

**The State of Oregon  
Oregon Health Authority**

**Issues the Following  
Request for Applications**

**for**

**Coordinated Care Organizations (CCOs)**

**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 <sup>1</sup>
Financial Application Due	May 14, 2012

The CCO Letter of Intent to Apply and 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.

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<sup>1</sup> Later Application dates also available. See Section 4.2 and Attachment 3.

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## 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 area for the period starting August 1, 2012, or such later date as OHA determines appropriate. All initial Medicaid Contracts will expire December 31, 2013, and thereafter may be renewed for one-year periods at OHA's discretion, for a period of up to six years. CCO Contracts will be re-solicited in six years.

Pending federal approvals of the proposed Medicare/Medicaid Alignment Demonstration, 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. The Medicare/Medicaid Alignment Demonstration will be conducted for three years, with the anticipated annual renewals during that time period.

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

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 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.

CCOS will provide 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 (2011) and SB 1580 (2012) Health System Transformation. 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 or experiencing health disparities; and to increase preventive services that will improve health and health care for all 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 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 OHP, growth in Medicaid expenditures has continued to outpace state general fund revenue. 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, the forty percent of Medicaid enrollees who are people of color, 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 Fully Capitated Health Plans (FCHPs), 2 Physician Care Organizations (PCOs), 8 Dental Care Organizations (DCOs), and 10 Mental Health Organizations (MHOs)—in addition to health services delivered using fee-for-service (FFS) and the DHS Medicaid-funded LTC delivery system.

Oregon’s Health System Transformation represents an evolution of OHP. CCOs will strengthen the focus on preventive and primary care, evidence-based and culturally-specific services, and more effective management of care. The goals of the CCO will be 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 to reward providers and beneficiaries for achieving good outcomes. In order to incent integration and efficiency, CCOs will receive all eligible Medicaid through a single global budget designed to allow maximum flexibility to support both innovation and investment in evidenced-based care. 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. 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.

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 using FFS into a CCO.

Approximately 200,000 additional Oregonians will become eligible for Medicaid in 2014 with the implementation of Patient Protection and Affordable Care Act. 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.

In mid-April, 2012, 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 (Medicare/Medicaid Alignment Demonstration, or Demonstration). 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. A copy of the Draft Medicare/Medicaid Alignment Demonstration proposal is available for review at: <http://cco.health.oregon.gov/DraftDocuments/Pages/Duals-Proposal.aspx>. If the proposal is approved by CMS, CCOs may apply for the Demonstration, submitting required information to meet CMS and Oregon criteria. Successful Applicants will receive a Three-Way Contract with CMS and the state, in order to simplify and unify funding and rules that plans face when serving individuals who are dually eligible. All subsequent references in this RFA to the Medicare/Medicaid Alignment Demonstration and Three-Way Contract include the condition that they pending federal approval. CCOs elect to participate in the Demonstration or Three-Way Contracts and will not be required to do so. Please see Appendix D for more information.

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 solicits innovative and creative responses from Applicants and identifies the criteria they 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 Applicants will be certified as CCOs for a period of up to six years. CCOs that apply to participate in the Medicare/Medicaid Alignment Demonstration and qualify to do so will be certified for the Demonstration for the three year Demonstration period. OHA may certify multiple CCOs in an area.

Certified CCOs will contract with OHA. Consistent with the CCO's Certification, the Contract will establish the CCO's plans for meeting the criteria laid out in the Application process, 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 updated annually through Contract renewal.

Pending federal approval of Oregon's Demonstration, for CCOs that apply to participate in the Medicare/Medicaid Alignment Demonstration, this RFA and Applicant information will be reviewed jointly with CMS for purposes of certification for the Demonstration, contingent on the CCO satisfying readiness requirements. The form of the Three-Way Contract and further requirements applying to certification for the Demonstration will be announced by addendum to this RFA and in guidance from CMS.

OHA rules and Contract language applicable to CCOs may be amended from time to time to incorporate requirements for providing Coordinated Care Services, including but not limited to Coordinated Care Services for individuals who are dually eligible for Medicare and Medicaid.

### **1.3. Definitions**

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

### **1.4. Authority**

OHA issues this RFA under the authority of ORS 414.651. 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 16, 2012.

### **1.5. Administrative Rules**

OHA has published certain temporary administrative rules governing CCOs and the Application process. OHA expects to publish additional temporary rules within days after the issuance of this RFA, to be followed by a permanent rule-making process for the CCO administrative rules. The official publication of all these administrative rules is with the Secretary of State; *see* [http://arcweb.sos.state.or.us/pages/rules/oars\\_400/oar\\_410/410\\_tofc.html](http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_410/410_tofc.html).

## **SECTION 2 – MINIMUM QUALIFICATIONS**

Applicants must meet all of the following minimum qualifications:

### **2.1. CCO Letter of Intent to Apply**

Applicant has submitted a CCO Letter of Intent to Apply in accordance with Attachment 5.

### **2.2. Legal Entity**

Applicant is a Legal Entity. (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 attests that it will have the Governance Structure described in the ORS 414.625(1)(o) at the time of Readiness Documentation Review described in Section 6.7.

## **SECTION 3 – SCOPE OF WORK**

Work to be performed under the Contract awarded through this RFA is to provide Coordinated Care Services for the CCO's Members, in accordance with the objectives of Health System Transformation, described in the CCO Implementation Proposal. Additional information is in the CCO Administrative Rules (Section 1.5), the Attachments and Tables of the RFA, the RFA Questionnaires (Appendices A-F), the Core Contract (Appendix G), and the Transformation Scope Elements (Appendix H). Pending federal approvals, the scope of work for the optional Medicare/Medicaid Alignment Demonstration will be announced by addendum and other requirements

to be released by CMS. 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 must be included in the Statement of Work. The Core Contract Statement of Work provisions in Appendix G implement core federal and state law requirements. A request for change to or clarification of the Core Contract must be submitted, in accordance with Section 7.1, not later than the Technical Application due date. The OHA may not be able to agree to a request for change that would be inconsistent with federal or state laws.

### **3.2. Transformation Scope Elements**

Applicants have considerable flexibility to design integrated and coordinated care systems. Certification as a CCO in order to achieve the goals of Health System Transformation anticipates that Applicants may propose innovative strategies to ensure Coordinated Care Services within their delivery system network and may request flexibilities to address community-directed objectives. Consequently, Applicants certified as CCOs will enter into Contracts with OHA responsive to those models of care and service delivery. The Applicant's proposed strategies and requested flexibilities will be elicited in the questionnaires (Exhibits A through F) included in this RFA.

Exhibit H contains certain Transformation Scope Elements that are a starting point for incorporating Health System Transformation concepts into Contract language adapted to Applicant's models and strategies. 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 may modify Exhibit H or substitute its own proposed approach to a Scope of Work capturing Transformation Scope Elements. 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 to the Transformation Scope Elements, or its alternative Scope of Work, to inform the OHA about how it proposes to accomplish the Work, including the flexibilities and local initiatives that it proposes. 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.

Applicant may, but is not required to, include the Transformation Scope Elements of Exhibit H in its proposed scope of work. Exhibit H is a starting point but not prescriptive. Applicant may revise or omit provisions of the Transformation Scope Elements in Exhibit H 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 Transformation Scope Elements presented in this RFA. In any event, Applicant must explain how its integrated and coordinated care systems will 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 OHA’s Office of Contracts and Procurement (OC&P) concerning this RFA, including all submission by Applicants, must be directed only to (a) the OHA web portal described in Section 4.1.2 below, or (b) the SPC named below:

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

In addition, OHA expects to announce, by addendum to this RFA, protocols Applicants must follow in any contact regarding this RFA with other State employees or officials. Any unauthorized contact regarding this RFA with other State employees or officials may result in Application rejection. All potential Applicants who have registered for the OHA web portal (see Section 4.1.3 below) must communicate through the exclusive channels identified in this section.

