent Medical Transportation (NEMT) statewide brokerage system and will they be expected to work with the current NEMT brokers to meet their non-emergency transportation responsibilities?

Answer 42. A task force formed at the direction of the Governor's office will be looking at all of the issues as far as the brokerages are concerned. Currently the plan is to not include NEMT as a requirement of the CCOs until 2013, and this will allow the task force time to review all of the issues and develop a proposal.

Question 43. Are CCOs going to cover Non-Emergent Medical Transportation in 2013 under the global budget?

Answer 43. See Answer 36

Question 44. Appendix B, Section 2, Standard #8, (h) – provide a definition of what Medication Therapy Management (MTM) in the context of a Patient Centered Primary Care Home.

Answer 44. Medication Therapy Management (MTM) in this question refers to including a community pharmacist into a holistic approach to care provided in the context of a PCPCH.

Question 45. Please discuss two related issues:

a. What role will naturopathic physicians, acupuncturists and other natural medicine providers have within CCOs? If such practitioners are included as providers how does the system account for payment levels commensurate with the more in-depth and personalized office visits often typical to the care provided by such providers.

b. What mechanisms are in place to assess potential risks and benefits of drug-nutrient and herb-drug interactions and provide guidance for safe and effective clinical management of such polypharmacy? Disclosure: MedicineWorks publishes resources for healthcare professionals to enable collaborative care.

Answer 45. There are largely issues for CCOs and providers to work out together on a case by case by case basis. As with MCOs, CCOs will be required to assemble provider panels sufficient to provide covered services to enrolled populations, in the context of patient-centered care with a focus on health outcomes.

Question 46. Attachment 7, letter g – provide clarification as to what section of Appendix B is "Services Area Request." What is the deliverable? Is it a table or answer(s) to written questions?

Answer 46. Appendix B Section 1 requires information regarding proposed service area for CCO.

Question 47. Regarding sharing PHI, since healthcare providers will need to coordinate the care of beneficiaries, including sharing PHI, will the State of Oregon provide an indemnification or equivalent to CCO providers regarding PHI and HIPAA? Unless the CCO is going to obtain releases from every beneficiary, we will not have the flexibility to coordinate care and thereby defeating the entire purpose of transforming care. The State of Oregon needs to provide the CCO protection from any liability connected to PHI. Sharing PHI and actually engaging a patient are two different issues.

Answer 47. ORS 414.679 (section 12 of HB 3650) authorizes the CCO and its network to use and disclose member information for purposes of service and care delivery, coordination, service planning, transitional services and reimbursement.

Also, SB 1580 (2012 Or Laws Chapter 8) provides:

SECTION 16.

(1) Notwithstanding ORS 179.505, a health care provider that is a participant in a coordinated care organization, as defined in ORS 414.025, shall disclose protected health information:

   (a) To other health care providers participating in the coordinated care organization for treatment purposes, and to the coordinated care organization for health care operations and payment purposes, as permitted by ORS 192.558; and
   (b) To public health entities as required for health oversight purposes.

(2) The disclosures described in subsection (1) of this section may be provided without the authorization of the patient or the patient's personal representative.
(3) Subsection (1) of this section does not apply to psychotherapy notes, as defined in ORS 179.505.

Question 48. Can you provide clarification around the format for submission of the information requested for Section 2, Standard #2 (Providers for Members with Special Health Care Needs) on page 71-72?

Answer 48. This requires a narrative response that describes the qualifications of specialty providers in the CCO network of providers that have the skills to provide Coordinated Care Services to Members with special health care needs as described in the section.

Question 49. Will there be any opportunity to better understand services such as non-urgent transportation costs? How can CCO cost estimates be created without such data?

Answer 49. OHA will provide historical utilization data to prospective or operating CCOs prior including non-emergent medical transportation in CCO global budgets. Prospective CCOs will not be asked to estimate costs for non-emergent medical transportation in their initial base cost estimate.

Question 50. Many CCOs will probably contract with affiliates or other organizations for administrative services, provider networks and other key elements of CCO performance. Are there any functions that a CCO may not contract for?

Answer 50. Risk management and any functions CMS might prohibit contracting out.

Question 51. Can you explain what is required on page 48 letter g? Service Area Request (Appendix B) not sure what part of Appendix B this is

Answer 51. This refers to Appendix B Section 1 – Service Area and Capacity, page 65 of the RFA "Service Area Table".

Long Term Care Memorandum of Understanding Questions

Question 52. When will the long term care MOU be posted?

Answer 52. The exact timeline for posting the LTC CCO MOU template is being finalized but we expect it will be finalized by mid-April.