#### 4.1.2. Official and Binding Communications

An electronic web portal established for the administration of this RFA, <http://cco.health.oregon.gov>, will be used to distribute all information regarding this RFA that applies to all Applicants, including addenda to this RFA. 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, written or oral, with State employees and officials other than the SPC are not official and binding unless confirmed by the SPC or 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.

#### 4.1.3. Account Registration

Announcement of this RFA will be posted on “ORPIN,” the Oregon Procurement Information Network. This is a web site hosted by the state’s Department of Administrative Services (DAS) for the purpose of posting and updating RFP information. ORPIN can be accessed with the following web address: <http://orpin.oregon.gov/open.dll/welcome> and view and view *Agency Opportunity number OHA-3402-12*. Possession of an ORPIN registration number is necessary for subsequent account registration on OHA’s web portal.

Official communications regarding this RFA will be on OHA’s web portal, not ORPIN. In order to use OHA’s web portal, all potential Applicants must register on OHA’s web portal. Potential Applicants are encouraged to register as soon as possible after the publication of this RFA.

FAQs, Applicant conference announcements, addenda, and other communications for Applicants may be sent only to registered Applicants. Only registered Applicants will be able to submit documents through the OHA web portal. 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. The following fields will be included in account registration:

- Name: first and last
- Email address
- Mailing address
- Phone
- Company or organization name

OHA web portal registration, may be in the name of a sponsoring organization which need not be the Applicant itself. By addendum to this RFA, OHA expects to publish terms and conditions for use of the web portal, which potential Applicants will have to accept as a condition of continued use of the web portal.

#### **4.1.4. Applicant Conferences**

OHA intends to conduct one or more public Applicant conferences, which will be recorded. Although the Applicant conferences will be public meetings, OHA may limit questions to potential Applicants who have registered an account on OHA's web portal (Section 4.1.3). Announcements of the time and place for Applicant conferences will be sent to all registered potential Applicants.

Following any conference, OHA will distribute in writing, in the form of Q&A or an addendum to this RFA, answers and clarifications on which Applicants may rely. As with all other communications, communications at an Applicant conference are not official and binding unless confirmed by the SPC or reflected in this RFA or an addendum thereto.

#### **4.1.5. Pre-Application Questions or Requests for Clarification**

Questions about, or requests for clarification of, this RFA document (including questionnaires, Contract terms and conditions, or the Application process) may be submitted by the date and time specified in Attachment 3. The exclusive method for submitting written questions or requests for clarification to this RFA is through the web portal. Notification of any answers or clarifications provided in response will be provided and published on the web portal. OHA will attempt to respond to all timely submitted questions or requests for clarification.

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.

## **4.2. 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. Application Schedule**

The Application schedule is set forth in Attachment 3.

Pending federal approval, the schedule for participation in CMS Medicare/Medicaid Alignment Demonstration Dually Eligible Beneficiaries is in Attachment 3, Part 2. See Appendix D in the RFA for more information.

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

#### **4.2.2. Subsequent Application Schedule for 2012**

In light of the developmental nature of the CCO system, OHA will continue to accept Applications after the initial Application date, if the Applicant has submitted its Letter of Intent to Apply by April 2, 2012. 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 2012, 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 and submit a CCO Letter of Intent to Apply by the due date in Attachment 3. The due date for the CCO Letter of Intent to Apply is the same for all Applicants. The CCO Letter of Intent to Apply must be submitted electronically in text-readable pdf form (as specified in Section 5.1.1) to OHA's web portal. When the web portal is open for submitting the CCO Letter of Intent to Apply, OHA will send a notice to all potential Applicants registered on the portal.

A CCO Letter of Intent to Apply must be submitted for any Contract effective date during 2012 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 Attachment 3, then OHA may decline to process the Application.

The CCO Letter of Intent to Apply must be in the form of Attachment 5. The form for the CCO Letter of Intent to Apply in Attachment 5 is mandatory.

A representative authorized to bind the Applicant must sign the CCO Letter of Intent to Apply electronically. OC&P may reject a CCO Letter of Intent to Apply not signed by an authorized representative.

The CCO Letter of Intent to Apply is non-binding, except as 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**

For organizations that are interested in participating in the Medicare/Medicaid Alignment Demonstration, Applicant must submit a Medicare Notice of Intent to Apply to CMS using the CMS forms and by the date required by CMS. The Medicare Notice of Intent to Apply submitted to CMS differs from the CCO Letter of Intent to Apply submitted to OHA. For Medicare Three-Way Contracts with a January 1, 2013 effective date, the Medicare Notice of Intent to Apply is due on April 2, 2012. If Applicant chooses to submit a Medicare Notice of Intent to Apply, Applicant must provide a copy of its Medicare Notice of Intent to Apply to OHA at the same time it submits the CCO Letter of Intent to Apply. OHA will post, on its web site, copies of all Medicare Notices of Intent to Apply received through this RFA process.

### **4.3. Closing Dates; Methods for Electronic Submittal of Applications**

- 4.3.1.** Only Applicants who have submitted a CCO Letter of Intent to Apply may submit an Application. The Technical and Financial Applications must be submitted to OHA's web portal by the dates specified in Attachment 3, 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 Attachment 3 apply to web portal submission. The web portal will post terms and conditions for its use, which Applicant must accept as a condition of web portal account registration (Section 4.1.3) and by its signature on its Application Cover Sheet, Attachment 1. OHA will announce to registered potential Applicants when the web portal is open for submitting Applications.
- 4.3.3.** OC&P will provide all Applicants with an email acknowledgment of receipt of delivery of the components of the Application.

### **4.4. Pre-Application Questions or Requests for Clarification**

Questions about, or requests for clarification of, this RFA document (including questionnaires, Contract terms and conditions, or the Application process) may be submitted by the date and time specified in Attachment 3. OHA's web portal is the exclusive method for submitting written questions or requests for clarification. Notification of any answers or clarifications provided in response will be provided and published on the Web Portal. OHA will attempt to respond to all questions or requests for clarification timely submitted through its web portal.

A request for change to or clarification of the Core Contract in Appendix G may be submitted, in accordance with Section 7.1, not later than the Technical Application due date. All other requests for changes to or clarification of the RFA must be submitted by the date and time specified in Attachment 3.

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 Posting of Application Submissions**

The SPC will post on the OHA web portal each CCO Letter of Intent to Apply, Medicare Notice of Intent to Apply, and (subject to potential claims of confidentiality for designated portions) the Technical Application, as they are received. OHA does not plan to post the Financial Applications.

### **SECTION 5 – APPLICATION REQUIREMENTS**

All Applications must 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.** Except where this RFA requires submissions to be in Excel format, electronic submissions (including the Letter of Intent to Apply) must be in Portable Document Format and must be text-readable (also referred to as text-searchable) rather than scanned or image format, provided that an individual page of a PDF document may contain an illustration or graphic insert that is in scanned or image format. Each pdf document and Excel document must be clearly named with RFA #3402, the Applicant's name (which may be abbreviated), and the document identification including applicable numbering. Applicants may submit supporting data in Excel format.
- 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 may be subject to civil penalties, damages, and criminal prosecution.
- 5.1.4.** If Applicant has submitted any information to CMS for purposes of Medicare Advantage Application, Applicant may provide in response to any substantially similar question on its Application a copy of the relevant portion of its CMS submission, updated as appropriate to address the Coordinated Care Services to be provided under a CCO Contract.

#### **5.2. Technical Application**

Applicant may submit a Technical Application only in accordance with its CCO Letter of Intent to Apply. 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. OC& P may reject an Application not signed by an authorized representative.
- 5.2.2. Attestations, Assurances and Representations:** Complete all sections of the Attestations, Assurances and Representations as required in Attachment 6.

- 5.2.3. Technical Application Check List:** Complete all sections of the Application Check List (Attachment 7).
- 5.2.4. Letters of Support from Key Community Stakeholders:** Provide letters of support from community partners and stakeholders, community mental health, chemical dependency, public health, and groups that identify themselves by age, ethnicity, race, economic status or other defining characteristics.
- 5.2.5. Questionnaires:** Furnish responses to the questionnaires in the following four appendices to this RFA, subject to the page limits shown. Separately submitted supporting documents, tables, and data are not subject to the page limits.

<b>Appendix</b>	<b>Page Limit</b>
A – CCO Criteria Questionnaire	50
B – Provider Participation and Operations Questionnaire	8
C – Accountability Questionnaire	15
D – Medicare/Medicaid Alignment Questionnaire	5

Subject to potential redaction in response to material which Applicant claims by submitting Attachment 2, the Technical Application, including responses to Questionnaires, will be posted in accordance with Section 4.5.

- 5.2.6. Readiness Review Submissions:** Applicant may indicate in its questionnaire responses that certain supporting documents or data will not be ready for submission until the Readiness Review date indicated in Attachment 3. Applicant must submit by the Readiness Review date any such supporting documents or data. OHA may respond that any of the supporting documents or data in question must be submitted promptly in order for OHA to review in connection with Certification and Contract award. See Section 6.7 for information about the Readiness Review.

### **5.3. Financial Application**

- 5.3.1. Submission:** 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, subject to the page limits shown. Separately submitted supporting documents, tables, and data are not subject to the page limits.

<b>Appendix</b>	<b>Page Limit</b>
E – Financial Reporting and Solvency Questionnaire	5
F – Global Budget Questionnaire	4

The Financial Application will not be publicly posted in accordance with Section 4.5.

- 5.3.2. Technical Assistance:** Before the due date for the Financial Application, Applicant may submit drafts of portions of its Financial Application for OHA technical assistance. Submission of a draft does not alter the due date for submission of the Financial Application in final form. Drafts should be clearly labeled “Draft for OHA Technical Assistance.”
- 5.3.3. Readiness Review Submissions:** Applicant may indicate in its Questionnaire E responses that certain supporting documents or data will not be ready for submission until the Readiness Review date indicated in Attachment 3. Applicant must submit by the Readiness Review date any such supporting documents or data. OHA may respond that any of the supporting documents

or data in question must be submitted promptly in order for OHA to review in connection with Certification and Contract award. This option is not available for Questionnaire F.

#### **5.4. Public Presentation by Applicant**

Prior to being certified, Applicant will be required to provide a public presentation in a community forum within the Applicant's service area and invite OHA to attend.

### **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.

Certification will be awarded 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 an initial pass/fail basis.

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

**6.1.2.** Has the Applicant completed and submitted all Section 5.2 and 5.3 Application Requirements, except those expressly deferred for Readiness Review?

#### **6.2. Technical Application Evaluation**

Evaluation of Applicant's Technical Application will be based on criteria included in this RFA and OAR 410-141-3015, including but not limited to the Applicant's demonstrated experience and capacity for:

**6.2.1.** Developing and implementing alternative payment methodologies that are based on the Triple Aim of improving health, health care and lower cost

**6.2.2.** Coordinating the delivery of physical health care, mental health and chemical dependency services, and oral health care.

**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 Members and in the CCO'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.

### **6.3. Financial Application Evaluation**

Evaluation of Applicant's Financial Application will include, criteria in the RFA and OAR 410-141-3015, as well as, 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 be based on criteria included in this RFA and OAR 410-141-3015, including 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, per OAR 410-141-3350:

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

**6.3.1.b.** Maintaining a net worth in an amount at least the greater of (i) five percent of the CCO's average annualized total revenue in the prior two quarters or (ii) its authorized control level risk-based capital (see OAR 410-141-3355) as of May 1, 2012.

**6.3.3.** Operating within a fixed global budget.

### **6.4. Revised Application**

OC&P may 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 it submit its Revised Application, which must include any and all discussed and all negotiated changes.

### **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 constitutes approval for OC&P to obtain any information OC&P deems necessary to conduct the evaluation. OC&P will 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; any prior history of quality and performance; and facility and personnel information. Failure to promptly provide this information may 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. 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 the Medicare/Medicaid Alignment Demonstration will be made for the responsive, responsible Applicants who choose to apply and who have been certified as a CCO and meet the certification standards for the Demonstration. OHA and CMS may enter into negotiations with Applicant before or after certification for the Demonstration. OHA and CMS may choose to not certify an Applicant for the Demonstration or may determine that the Applicant may potentially be certified for the Demonstration in the future if specified conditions are met. At any time after initial certification, OHA or CMS may deny, revoke, debar, or revise Applicant's certification for the Demonstration, 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 the Medicare/Medicaid Alignment Demonstration. 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 CCO Certification, for a Contract, for certification for the Medicare/Medicaid Alignment Demonstration, or for a Three-Way Contract is rejected, Applicant will be promptly notified, in accordance with Section 6.8.
- 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. Readiness Review and Notice to Proceed

- 6.7.1. Readiness Review:** After signing of the Contract, and before its Effective Date, OHA will conduct a readiness review to determinate Applicant's readiness to serve Medicaid beneficiaries. OHA may request documentation from Applicant due by the readiness review document due date shown in Attachment 3. OHA may include in the Contract conditions that Applicant must meet by the readiness review date. For example, OHA may require Applicant to provide OHA with customary legal opinions on the CCO, including a substantive non-consolidation opinion, in form and substance acceptable to OHA and rendered by a law firm acceptable to OHA. In addition, Applicant may elect to defer submitting documentation supporting the answers in its Technical Application or Appendix F Questionnaire response until the readiness review document due date; Applicant must list, in response to questions A.I.s and E.1.2.a, the deferred documents that it plans to submit by the readiness review document due date. Notwithstanding Applicant's response to questions A. I.s and E.1.2.a, OHA may require any documentation earlier as necessary to determine Applicant's qualifications for Certification or Contract award.
- 6.7.2. Notice to Proceed:** If OHA determinates, after its readiness review, that Applicant is ready to serve Medicaid beneficiaries, OHA will issue a notice to proceed to Applicant. The notice to proceed will confirm the effective date of Applicant's Contract to serve Medicaid beneficiaries. If OHA determinates, after its readiness review, that Applicant is unready to serve Medicaid beneficiaries, OHA will not issue a notice to proceed to Applicant, and the effective date of Applicant's Contract to serve Medicaid beneficiaries will be delayed.

## 6.8. Disposition of Applications

- 6.8.1. 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.
- 6.8.2. 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 electronically; or
  - 6.7.2.b.** The Applicant makes any unauthorized contact regarding this RFA with State employees or officials other than the SPC.
- 6.8.3. 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 the Medicare/Medicaid Alignment Demonstration 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 the Demonstration.
- 6.8.4. 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.
- 6.8.5. 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.
- 6.8.6. 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 the Medicare/Medicaid Alignment Demonstration 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.
- 6.8.7. 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 the Medicare/Medicaid Alignment Demonstration; to deny, revoke, or revise Applicant's Certification as a CCO or for the Demonstration; 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>. A request for change to or clarification of the Core Contract must be submitted not later than the Technical Application due date.

### 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;
- 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 the Medicare/Medicaid Alignment Demonstration, or award a Three-Way Contract more limited than what the Application sought.

### **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 this RFA no later than the date identified in Attachment 3. Any written protest to this RFA shall be delivered to the SPC identified in Section 4.1 and shall contain the following information:

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

### **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 date the Technical Applications are due in Attachment 3. An Applicant must prepare and submit any modification to its Application through the Web Portal.
- 7.6.2.** Withdrawals: An Applicant may withdraw its Application by written notice, signed by an authorized representative of the Applicant, through the web portal prior to the Financial Application Due date in Attachment 3.

### **7.7. Release of Information**

No information shall be given to any Applicant (or any other individual) relative to its standing during the RFA process. The information in the Application may be shared with OHA, 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 OHA.