Question 53. Due to the shortness of Application timelines and the time potentially needed to get approvals by multiple parties, will draft MOU's be acceptable with LTC partners etc?

Answer 53. Yes. In particular for long term care, a finalized MOU is not required at the time of Application, but will be required at a later date, prior to the Contract effective date.

Metrics Questions

Question 54. Appendix C, C.1.1.g Describe the Applicant's capacity to collect and report to OHA the accountability measures listed in Table C-1 (pg 74 regarding the "Measures to be collected by CCOs or EQRO"). It is unclear how to answer this as the four measures listed do not have specifications indicating how OHA would require capture of data for these measures. For example Planning for end of life care (documentation of wishes for members 65+) could be collected via claims data (CPT category II codes), chart review, and/or member survey. The measure description lists that it could be a "sample-rather than population based" however the sample size and collection method combined would determine the plan's capacity to collect the data for the measures?

Answer 54. Where the measure specifications are not provided and the measure is not a standard one (e.g. the end-of-life care measure mentioned) the applicant can describe its capacity to collect the measure in more general terms, and outline what data sources it currently has available that would provide data on the question. Of the 4 measures listed for CCO reporting, the 2nd (Screening for clinical depression and follow-up) and 3rd (Timely transmission of transition record) are standard measures, so the applicant can refer to the specifications listed by NQF or the measure standard when describing its capacity regarding those measures.

Mental Health Questions

Question 55. The gulf between the enormous documentation requirements for mental health services provided by CMHPs and the fairly simple requirements for services provided in a primary care setting is a big barrier to integration. When can we expect these two different sets of requirements to be synchronized?

Answer 55. AMH has been working collaboratively and been part of the process of the development of the CCO application process. There is separate funding that goes out to the community MH providers, and with that funding there are requirements and we have been working to simplify those requirements. We are definitely doing everything we can with technology and working collaboratively with the CCOs on requirements, but there will always be MH service requirements that are different from those in the physical health setting.

Question 56. Appendix A, A.1.4 related to the CCO's required MOUs with the Local Mental Health Authority - by when in the application process is this MOU to be formally established by all parties?

Answer 56. It is recommended that the Applicant should develop these relationships as early in the Application process as feasible. The MOU should be established during the application process,

and not later than the Readiness Review, unless the Applicant explains good cause under ORS 414.153.

Question 57. It appears that CCO's will create a new level of "authority" for the provision of Medicaid covered Mental Health Services – whereas, previous to CCO's both Medicaid and Indigent (non-Medicaid/Service Element Funds) mental health services were under the auspice of the LMHA. Now is appears that there are two parallel and possibly conflicting authorities – would this assessment be correct?

Answer 57. While the Medicaid funds that have been managed by the MHOs will be managed by the CCOs, HB 3650 requires CCOs to have written agreements with each county in which they operate, unless an agreement is not feasible or the county opts out. This provides the LMHA the opportunity to continue to bring together both Medicaid and non-Medicaid funds to meet the needs of their community as is done with the MHOs.

Currently there is a symbiotic relationship between the Medicaid and Indigent services – whereas, the significantly larger amount of Medicaid funding helps provide the infrastructure and staffing level to adequately provide mental health services to the Indigent population.

Question 58. How does the Oregon Health Authority envision these two funding streams (Medicaid and Service Element funds) co-existing in the CCO world?

Answer 58. To optimally meet the health needs of the local community the CCOs and LMHAs will be most successful if they form local partnerships based on the community health assessment to meet the goals of the community health plan.

Question 59. Will the Indigent funds become part of the CCO global budget? If so, this would mean that all Mental Health funds will be under the CCO – which begs the question of how the LMHA can still exist (i.e. have the responsibility outlined in the statute without the authority to direct the provision of services)?

Answer 59. The indigent funds would only become part of the CCO responsibility if there were agreement between the LMHA and the CCO that such an arrangement provided the best opportunity to serve both the Medicaid and indigent members of the community. This agreement would be designed to support the statutory responsibilities of the LMHA.

Question 60. Even if indigent funds still go directly to the CMHP and the Medicaid "mental health dollars" are allocated to the CCO in their global budget – it would still mean that the LMHA would only have direct control over a limited amount areas stated in Statute as being the responsibility of the LMHA (e.g. Protective Service Investigations and Civil Commitments). Again, this raises questions about the realistic expectations of AMH regarding the LMHA.

Answer 60. The LMHAs will be held accountable relative to the state resources provided through the County Financial Assistance Agreements.