## **7.8. Public Information**

**7.8.1.** The following are public records that OHA intends to disclose publicly when received:

**7.8.1.a.** A CCO Letter of Intent to Apply, and any change to or withdrawal of a CCO Letter of Intent to Apply;

**7.8.1.b.** A Medicare Notice of Intent to Apply;

**7.8.1.c.** Subject to potential redaction under 7.8.3, a Technical Application.

**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), subject to potential redaction under 7.8.3.

**7.8.3.** If Applicant considers any portion of an Application or protest a trade secret as defined in Oregon Revised Statutes 192.501(2) or otherwise exempt from disclosure under Oregon Public Records Law, in order to seek protection from disclosure 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. After review of Attachment 2 as submitted, OHA may redact portions of the Application if it determines that confidential information claimed to be exempt is in fact exempt from disclosure. Interpretation of the Oregon Public Records Law, as determined by OHA upon advice of the Oregon Department of Justice, shall determine if the confidential information claimed to be exempt is in fact exempt from disclosure. OHA may release information notwithstanding its being in fact exempt from disclosure. OHA will not be liable to Applicant or any other person for release of information Applicant claims to be confidential.

**7.8.4.** Any person may request copies of public information. However, copies of Financial 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.

**7.8.5.** 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. Medicaid Contract Period**

Initial term of the Medicaid 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 Medicaid Contract for additional time, with one year renewals, and for additional dollars without further solicitation for a total term of Certification of up to six years. Modifications or extensions shall be by written amendment or renewal duly executed by the parties to the original Contract; see Core Contract, Appendix G.

## **7.12. Contractual Obligation**

OHA is not obligated to enter into a Contract with any Applicant and 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 generally subject to negotiation, but may be changed through submission of a question or protest before the deadline identified in Attachment 3, through Applicant's request for changes to the Core Contract submitted as part of the Technical Proposal. OHA, may not be able to agree to a request for change that would be inconsistent with federal or state laws. 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.

The Contract must be approved by CMS. CMS requires the signed Contract to be sent to CMS no less than 45 days before the Medicaid effective date.

## **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," by the readiness review date.

## **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.** Induce any other person or organization to submit or not submit an Application.

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

- 7.15.1.d. 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.e. 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.f. 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 will be submitted so as to allow OHA using its best impartial judgment in evaluating them. 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 an Applicant under this RFA, 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 an 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 using, for work connected with this RFA, a former employee or consultant 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. Federally Required Conflict of Interest Safeguards**

- 7.15.6.a.** Applicant and its Affiliates shall not recruit, promise future employment, or hire any DHS or OHA employee (or their relative or member of their household) who has participated personally and substantially in the procurement under this RFA as a DHS or OHA employee.
- 7.15.6.b.** Applicant and its Affiliates shall not offer to any DHS or OHA employee (or any relative or member of their household) any gift or gifts with an aggregate value in excess of \$50 during a calendar year or any gift of payment of expenses for entertainment
- 7.15.6.c.** Applicant and its Affiliates shall not retain a former DHS or OHA employee to make any communication with or appearance before OHA on behalf of Applicant in connection with this RFA if that person participated personally and substantially in the procurement under this RFA as a DHS or OHA employee.
- 7.15.6.d.** If a former DHS or OHA employee authorized or had a significant role in this RFA, Applicant and its Affiliates shall not hire such a person in a position having a direct, beneficial, financial interest in the resulting Contract during the two year period following that person’s termination from DHS or OHA.
- 7.15.6.e.** For purposes of this Section:
- (1) “Participates” means actions of a DHS or OHA employee, through decision, approval, disapproval, recommendation, the rendering of advice, investigation or otherwise in connection with the RFA or resulting Contract.
  - (2) “Personally and substantially” has the meaning set forth in 5 CFR 2635.402(b)(4).
  - (3) See the State Public Ethics Law, ORS 244.020, for the definitions of “gift,” “relative” and “member of household”.

**7.15.6. 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 Legal Entity (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. 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.
2. Information and costs included in this Application will remain valid for 180 days after the Application due date or until a Contract is approved, whichever comes first.
3. 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.
4. The undersigned recognizes that this is a public document and will become open to public inspection, except as described in Section 7.8.
5. Applicant 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.
6. Applicant acknowledges receipt of all addenda issued under this RFA, as listed on OHA’s web portal.
7. If awarded a Contract, Applicant will be required to complete, and will be bound by, a Contract described in this RFA. Applicant agrees to the Core 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.
8. If awarded a Contract, Applicant will meet the highest standards prevalent among Medicaid health plans in Oregon.
9. Applicant and its Affiliates complied with the Code of Conduct in Section 7.15 of the RFA in connection with the RFA.
10. Applicant accepts the terms and conditions for OHA’s web portal, as posted on the web portal.
11. Applicant will negotiate in good faith regarding the statement of work for the Contract.

Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

(Authorized to Bind Applicant)

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

**Applicant Name:** \_\_\_\_\_

**Instructions for completing this form:**

**Applicant may not designate any portion of its Letter of Intent to Apply or CMS Notice of Intent to Apply as confidential.**

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**

<b>Event</b>	<b>1<sup>st</sup> Application Date</b>	<b>2<sup>nd</sup> Application Date</b>	<b>3<sup>rd</sup> Application Date</b>	<b>4<sup>th</sup> Application Date</b>
RFA Posted	March 19, 2012	March 19, 2012	March 19, 2012	March 19, 2012
Written Questions and Requests for Clarification Due	March 26, 2012	March 26, 2012	March 26, 2012	March 26, 2012
Registration on OHA Web Portal	March 29, 2012	March 29, 2012	March 29, 2012	March 29, 2012
Written Answers and Clarifications Returned	March 30, 2012	March 30, 2012	March 30, 2012	March 30, 2012
Letter of Intent Due to OHA	April 2, 2012	April 2, 2012	April 2, 2012	April 2, 2012
RFA Protests Due	April 4, 2012	April 4, 2012	April 4, 2012	April 4, 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 14, 2012	July 17, 2012	August 16, 2012	September 14, 2012
Medicaid Contract to CMS <sup>†</sup>	June 15, 2012	July 18, 2012	August 17, 2012	September 17, 2012
Readiness Review Documentation Due	July 3, 2012	August 1, 2012	August 31, 2012	October 1, 2012
Notice to Proceed	July 16, 2012	August 15, 2012	September 14, 2012	October 15, 2012
<b>Medicaid Contract Effective</b>	<b>August 1, 2012</b>	<b>September 1, 2012</b>	<b>October 1, 2012</b>	<b>November 1, 2012</b>

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<sup>†</sup> 45 days before Medicaid Contract Effective Date, unless CMS approves later submission.

**Part 2 – Medicare/Medicaid Alignment Demonstration Application Schedule**

<b>Event*</b>	<b>1<sup>st</sup> Application Date</b>	<b>2<sup>nd</sup> Application Date</b>	<b>3<sup>rd</sup> Application Date</b>	<b>4<sup>th</sup> Application Date</b>
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	April 30, 2012
Previously Submitted Part D Formulary Due to CMS	May 7, 2012	May 7, 2012	May 7, 2012	May 7, 2012
Demonstration Application to CMS Medicare/Medicaid Alignment Benefit Package Due to CMS	May 14, 2012	May 14, 2012	May 14, 2012	May 14, 2012
CMS and OHA Certification for Dual Eligible	May 24, 2012	May 24, 2012	May 24, 2012	May 24, 2012
Three-Way Contract Signed	June 4, 2012	June 4, 2012	June 4, 2012	June 4, 2012
<b>Medicare/Medicaid Alignment Benefits Effective</b>	July 31, 2012	July 31, 2012	August 6, 2012**	***
	Sept. 20, 2012	Sept. 20, 2012	Sept. 20, 2012	***
	<b>January 1, 2013</b>	<b>January 1, 2013</b>	<b>January 1, 2013</b>	***

\*Required for organizations that choose to apply for the Medicare/Medicaid Alignment Demonstration. Additional details/requirements will be shared in forthcoming CMS guidance. *See RFA Appendix D for more information.*

\*\*Currently under discussion with CMS due to risk that joint CMS/OHA readiness review for participation in Medicare/Medicaid 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 when capitalized:

**a. Terms Defined by Rule**

The CCO definition rule, OAR 410-141-3000, incorporate by reference, the definitions in OAR 410-141-0000 and 410-120-0000. *See* RFA Section 1.5 for links to rule postings. In this RFA, the following terms have the meanings defined in OAR 410-141-0000 and 410-120-0000:

**Terms Defined in OAR 410-141-0000**

Action	Fully Capitated Health Plan (FCHP)
Appeal	Grievance
Coordinated Care Services	Grievance System
CCO Payment	Health Services
Cold Call Marketing	Health System Transformation (HST)
Community Advisory Council	Marketing
Coordinated Care Organization (CCO)	Mental Health Assessment
Corrective Action or Corrective Action Plan	Mental Health Organization (MHO)
Covered Services	Non-Participating Provider
Declaration for Mental Health Treatment	Participating Provider
Dental Care Organization (DCO)	Physician Care Organization (PCO)
Diagnostic Services	Prioritized List of Health Services
Disenrollment	Service Area
Enrollment	
Exceptional Needs Care Coordination (ENCC)	

**Terms defined in OAR 410-120-0000**

Abuse	Clinical Record
Acute	Contested Case Hearing
Addictions and Mental Health Division (AMH)	Co-Payments
Advance Directive	Cost Effective
Aging and People with Disabilities (APD)	Date of Service
Adverse Event	Dental Services
Allied Agency	Dentist
Ambulance	Department of Human Services (Department)
American Indian/Alaska Native (AI/AN)	Diagnosis Related Group (DRG)
American Indian/Alaska Native (AI/AN) Clinic	Division of Medical Assistance Programs (Division)
Ancillary Services	Member
Area Agency on Aging (AAA)	Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)
Automated Voice Response (AVR)	Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (aka, Medichex)
Benefit Package	Electronic Data Interchange (EDI)
Children, Adults and Families Division (CAF)	EDI Submitter
Children's Health Insurance Program (CHIP)	Electronic Verification System (EVS)
Citizen/Alien-Waived Emergency Medical (CAWEM)	Emergency Department
Claimant	Emergency Medical Condition
Client	

Emergency Medical Transportation  
Emergency Services  
Evidence-Based Medicine  
False Claim  
Family Planning Services  
Federally Qualified Health Center (FQHC)  
Fee-for-Service Provider  
Flexible Service  
Flexible Service Approach  
Fraud  
Fully Dual Eligible  
General Assistance (GA)  
Healthcare Common Procedure Coding System (HCPCS)  
Health Evidence Review Commission  
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)  
Medicheck for Children and Teens  
Mental Health Case Management

National Correct Coding Initiative (NCCI)  
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) 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  
Prepaid Health Plan (PHP)  
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)  
 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

**b. 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
- (4) Community health worker
- (9) Income
- (13) Patient centered primary care home
- (14) Peer wellness specialist
- (15) Person centered care
- (16) Personal health navigator
- (17) Quality measure
- (18) Resources

**c. 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 legal entity that submits an Application and seeks certification and a Contract. The legal entity is described as the Applicant upon submission of the CCO Letter of Intent to Apply.
- c. Application** means a written response submitted 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 Medicare/Medicaid Alignment Demonstration** means a determination by CMS and OHA that an Applicant or CCO is qualified to participate in the Medicare/Medicaid Alignment Demonstration.
- 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. **Medicare/Medicaid Alignment Demonstration or 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 interested CCOs demonstrating readiness may receive a Three-Way Contract with the CCO, OHA and CMS for the dually eligible 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. **Governance Structure or Governing Board** means the Board of Directors or Board of Trustees of a corporation, or the comparable governing body for any other form of Legal Entity.
- n. **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.

- o. Legal Entity** means a single Legal Entity capable of entering into a risk Contract that covers coordinated care services with the State and conducting the business of a coordinated care organization.
- p. Licensed Insurer** means an organization that holds a Certificate of Authority from DCBS as a health care service contractor or health insurance company.
- q. Office of Contracts and Procurement (OC&P)** means the entity that is responsible for the procurement process for OHA.
- r. OHPB** means the Oregon Health Policy Board.
- 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 dually eligible beneficiaries.
- v. Work** means the required activities, tasks, deliverables, reporting, and invoicing requirements, as described in Section 3-Scope of Work of this RFA.

**ATTACHMENT 5 – CCO LETTER OF INTENT TO APPLY  
RFA #3402**

[On Applicant’s Letterhead]

1. What is Applicant’s Legal Entity name, Oregon headquarters location, and key contact person?
2. What is the Applicant’s desired service area by county or zip code?
3. Who are the Applicant’s key potential Affiliates or sponsoring organizations, if known?
4. What is the Applicant’s desired member capacity? If the Applicant desires to have no limit on capacity, so state.
5. Does the Applicant, or an Affiliate or intended subcontractor of the Applicant, have a contract with the Oregon Health Authority as a Medicaid managed care organization (MCO)? If so, does Applicant expect that contract to be terminated immediately before the effective date of Applicants’s CCO Contract?
6. Is the Applicant, or an Affiliate or intended subcontractor of the Applicant, licensed or expected to be licensed as an insurer (including health care service contractor) with the Oregon Insurance Division?
7. Does the Applicant, or an Affiliate or an intended subcontractor of the Applicant, have or expect to have a contract as a Medicare Advantage Plan with the Center for Medicare and Medicaid Services (CMS)?
8. Attachment 3 describes four possible Application timelines in 2012. Which due date does the Applicant elect for submitting its Technical and Financial Applications? Choose one pair:

<b>Technical/Cost Application dates:</b>	<b>April 30/May 14</b>	<b>June 4/June 11</b>	<b>July 2/July 9</b>	<b>August 1/August 8</b>
<b>Medicaid Contract effective:</b>	August 1, 2012	September 1, 2012	October 1, 2012	November 1, 2012

9. Does the Applicant intend to submit a Medicare Notice of Intent to Apply to CMS? If so, please provide a copy to OHA.

The Applicant acknowledges that this Letter of Intent is non-binding, except that OHA will consider this Letter of Intent will remain in effect and OHA may rely on it until the Applicant changes or withdraws it in accordance with the RFA. The Applicant will submit its Technical and Financial Applications on the dates set forth in this Letter of Intent to Apply, unless Applicant submits to OHA changes to this Letter of Intent to Apply. The Applicant understands this Letter of Intent to Apply will be made public.

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Electronic signature  
Authorized representative of the Applicant (may be Applicant’s sponsor if Applicant is not yet formed)

**ATTACHMENT 6 – ATTESTATIONS, ASSURANCES AND REPRESENTATIONS**

Applicant Name: \_\_\_\_\_

**Instructions:** For each attestation, assurance or descriptive representation below, Applicant will check “yes,” “no,” or “qualified.” On attestations and assurances, a “yes” answer is normal, and an explanation will be furnished if Applicant’s response is “no” or “qualified.” On informational representations, no particular answer is normal, and an explanation will be furnished in all cases. Applicant must respond to all attestations, assurances, and informational representations. The table headings indicate if an item is an attestation, assurance, or informational representation.

These attestations, assurances, and informational representations must be signed by one or more representatives of Applicant who have knowledge of them after due inquiry. They may be signed in multiple counterparts, with different representatives of Applicant signing different counterparts.

Unless a particular item is expressly effective at the time of Application, each attestation, assurance or informational representation is effective starting at the time of readiness review and continuing throughout the term of the Contract.