The LMHA not only describes the role and responsibilities of the County Commissioners, but also the roles and responsibilities of the Community Mental Health Programs (CMHP) and local advisory boards. The statute states that the LMHA's are not only held accountable – but are also responsible for holding others (CMHP, Local Advisory Boards, Local Planning Process) accountable to assure that mental health services are adequately delivered. Quality mental health services are not only a health concern, but a public safety concern – and in this regard, the

LMPH residing in the Board of County Commissioners has made sense since they have vested interest in both.

Question 61. What remains the responsibility of the CMPHs and what becomes that of the CCO?

Answer 61. The CMHPs will be responsible for the services funded through the County Financial Assistance Agreements and are encouraged to use the written agreements required by HB 3650 to form working partnerships with the CCOs.

Question 62. Do we still have local mental health advisory boards – and if so, who are they to advise? – and on what matters shall they be advising on?

Answer 62. The statutes require local mental health advisory boards. It will be important to review the statutes in relation to the community-focused requirements of HB 3650 and SB 1580 for community health assessments, community health plans and community advisory councils.

Question 63. Will we still be responsible for the local planning processes?

Answer 63. There is a need to rethink other statutory planning requirements, (e.g., biennial implementation plans) in light of the requirements for community health plans which should include substance abuse disorders and mental health treatment service needs. These planning requirements need to be integrated at the community level.

Question 64. How will jail diversion and the issue of public safety be addressed by the CCO's?

Answer 64. For CCO members, improved access, aggressive care coordination and community-based services included in the Global Budget should be aimed to identify illness early and treat them effectively thus avoiding criminal justice involvement resulting from untreated mental illness. However, the General Fund services identified in the County Financial Assistance Agreements for jail diversion will continue to be the responsibility of the LMHA. As LMHAs work out the agreements with CCOs required by HB 3650 issues of CCO funding for public safety outcomes should be addressed.

Question 65. Again, does the LMHA change if the LMHA is not directly responsible for some or all services being provided?

Answer 65. The LMHA will continue to be responsible for the services funded through the County Financial Assistance Agreements and to develop meaningful agreements with the CCOs as required by HB 3650.

Question 66. Finally and *very importantly*, neither the rules nor the application address the mental health programs provided by our county partners, including commitment programs and the Mental Health Authority. Without considerably more clarity, it would be difficult for us to submit an application.

Answer 66. The RFA does not alter the benefit package of covered services. Mental health and addiction services currently covered under the Oregon Health Plan will be provided on an integrated and coordinated basis by Coordinated Care Organizations.

Question 67. Any recommendations in the process for gaining support from county government, local mental health authority?

Answer 67. Applicants could talk with county commissioners, especially the commissioner who is lead on mental health and addiction services and with the county mental health director. Topics that Applicants could use are potential partnerships that mutually benefit the community.

Question 68. With many CCOs having little or no experience with the complex mental health operations including AMHI and ICTS, who would CCOs best approach managing and funding these services in both short term and longer term

Answer 68. For both AMHI and ICTS the current MHOs have demonstrated success in assisting adults with severe, persistent mental illness to move from more restrictive to less restrictive and more integrated environments (AMHI). They also have demonstrated success in reducing length of stay in psychiatric residential treatment programs, increasing the array of flexible services in the community thus serving more children and adolescents at the ICTS level of care and improving outcomes.

Question 69. Will CCOs be responsible for care for persons with serious mental illnesses coming out of the state hospital, or will Medicaid funds be carved out for residential services etc for these individuals?

Answer 69. As is currently the case with the MHOs, the CCOs will be responsible for all OHP benefits for their Members upon discharge from the state hospitals. Currently the specific Medicaid funded services delivered in 24/7 structured residential settings by the staff of the facility are **not** in the OHP benefit. This is not scheduled to change in 2012.

The majority of individuals leaving the state hospital transition to independent community settings such as their own home, living with family or in supported housing. Currently, most individuals living in a community setting have their mental health needs met through the MHOs capitation including those that require more intensive care coordination. As the CCOs take responsibility for the capitated mental health services, this function is included as well. The RFA, **A.3.5. Coordination, Transition and Care Management** (i) requests that the Applicants address a plan for appropriate transitional care for their Members including transitions to and from the state hospital and residential system.

As noted above there are some Medicaid covered services that are not included in the capitated payment to MHOs and will not be included in the CCOs' global budgets at implementation. This distinction is temporary and will allow OHA staff the time necessary to work through the operational issues that prevented the funding from being included. The additional services may be included as early as Jan 1, 2013.

Enrollees/Covered Populations Questions

Question 70. If a new CCO and an existing MCO are in the same county how would the new CCO obtain enrollees?

Answer 70. We are in the process of working out the details of client transition.

Question 71. Will Members with primary commercial insurance and OHP secondary be included in the covered populations?

Answer 71. Yet to be determined. That policy will be developed soon and we will publish a response.