**Attestations for Appendix A – CCO Criteria**

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
<p><b>Attestation A-1.</b> Applicant will have an individual accountable for each of the following operational functions:</p> <ul style="list-style-type: none"> <li>• Contract administration</li> <li>• Outcomes and evaluation</li> <li>• Performance measurement</li> <li>• Health management and care coordination activities</li> <li>• System coordination and shared accountability between DHS Medicaid-funded LTC system and CCO</li> <li>• Mental health and addictions coordination and system management</li> <li>• Communications management to providers and Members</li> <li>• Provider relations and network management, including credentialing</li> <li>• Health information technology and medical records</li> <li>• Privacy officer</li> <li>• Compliance officer</li> </ul>				

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
<b>Attestation A-2.</b> Applicant will participate in the learning collaboratives required by ORS 442.210.				
<b>Attestation A-3.</b> Applicant will 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 DHS in order to identify and track the elimination of health inequities.				

**Attestations for Appendix B – Provider Participation and Operations Questionnaire**

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
<b>Attestation B-1.</b> Applicant will, as demonstrated with policies and procedures, (i) 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 Member and (ii) reimburse providers for dispensing a 72-hour supply of a drug that requires prior authorization in accordance with OAR 410-141-0070.				
<b>Attestation B-2.</b> Applicant will 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.				
<b>Attestation B-3.</b> Applicant will assure that all provider and supplier contracts or agreements contain the required contract provisions that are described in the Contract.				
<b>Attestation B-4.</b> Applicant will have executed provider, facility, and supplier contracts in place to demonstrate adequate access and availability of Covered Services throughout the requested service area.				
<b>Attestation B-5.</b> Applicant will have all provider contracts or agreements available upon request.				
<b>Attestation B-6.</b> As Applicant implements, acquires, or upgrades				

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
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.				
<b>Attestation B-7.</b> Applicant’s contracts for administrative and management services will contain the OHA required contract provisions.				
<b>Attestation B-8.</b> Applicant will 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.				
<b>Attestation B-9.</b> Applicant will have executed written agreements with providers (first tier, downstream, or related entity instruments) structured in compliance with OHA regulations and guidelines.				
<b>Attestation B-10.</b> 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, will provide ongoing primary care and specialty care as needed and guarantee the continuity of care and the integration of services through: <ul style="list-style-type: none"> <li>• Prompt, convenient, and appropriate access to Covered Services by enrollees 24 hours a day, 7 days a week;</li> <li>• The coordination of the individual care needs of enrollees in accordance with policies and procedures as established by the Applicant;</li> <li>• Enrollee involvement in decisions regarding treatment, proper education on treatment options, and the coordination of follow-up care;</li> <li>• Effectively addressing and overcoming barriers to enrollee compliance with prescribed treatments and regimens; and</li> <li>• Addressing diverse patient populations in a culturally competent manner.</li> </ul>				
<b>Attestation B-11.</b> Applicant will establish policies, procedures, and standards that: <ul style="list-style-type: none"> <li>• Assure and facilitate the availability, convenient, and timely access to all</li> </ul>				

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
<p>Medicaid Covered Services as well as any supplemental services offered by the CCO,</p> <ul style="list-style-type: none"> <li>• Ensure access to medically necessary care and the development of medically necessary individualized care plans for enrollees;</li> <li>• Promptly and efficiently coordinate and facilitate access to clinical information by all providers involved in delivering the individualized care plan of the enrollee;</li> <li>• Communicate and enforce compliance by providers with medical necessity determinations; and</li> <li>• Do not discriminate against Medicaid enrollees, including providing services to individuals with disabilities in the most integrated setting appropriate to the needs of those individuals.</li> </ul>				
<p><b>Attestation B-12.</b> Applicant will have 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.</p>				
<p><b>Attestation B-13.</b> Applicant will provide all services covered by Medicaid and comply with OHA coverage determinations.</p>				
<p><b>Attestation B-14.</b> Applicant, Applicant staff and its affiliated companies, subsidiaries or subcontractors (first tier, downstream, and related entities), and subcontractor staff will be 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).</p>				
<p><b>Attestation B-15.</b> 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.</p>				

**Medicaid Assurances for Appendix B – Provider Participation and Operations Questionnaire**

<p><b>Assurance B-1. Emergency and Urgent Care Services.</b> Applicant will 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 will 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]</p>				
<p><b>Assurance B-2. Continuity of Care.</b> Applicant will 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 will 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]</p>				
<p><b>Assurance B-3.</b> Applicant will 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 Members from the Applicant’s primary care and referral providers. Applicants will 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 will document all monitoring and Corrective Action activities. Such policies and procedures will 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]</p>				
<p><b>Assurance B-4.</b> Applicant will have an ongoing quality performance improvement program for the services it furnishes to its Members. The program will 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</p>				

<p>expected to have a favorable effect on health outcomes and Member satisfaction. The improvement program will track outcomes by race, ethnicity and language. The Applicant will 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]</p>				
<p><b>Assurance B-5.</b> Applicant will make Coordinated Care Services accessible to enrolled Members. The Applicant will not discriminate between Members and non-Members as it relates to benefits to which they are both entitled. The Applicant will 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]</p>				
<p><b>Assurance B-6.</b> Applicant will have written procedures approved in writing by OHA for accepting, processing, and responding to all complaints and Appeals from Members or their Representatives that are consistent with Exhibit I of the Appendix G "Core Contract". The Applicant will 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]</p>				
<p><b>Assurance B-7.</b> Applicant will develop and distribute informational materials to potential Members that meet the language and alternative format requirements of potential Members. The Applicant will 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]</p>				
<p><b>Assurance B-8.</b> Applicant will 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 will 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]</p>				
<p><b>Assurance B-9.</b> Applicant will have written policies and procedures to</p>				

<p>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 will 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]</p>				
<p><b>Assurance B-10.</b> Applicants will provide Intensive Care Coordination (otherwise known as Exceptional Needs Care Coordination or ENCC) to Members who are Aged, Blind or Disabled. The Applicant will 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]</p>				
<p><b>Assurance B-11.</b> Applicant will 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 will have monitoring systems in operation and review the operations of these systems on a regular basis. The Applicant will 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]</p>				
<p><b>Assurance B-12.</b> Applicant will 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 will have monitoring systems in operation and review the operations of these systems on a regular basis. The Applicant will 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]</p>				

<p><b>Assurance B-13.</b> Applicant will 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 will have monitoring systems in operation and review the operations of these systems on a regular basis. The Applicant will 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]</p>				
<p><b>Assurance B-14.</b> Applicant will 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 will have monitoring systems in operation and review the operations of these systems on a regular basis. The Applicant will 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]</p>				

**Informational Representations for Appendix B – Provider Participation and Operations Questionnaire**

<b>Informational Representation</b>	<b>Yes</b>	<b>No</b>	<b>Yes, Qualified</b>	<b>Explanation</b>
<b>Representation B-1.</b> Applicant will have contracts with related entities, contractors and subcontractors to perform, implement or operate any aspect of the CCO operations for the CCO Contract.				
<b>Representation B-2.</b> Applicant has an administrative or management contract with a delegated entity to manage/handle all staffing needs with regards to the operation of all or a portion of the CCO program.				
<b>Representation B-3.</b> Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the systems or information technology to operate the CCO program for Applicant.				
<b>Representation B-4.</b> Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the claims administration, processing and/or adjudication functions.				
<b>Representation B-5.</b> Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the Enrollment, Disenrollment and membership functions.				
<b>Representation B-6.</b> Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the credentialing functions.				
<b>Representation B-7.</b> Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the utilization operations management.				
<b>Representation B-8.</b> Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the Quality Improvement operations.				
<b>Representation B-9.</b> Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of its call center operations.				
<b>Representation B-10.</b> Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the financial services.				