Question 72. How will patients be assigned to the CCO in the area if there are multiple CCOs in an area?

Answer 72. Eligibles in the service area will choose among available CCOs, and will be assigned on an equitable basis if they do not choose.

Question 73. How will OHA consider the number of members to be included in granting approval? Will there need to be a minimum # of people served?

Answer 73. There will be no set minimum number of enrollees, but a CCO's enrollment will need to be sufficient for financial solvency.

Data/Policy Related to Race/Ethnicity Questions

Question 74. In Section A.1.6, there is reference to OHA's race, ethnicity, and language data policy. Where can this be found?

Answer 74. We will answer that in writing and direct you to that information as soon as the policy is finalized.

Question 75. Will we get race and ethnicity data from the state on enrollment?

Answer 75. OHA will share with Applicants available data on race and ethnicity that is relevant and appropriate to the RFA process.

Question 76. When individuals are enrolled in the CCO, will we get member level race and ethnicity data, or are the plans supposed to collect that data? Surely the state collects that information on enrollment.

Answer 76. The state does collect information about enrollees, but in addition to that there are needs assessments performed by counties and hospitals and mental health authorities around the state which will also provide relevant data on the populations in the service area. OHA is assembling data on race and ethnicity and on other population characteristics related to health disparities and will make this data available to CCOs in appropriate scope and format.

Financial Questions

Question 77. Will there be any incentive funds available for early adopters?

Answer 77. This remains to be determined pending CMS decisions.

Question 78. Will additional technical guidance be available for the financial application?

Answer 78. OHA will offer technical assistance via Applicant Conferences for entities that have submitted a Letter of Intent. The dates of Applicant Conferences will be made available on the web portal.

Question 79. With regard to the five year proforma, how strict is the OHA going to hold the CCOs to the 5 year proforma, will it allow for course corrections and what is the process for course corrections

Answer 79. We are not expecting that the 5 year proforma will get everything exactly right for every year. The Applicant is expected to develop best estimates based on projected revenue from premiums and other sources, and projected expenditures for operating expenses and health care services. OHA will allow for course corrections after implementation as necessary to reflect actual experience.

Question 80. Can the admin budget be submitted in the form of a PMPM or do you require a detail line item budget? For example, if you outsource to a TPA with a flat fee would you still need to detail line item that cost?

Answer 80. The administrative budget should be submitted in the form of an *estimated* Per Member Per Month (PMPM) since converting administrative costs to PMPM form requires estimations of enrollment level in the CCO. The Applicant should also provide a line item administrative budget.

Question 81. Appendices F & H and other portions of the document appear to incorporate non-Medicaid mental health and addictions services into the global budget over time (by July 1, 2013). That raises questions with respect to the viability of the counties Local Mental Health Authority. Is that OHA's intent?

Answer 81. This is the Medicaid portion of the services and is outside of the funding that goes to the local mental health authority for the indigent population and services.

Question 82. Will the rate manuals be published when determining the level of funding?

Answer 82. We will need clarification of this question before it can be answered.

Question 83. Please discuss the process that will occur between the first wave of the base cost estimate bid (May 14) and the award (May 28) in terms of bid iterations. For example, I believe the original base cost estimate bid should not include an adjustment for an infusion of FFS members because more information from the state will come after that. Since awards are released 5/28, does that imply the iterative process of submitting a bid inclusive of FFS members must occur between 5/14 and 5/28?

Answer 83. Actuarial services unit is going to make available technical assistance for all applicants with respect to lowest cost estimate. Rather than answer those questions here, we'll respond in writing with more information. Once we receive letters of application we'll be able to begin scheduling technical assistance meetings for applicants.

Question 84. The Letter of Intent allows the CCO to request a member capacity without a limit. How will the CCO determine the appropriate minimum financial reserves without a determined amount of Members?

Answer 84. OHA is developing a method for setting the financial reserves in terms of estimated enrollment. Minimum financial reserve requirements will be revised as actual enrollment numbers become available.

Question 85. In several different meetings, it has been noted that the Governor's office and OHA have met with CMS about additional funding for this transformation effort yet today, it was noted that there will not be incentives for early adopters or CCOs being developed in first year etc. Can you please clarify?

Answer 85. The additional funding from CMS is uncertain at this point. Expect to have clarity on that within the next two weeks. The other thing that's uncertain is how CMS will prescribe that this money will be used in transformation. It really is a separate question from incentives for early adopters. As we get information about this funding, it will be published as soon as it's available. When we get CMS guidelines for the use of that funding, that will be published as well.

Question 86. In Program Areas in Table F-1. Our specific question is concerning the Breast and Cervical Cancer Medical: Currently there is OHP and Medicaid Fee for Service and Preventative or Exception (non-regular) fee for service. Are the non-regular pieces (i.e. breast cancer treatment for those clients diagnosed with breast cancer who are currently enrolled in the Oregon Breast and Cervical Cancer Program) not included in the Global budget and an exception (billing as currently done)?

Answer 86. This question will be addressed for applicants in the Financial Application Technical Assistance meetings which will be scheduled weekly in April. Applicants will be notified of the schedule during the week of April 2.

Question 87. Currently there is OHP, Medicaid Fee for Service, Preventative and Exception (non-regular) fees for service. Are the non-regular pieces (i.e. breast cancer treatment for those clients diagnosed with breast cancer who are currently enrolled in the Oregon Breast and Cervical Cancer Program) not included in the Global budget and will be an exception (billing as currently done)?

Answer 87. This question will be addressed for Applicants at the Financial Application technical assistance meetings to be scheduled weekly in April.

Question 88. Furthermore, the application asks for low cost estimates ("…the capitated portion CCO capitation rate setting would combine the information provided by Applicants with a method similar to the lowest cost estimate approach OHA took in setting rates for the first year of the 2011-13 biennium..."). Somewhat reluctantly, DCIPA, LLC was able to do a low cost estimate last year because the services and membership did not change. With this application, it will be very difficult to come up with a low cost estimate if we do not know which populations will be included (e.g., those with primary commercial insurance), with the addition of new, very expensive populations (e.g., those with end stage renal disease), with the addition of the "open card" population for which we have no data, and of new requirements that are only vaguely described in the rules and application.

Answer 88. Technical assistance for the Financial Application will be provided to applicants at scheduled meetings. Invitations will be sent to Entities submitting a Letter of Intent.

Question 89. If administrative operations are handled outside of the CCO organization will you accept a PMPM admin budget or do you required detail line item budget

Answer 89. For purposes of the Cost Estimate we will accept a PMPM, a percentage or a fixed amount as representative of the administrative portion of the rate. The Financial Solvency and Pro-forma RFA requirements should have sufficient detail to provide direction in this area.

Question 90. There is not a reference in Appendix F to a table or definition of "all Medicaid funded" programs. Where can this be found?

Answer 90. Table F-1 provides a list of programs, services and functions along with their scheduled inclusion in CCO global budgets on a mandatory or optional basis.

Question 91. Can you explain how an applicant is supposed to develop baseline costs when no single entity has access to historical encounter data, historical costs, or anticipated contract rates?

Answer 91. Additional data will be made available once the Letters of Intent are submitted and potential applicant coverage areas can be determined. Additionally, the Actuarial Services Unit is prepared to assist all applicants both individually and as a group to work through any specific challenges applicants maybe experiencing.

Question 92. CCOs will result in fewer 3rd party payors. How are you addressing this and have you given any of these organizations direction on how to perhaps consolidate?

Answer 92. Under this RFA, CCOs are only associated with the medical assistance program.

Question 93. Where can we get a description of the programs in F-1?

Answer 93. Programs, services and functions listed in Table F-1 represent a broad array Medicaid-funded benefits, not all of which are currently available statewide. Upon receipt of letters of intent with proposed service areas, OHA will work with prospective CCOs to better understand the Medicaid programs, services and functions currently available in the proposed service area.

Question 94. It is our understanding that cost-based reimbursement for A & B hospitals would be built into the CCO global budget—at least until July 2014— if CCOs contract with those entities. Is this accurate?

Answer 94. Type A & B hospitals must be reimbursed by CCOs on a cost basis as they are currently.

Question 95. In looking at 6.3 Financial Application Evaluation, I noticed that the final RFA has an additional (or) under 6.3.1.b regarding authorized control level risk-based capital (RBC). The reference to OAR 410-141-3355 does not exist according to my research into the rules? Is the DCBS information regarding MCO RBC useful or is there a way to find the specific rule, OAR 410-141-3355

Answer 95. OAR 410-141-3355 is the correct reference. It was filed with the Secretary of State earlier this week and should be posted on the OHA website very soon.

Medicare/Medicaid Alignment Demonstration Questions

Question 96. Will Duals be paid under the global budget or separately from CMS?

Answer 96. CCOs will not be required to participate in the Medicare/Medicaid Alignment Demonstration, but for organizations that choose to participate in the demonstration, then the payment would be a blended rate where the Medicaid portion would be paid for by the state and the Medicare portion would be paid by CMS. Under the demonstration, the organization would still be receiving payments from both the state and from the federal government, but they would be two parts of a blended payment rate for the overall package of services.

Question 97. If payments are blended Medicaid and Medicare, does this mean methadone programs are excluded since we cannot receive Medicare funds? (Medicare does not cover methadone services).