Informational Representation	Yes	No	Yes, Qualified	Explanation
<b>Representation B-1.</b> Applicant will have contracts with related entities, contractors and subcontractors to perform, implement or operate any aspect of the CCO operations for the CCO Contract.				
<b>Representation B-11.</b> Applicant will have an administrative or management contract with a delegated entity to delegate all or a portion of other services that are not listed.				

(Applicant Authorized Officer)

Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

## ATTACHMENT 7 –APPLICATION CHECKLISTS

The checklist presented in this Attachment 7 is provided to assist Applicants in ensuring that Applicant submits a complete Technical Application and Financial Application that will satisfy the pass/fail requirements for an Application submission in accordance with RFA section 6.1.2.

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### 1. Technical Application, Mandatory Submission Materials

- a. Application Cover Sheet (Attachment 1)
- b. Attestations, Assurances and Representations (Attachment 6).
- c. This Technical Application Checklist
- d. Letters of Support from Key Community Stakeholders.
- e. Résumés for Key Leadership Personnel.
- f. Organizational Chart.
- g. Services Area Request (Appendix B).
- h. Questionnaires
  - (1) CCO Criteria Questionnaire (Appendix A).
  - (2) Provider Participation and Operations Questionnaire (Appendix B).
  - (3) Accountability Questionnaire (Appendix C)
    - Services Area Table.
    - Publicly Funded Health Care and Service Programs Table
  - (4) Medicare/Medicaid Alignment Demonstration Questionnaire (Appendix D).

### 2. Technical Application, Optional Submission Materials

If Applicant elects to submit the following optional Application materials, the materials must be submitted with the Technical Proposal:

- a. Transformation Scope Elements (Appendix H).
  - b. Applicant’s Designation of Confidential Materials (Attachment 2).
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**3. Financial Application, Mandatory Submission Materials**

**APPENDIX E**

- a. Certified copy of the Applicant's articles of incorporation.
- b. Listing of ownership or sponsorship.
- c. Chart or listing presenting the identities of and interrelationships between the parent, the Applicant.
- d. Current financial statements.
- e. Contractual verification of all owners of entity.
- f. Guarantee documents.
- g. Developmental budget.
- h. Operational budget.
- i. Monthly staffing plan.
- j. Pro Forma Projections for the First Five Years.
- k. Quarterly developmental budget.
- l. Quarterly operational expenses.
- m. Reinsurance policy.

**APPENDIX F**

- a. Base Cost Template
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## ATTACHMENT 8 - TABLES

The following tables are in a separate document:

**Table B-1: Participating Provider Table**

**Table B-2: Provider Type Codes**

**Table C-1: Year 1 CCO Accountability Metrics**

**Table E-1: Pro Forma Projections for the First Five Years**

**Table E-2: Monthly Developmental Budget**

**Table E-3: Monthly Operational Budget**

**Table E-4: Monthly Staffing Plan**

**Table F-1: Medicaid Program and Services for Inclusion in the CCO Global Budget**

**Table F-2: Estimated Costs and Capitation Rates Spreadsheet**

The lettering of each table indicates the Questionnaire where it is used.

## APPENDIX A – CCO Criteria Questionnaire

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

**Part I: Background Information about the Applicant**

**Part II: Community Engagement**

**Section 1:** Governance and Organizational Relationships

**Section 2:** Member Engagement and Activation

**Section 3:** Transforming Models of Care

**Section 4:** Health Equity and Eliminating Health Disparities

**Section 5:** Payment Methodologies that Support the Triple Aim

**Section 6:** Health Information Technology

For background and guidance, see the CCO Implementation Proposal. Additional Information is located in ORS Chapter 414 related to CCOs and the CCO administrative rules.

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 Members on implementation.

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

### A.I. 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 410-141-3268). If so, describe.
- e. Does the Applicant request changes to or desire to negotiate any terms and conditions in the Core Contract, other than those mandated by Medicaid or Medicare? If so, set forth (in a separate document, which will not be counted against page limits) the alternative language requested.
- f. What is the proposed service area 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.** 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 October 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
- j.** 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 October 1, 2011?
- k.** Does the Applicant include more than one current MCO (e.g., a combination of a current FCHP and MHO)? If so, provide the information requested in this section regarding each applicable current MCO.
- l.** 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?
- m.** 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 insurer 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
  - Other
- n.** 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?
- o.** Does the Applicant hold a current certificate of insurance from the State of Oregon Department of Consumer and Business Services, Insurance Division?
- p.** 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 DHS Medicaid-funded LTC 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.
- q. 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
- r. Provide an organizational chart showing the relationships of the various departments.
- s. Is Applicant deferring submission of any supporting documents, tables, or data that are part of its Technical Application until its readiness review under Section 6.7.1? Please list all deferred submission documents.

## **A.II. 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 Board of each county located wholly or partially within the CCO’s service area.

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 Governance Structure, Community Advisory Council (CAC), and how the governance model will support a sustainable and successful organization that can deliver the greatest possible health care within available resources, where success is defined through the triple aim.

- A.1.1.a.** Provide a description of the proposed Governance Structure, consistent with ORS 414.625.
- A.1.1.b.** Provide a description of the proposed community advisory council (CAC) in each of the proposed services areas and how the CAC was selected consistent with ORS 414.625.
- A.1.1.c.** Provide a description of the relationship of the Governance Structure with the CAC, including how the Applicant will ensure transparency and accountability for the governing body’s consideration of recommendations from the CAC.

- A.1.1.d.** Describe how the CCO Governance Structure will reflect the needs of Members with severe and persistent mental illness and Members receiving DHS Medicaid-funded LTC services and supports through representation on the Governing Board or CAC.

### **A.1.2. 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 across the CCO's entire network of providers and facilities.

- A.1.2.a.** If a CAP is established, describe the role of the CAP and its relationship to the CCO governance and organizational structure.
- A.1.2.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.1.3. Agreements with Type B Area Agencies on Aging and DHS local offices for APD (APD)**

While DHS Medicaid-funded LTC 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 DHS Medicaid-funded LTC services, and will be responsible for coordinating with the DHS Medicaid-funded LTC system. To implement and formalize coordination and ensure relationships exist between CCOs and the local DHS Medicaid-funded LTC providers, CCOs will be required to work with the local type B AAA or DHS' APD local office to develop a Memorandum of Understanding (MOU) or contract, detailing their system coordination agreements regarding Members receiving DHS Medicaid-funded LTC services.

- A.1.3.a.** Describe the Applicant's current status in obtaining MOU(s) or contracts with Type B AAAs or DHS local APD office.
- A.1.3.b.** If MOUs or contracts have not been executed, describe the Applicant's good faith efforts to do so and how the Applicant will obtain the MOU or contract.

### **A.1.4. Agreements with Local Mental Health Authorities and Community Mental Health Programs**

To implement and formalize coordination, CCOs will be required to work with local mental health authorities and community mental health programs to develop a Memorandum of Understanding (MOU) or contract, detailing their system coordination agreements regarding members receiving mental health services.

- A.1.4.a.** Describe the Applicant's current status in establishing working relationships with the Local Mental Health Authorities (LMHAs) and Community Mental Health Programs (CMHPs) operating in the service area to maintain a comprehensive and coordinated mental health delivery system and to ensure member access to mental health services, which are not provided under the global budget.
- A.1.4.b.** How will Applicant ensure that members receiving services from extended or long-term psychiatric care programs (e.g., secure residential facilities, PASSAGES projects, state

hospital) shall receive follow-up services as medically appropriate to ensure discharge within five working days of receiving notification of discharge readiness?

**A.1.4.c.** How will Applicant coordinate with Community Emergency Service Agencies (e.g., police, courts and juvenile justice, corrections, and the LMHAs and CMHPs) to promote an appropriate response to members experiencing a mental health crisis?