Answer 97. The blended payment rate will cover all services currently covered by Medicare Parts A, B, and D, and all services currently covered by Medicaid. Even if a service is not covered by Medicare, such as methadone, if it is currently covered for dually eligible individuals under Medicaid, it will be covered under the blended payment rate.

Question 98. Must CCOs electing to participate in the Alignment component have an established FCHP with an approved Medicare Advantage Plan?

Answer 98. To participate in the demonstration, there is no requirement to have prior experience as a FCHP or as a MA organization. CMS has said that they will provide technical assistance to ensure that new organizations that don't have prior experience in MA may be able to participate in this demonstration if they wish. For organizations that do have prior experience as an MA plan, CMS will take into account that prior experience and plans that have been flagged for low performance may not be eligible for certain parts of the demonstration, but prior experience is not required. That being said, organizations will find that many of the Medicare Advantage requirements apply and that it may be easier to satisfy those requirements having prior experience.

Question 99. Please repeat if not already addressed...Will the CMS NOIA be required in order to register to submit a Letter of Intent to OHA?

Answer 99. No. Participation in the CMS Medicare/Medicaid Alignment Demonstration is not required for CCOs; and therefore while it is required that potential CCOs notify us if they are submitting a Notice of Intent to Apply (NOIA), they are not required to submit the NOIA.

Question 100. What is OHA's intent as it relates to FCHPs who are becoming CCOs who already have MA plans on board to manage their SNP members. Will the CCO need to become a separate MA plan?

Answer 100. We assume this question is with regard to the CMS Medicare/Medicaid Alignment Demonstration. As we noted earlier, CCOs wishing to participate in this demonstration do not need to have a MA plan, nor do they need to officially become a MA plan. They will be providing the Medicare services through a CMS demonstration that requires meeting many of the MA requirements, but does not require a CCO to formally be an MA plan. CCOs that do not participate in the demonstration may also maintain a separate, affiliated MA plan.

Question 101. If we have an MA plan, and are pursuing a CCO application, would we want to also pursue the demonstration plan? I realize it is not required, but I'm not clear of the differences

between maintaining my MA plan and the CCO, and becoming a CCO with a demonstration plan. Can I do all three?

Answer 101. Participating in the demonstration does not preclude an organization from maintaining a separate Medicare Advantage plan and because the NOIA is non-binding, we encourage organizations to apply if they think they may be interested in participating. There is more information about the parameters of the demonstration plan in Appendix D of the RFA, and there are links to additional CMS guidance, so any entity considering applying is advised to look at that information.

Question 102. Can you articulate the specific services required to be offered, and those that are optional under the demonstration project? For example, could one choose between Drugs, Hospital, and Mental Health?

Answer 102. In general, the benefit package for the demonstration will be the combination of the existing Medicare and Medicaid benefit packages. Any additions to that will be provided at a later date.

Question 103. When will we have more clarity regarding the actual blended rate that would be used in the demonstration project?

Answer 103. In general, the benefit package for the demonstration will be the combination of the existing Medicare and Medicaid benefit packages. Any additions to that will be provided at a later date.

Question 104. For CCOs who want to be involved in the demonstration for full Dual SNPs, is it correct that along with this CCO application with the OHA, there will be a separate CMS application to complete as well? If so when are the due dates for that and is there a draft CMS demonstration application.

Answer 104. For the CMS Medicare-Medicaid Alignment Demonstration (which does not require an organization to have a Special Needs Plan), there will be a separate CMS application to complete, which will be released by CMS shortly. In the RFA, there is a timeline that shows specific dates associated with the CMS Medicare/Medicaid Alignment Demonstration which is in Attachment 3, Part 2. There are a number of deadlines. A few of the key ones:

- the NOIA is due to CMS on Monday, April 2;
- a number of Part D requirements that are coming up in April or May;
- an overall demonstration application to CMS, is due to CMS on May 24, and is related to the plan's ability to meet the Medicare requirements.

Please refer to Attachment 3, Part 2; Appendix D of the RFA; and also refer to future guidance and communications from CMS and OHA. CMS guidance will be communicated to plans that have submitted NOIAs, and will be posted on the CCO Medicare/Medicaid Alignment website.

Question 105. If it is anticipated that the final rate may not be released until June, how would a CCO be able to evaluate whether it would want to complete the Demonstration Application which is due May 24th?

Answer 105. We're aware that this is an issue and are exploring with CMS the possibility of communicating to CCO Applicants any information that we have in advance of the May 24 date, such as information about the rate parameters and methodology, that could help CCO Applicants evaluate whether the demonstration could be a fit for them.

Question 106. Are the Demonstration Applications binding taking into consideration the current unknowns?

Answer 106. Entities will be able to withdraw a Demonstration Application after it has been submitted to CMS if they choose not to participate.

Question 107. For the demonstration application NOIA just discussed, is it the entity that is applying as a CCO who will need to complete the CMS NOIA or can it be an affiliate/subsidiary entity who already has a CMS contract?

Answer 107. CMS indicated that it is their preference that a potential CCO would fill out the NOIA, since they want the three-way contract to be between OHA, CMS and the CCO. But to the extent that a CCO organization is still forming, both the CCO lead entity (i.e., the entity that completes the OHA Letter of Intent) and its affiliate(s) or subsidiary(s) could fill out separate NOIAs. CMS has the ability update the name on the NOIA at a later date. We would then encourage CCO Applicants who submit multiple NOIAs to describe to OHA their intentions in their OHA Letter of Intent.

Question 108. Can the formulary needing to be submitted by the CCO be the same formulary submitted to CMS that affiliate or subsidiary who already has a SNP has submitted? Will there be required drugs on the CCO formulary that are considered Part D excluded?

Answer 108. For the Medicare/Medicaid Alignment Demonstration, organizations that have already submitted a Part D formulary to CMS for 2013 will be able to use that formulary for their demonstration submission as well. Additional supplemental formulary submissions may be required for the demonstration which may include additional Part D excluded drugs that are required to be covered for Medicaid.

Question 109. If a downstream entity of the CCO already has a SNP Contract for Individuals Dually Eligible with CMS, can that contract be transferred to/used by to the CCO for the Demonstration contract or will another CMS contract number be generated for the CCO?

Answer 109. CMS has stated that a new contract number will be required for entities applying to participate in the demonstration and it is not possible to use an existing contract for the demonstration purposes.

Question 110. How will areas that have a Medicare SNP plan be impacted by CCO's with a demonstration plan? Will MA members elect a CCO? Will the fee for service members be passively enrolled into the CCO? Will the MA plan lose members if they are not affiliated with a CCO?

Answer 110. The intention is that dually eligible individuals can elect to receive their Medicare benefits through a CCO with a demonstration plan; just as they could through a MA plan. Dually eligible individuals with Medicare FFS members will be passively enrolled into CCOs participating in the demonstration in their area. Passive enrollment includes a prior 90-day beneficiary notification period with the opportunity to opt out of the CCO. All dually eligible individuals enrolled in a demonstration plan retain their Medicare rights to switch to FFS Medicare or to another MA plan. On the last question, this decision is pending.

Question 111. If you don't want attachments to the Letter of Intent, why don't you just ask if we have applied (included in the questions already) and not need proof?

Answer 111. See answer 113 below.

Question 112. Section 1.2.2 Description of Oregon's Integrated and Coordinated Health Care Model, fourth paragraph, third sentence: "For individuals who are dually eligible, after approval by the Center for Medicare and Medicaid Services (CMS), electing CCOs will also receive Medicare funding through the global budget."

Please clarify the following:

- If reimbursement for Duals from CMS will be included in the reimbursement from the State, or will CCOs receive direct reimbursement from CMS?
- If the funding is coming from the state, how the actual reimbursement will be calculated- i.e. presumably risk scores still directly influence the payment amounts?

Answer 112. For CCOs that choose to apply for the Medicare/Medicaid Alignment Demonstration, a blended payment rate will be paid to cover integrated Medicare and Medicaid services. This blended payment rate will be determined jointly by OHA and CMS, and OHA and CMS will each pay their share of the blended payment rate directly to the plan. The amount and structure of the payment, including any risk adjustment, is still being discussed with CMS.

Question 113. The following is a series of questions about how to provide a copy of the Medicare Notice of Intent to Apply (NOIA) with the Letter of Intent, given that the NOIA format is web-based:

- Since the NOIA for the alignment project is a web based application, how are we to submit a copy to the State?
- Could an answer be given before Friday regarding the requirement that a copy of the NOIA to CMS be submitted with the letter of intent? I am not sure there is the capability to print from the NOIA site and there is a potential lag between submission of the NOIA and confirmation received from CMS.
- You can copy and paste CMS application web pages, but it is about 10 screens. Will it suffice to paste into word and submit?
- Because there wasn't the opportunity to print at the end of the NOIA and if you didn't paste and print previous screens, would a print screen of the final screen of confirmation that "your Survey has been Accepted" be acceptable?
- If you don't want attachments to the Letter of Intent, why don't you just ask if we have applied (included in the questions already) and not need proof?

Answer 113. If an organization is not able to provide a copy of the NOIA with their Letter of Intent, it will be adequate to indicate that a NOIA was submitted and to provide the answers to questions 5, 7, 9, and 11 of the NOIA (in some cases these answers will be "not applicable"):

- 5. Approximately how many full dual eligible individuals do all of the SNP products offered by the legal entity identified above currently serve?
- 7. Approximately how many full dual eligible individuals do all of the SNP products offered by the parent organization identified above currently serve?
- 9. Approximately how many full dual eligible individuals do the Medicaid managed care products operated by the legal entity identified above currently serve in all States in which that parent organization operates?

- 11. Approximately how many full dual eligible individuals do the Medicaid managed care products operated by the parent organization identified above currently serve in all States in which that parent organization operates?

OHA Technical Assistance/RFA Q&A

Question 114. When will the written answers to the webinar questions be posted on the web site? They are not there yet, correct?

Answer 114. Some were posted via Addendum #2 on Thursday, March 22, 2012.

Question 115. Who at OHA will be available to answer questions in preparing RFAs, and what's the best way to communicate

Answer 115. Questions should be submitted in writing to the single point of contact identified in the RFA. For additional clarification, we do plan to offer technical assistant at Applicant Conferences between April 2, 2012 and the date initial applications are due. Applicant Conferences will be available to all parties who have submitted Letters of Intent. A schedule will be posted on the web portal next week.

Question 116. Will the answers to the questions that were submitted via the Portal be posted for the public on the website also?

Answer 116. Yes.

Question 117. Will a FAQ be developed as a result of the questions submitted through the OHA web portal?

Answer 117. The only collection of responses from this webinar will be made available through RFA addenda.

Miscellaneous Questions

Question 118. How do we address conflicts in the RFA with the draft contract in Attachment G?

Answer 118. If you could point those out to us more specifically, we will try to address them. If there are conflicts that need to be worked out after this Friday, we will take the time necessary to resolve those.

Question 119. Has OHA received any applications to date?

Answer 119. No.

Question 120. Have any applicant conferences as noted in the RFA section 4.1.4 been scheduled in the future?

Answer 120. The applicant conferences, beyond those already held in March, have not yet been scheduled. They will be scheduled very soon and all applicants that have submitted a letter of intent will be notified.

Question 121. We are a rural clinic & hospital in Washington on the Oregon border. How exactly does this affect our organization? We are currently contracted with OHP and the managed care programs available to OHP clients in this area. The nearest Oregon facility able to provide care to these patients is in Pendleton - a 45 minute drive for some of these patients; we are 10 minutes from them.

Answer 121. Please check the website Health.Oregon.gov after April 3rd to see if an Entity in your area has submitted a Letter of Intent to apply for CCO status. If there is an applicant you should contact them to express your interest and concerns.

Question 122. The RFA requires each CCO applicant to hold a public information session in their local community. I did a check of the website, but couldn't find anything that would allow the public to find out when and where applicants are having these public sessions – didn't see anything like this on the DMAP public meetings calendar. Can you please help point me in the right direction?

Answer 122. Applicants are responsible for scheduling these public meetings and announcing the meeting information to the communities they serve. If you identify applicants in your community when Letters of Intent are posted next week you can contact them to get specific information regarding their public information session.

Question 123. We've been getting mixed messages about the MCO contracts. We've heard that MCO contracts may require us to meet CCO requirements even if we aren't ready to become a CCO. Can you confirm this?

Answer 123. HB 3650 Section 14 directs that MCOs contracting with the OHA are subject to the applicable requirements for CCOs under Sections 4, 6, 8, 10, and 12. OHA is in the process of determining how these requirements can reasonably be applied.

Question 124. When you get back to us in writing about the MCO contract, can you give us an estimated date that we'll know more?

Answer 124. We will provide information on HB 3650 requirements for MCOs on or about May 30, 2012.

Question 125. Section 5.4 of the RFA says that applicants are required to provide a public presentation and invite OHA to attend. We have scheduled two community forums, and I am wondering who from OHA is to be invited.

Answer 125. The OHA will identify the appropriate representative once an invitation is received.

Question 126. Does Oregon Public Meeting Law apply to CCOs? And specifically, will CCO Board meetings be subject to Oregon's Public meeting law?

Answer 126. Oregon Public Meeting Law does not apply to CCOs, including their Board meetings, unless the CCO is a public body. Governance Boards are required to have community representatives.

Question 127. The question about transparency really is about ethics and I'm asking it toward the goal of increasing trust amongst groups of providers. Will providers be familiarized with the authorization process? Will the level of funding from the feds be public knowledge?

Answer 127. This observation will be important for CCOs and their provider network. The RFA asks for information about how CCOs will assure communication within its provider network, including communication with primary care providers.