#### **A.1.5. Social and support services in the service area**

**A.1.5.a.** In order to carry out the Triple Aim, it will be important for CCOs to develop meaningful relationship with social and support services in the services area. 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, including for individuals with mental illness and substance abuse disorders
- 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, tribal organizations, urban Indian organizations, Indian Health Services and services provided for the benefit of Native Americans and Alaska Natives
- Housing
- Community-based family and peer support organization
- Other social and support services important to communities served

#### **A.1.6. Community Health Assessment and Community Health Improvement Plan**

This section should detail the Applicant’s anticipated process for developing a community health assessment, including conducting the assessment and development of the resultant Community Health Improvement Plan. 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 health assessment. Applicant is encouraged to partner with their local public health authority, hospital system, type B AAA, APD field office, local mental health authority.

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

While developing the initial Community Health Assessment CCOs 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:

[http://public.health.oregon.gov/ProviderPartnerResources/HealthSystemTransformation/Documents/9623B\\_phaHAssessment.pdf](http://public.health.oregon.gov/ProviderPartnerResources/HealthSystemTransformation/Documents/9623B_phaHAssessment.pdf). 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.

In order to avoid duplication the community health 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.

**A.1.6.a.** The Applicant should describe:

- Applicant's community health assessment process, and a strategy to update periodically according to Administrative Rules
- Applicant should describe the mechanisms by which the CAC will meaningfully and systematically engage diverse populations as well as individuals receiving DHS Medicaid-funded LTC and individuals with severe and persistent mental illness, in the community health assessment process.

## **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.** Describe how the Applicant will ensure a comprehensive communication program to engage and provide all Members, not just those Members accessing services, with appropriate information related to benefits and accessing physical health, behavioral health and oral health services, including 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; and
- Meaningfully engage the CAC to monitor and measure patient engagement and activation.

## **Section 3 – Transforming Models of Care**

Transformation relies on ensuring that 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 HST 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 health 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**

**A.3.1.a.** Describe Applicant’s plan to support the provider network through the provision of:

- Technical assistance.
- Tools for coordination.
- Management of Provider concerns.
- Relevant Member data.
- Training and tools necessary to communicate in a linguistically and culturally appropriate fashion with Members and their families.

**A.3.1.b.** Describe Applicant’s plan for engaging Members in achieving this transformation.

Integral to transformation is the patient-centered primary care home (PCPCH), as currently defined by Oregon’s statewide standards in OAR. 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.c.** 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; and
  - 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 two-way communication and coordination between the PCPCH and its other contracting health and services providers to in a timely manner for comprehensive care management.

**A.3.1.d.** Describe how the Applicant’s PCPCH delivery system will coordinate PCPCH providers and services with DHS Medicaid-funded LTC providers and services.

**A.3.1.e.** 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 System Transformation.
- A.3.2.c.** Describe how the Applicant will require two-way communication and coordination between its patient-centered primary health care providers and other contracting health and services providers in a timely manner for comprehensive care management.
- A.3.2.d.** Describe how the Applicant's patient centered primary health care delivery system will coordinate with PCPCH providers and services with DHS Medicaid-funded LTC 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, and include non-traditional health care workers including Community Health Workers, Personal Health Navigators and certified, qualified interpreters.

- A.3.3.a.** Describe the actions taken to assure that coordinated care services are geographically located in settings that are as close to where members reside as possible, are available in non-traditional settings and ensure culturally-appropriate services, including outreach, engagement, and re-engagement of diverse communities and under-served populations(e.g., members with severe and persistent mental illness) and delivery of a service array and mix comparable to the majority population.
- A.3.3.b.** What barriers are anticipated with having sufficient access to coordinated care services for all covered populations by Contract Start Date? What strategies would the Applicant employ to address these barriers?
- A.3.3.c.** Describe how the Applicant will engage their Members of all covered populations to be fully informed partners in transitioning to this model of care.

### **A.3.4. Provider Network Development and Contracts**

- A.3.4.a.** Describe how the Applicant will build on existing provider networks that delivery coordinated care and a team based approach, including how it will arrange for services with providers external to the CCO service area, to ensure access to a full range of services to accommodate member needs.
- A.3.4.b.** Describe how the Applicant will develop mental health and chemical dependency service alternatives to unnecessary inpatient utilization for children and adults, including those with addictive disorders. Discuss strategies the Applicant has used to develop services that divert

members from non-medically necessary inpatient care, decrease length of stay, and prevent readmissions.

- A.3.4.c.** Describe how the Applicant will develop a behavioral health provider network that supports members in the most appropriate and independent setting, including their own home or independent supported living.

### **A.3.5. Coordination, Transition and Care Management**

#### Care Coordination:

- A.3.5.a.** Describe how the Applicant will support the flow of information between providers, including DHS Medicaid-funded LTC care providers, mental health crisis services, and home and community based services, covered under the State's 1915(i) State Plan Amendment (SPA) for Members with severe and persistent mental illness, in order to 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 and other service providers such as Community Developmental Disability Programs and brokerages for Members with developmental disabilities, that effectively coordinates services and supports for the complex needs of these Members.
- A.3.5.e.** Describe how the Applicant will meet state goals and expectations for coordination of care for Members with severe and persistent mental illness receiving home and community based services covered under the State's 1915(i) SPA and Members receiving DHS Medicaid-funded LTC services, given the exclusion of DHS Medicaid-funded LTC services from global budgets.
- A.3.5.f.** Describe the evidence-based or innovative strategies the Applicant will use within their delivery system network to ensure coordinated care, including the use of non-traditional health workers, 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.g.** 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.h.** 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.i.** 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 and the state hospitals.
- A.3.5.j.** Describe the Applicant’s plan to coordinate and communicate with Type B AAA or APD to promote and monitor improved transitions of care for Members receiving DHS Medicaid-funded LTC services and supports, so that these Members receive comprehensive transitional care.
- A.3.5.k.** 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, including Members with severe and persistent mental illness receiving home and community-based services covered under the State’s 1915(i) State Plan Amendment. Care plans will reflect Member or family/caregiver preferences and goals to ensure engagement and satisfaction.

- A.3.5.l.** 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, including Members with severe and persistent mental illness receiving home and community based services covered under the State’s 1915(i) SPA.
- A.3.5.m.** 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 DHS Medicaid-funded LTC services.
- A.3.5.n.** Describe how the Applicant will factor in relevant referral, risk assessment and screening information from local type B AAA and APD offices and DHS Medicaid-funded LTC providers; and how they will communicate and coordinate with type B AAA and APD offices

- A.3.5.o.** Describe how the Applicant will reassess high-needs Members at least semi-annually or when significant changes in status occur to determine whether their care plans are effectively meeting their needs in a person-centered, person-directed manner.
- A.3.5.p.** Describe how individualized care plans will be jointly shared and coordinated with relevant staff from type B AAA and APD with and DHS Medicaid-funded LTC providers

### **A.3.6. Care Integration**

#### **Mental Health and Chemical Dependency Services and Supports**

- A.3.6.a.** Describe how the Applicant has or will develop 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 and all covered populations.
- A.3.6.b.** Describe how the Applicant will provide care coordination, treatment engagement, preventive services, community-based services, behavioral health services, 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 with limited social support systems. Describe also how the Applicant will transition Members out of hospital, including state hospitals and residential care settings into the most appropriate, independent and integrated community-based settings.
- A.3.6.c.** Describe how the Applicant has integrated care and service delivery to address mental health and chemical dependency issues by proactively screening for and identifying Members with them, arranging and facilitating the provision of care, development of crisis intervention plans as appropriate, and coordinating care with related Health Services including DHS Medicaid-funded LTC 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, including:
- Integrated prevention services at the clinical and community level
  - Integration of primary care across systems
  - Qualified service providers and community resources designed and contracted to deliver care that is strength-based, family-focused, community-based, and culturally competent;
  - Network of crisis response providers to serve members of all ages; and
  - Recognized evidence-based practices, best emerging practices and culturally competent services that promote resilience through nationally recognized integrated service models

#### **Oral Health**

No later than July 1, 2014, ORS 414.625 requires each CCO to have a formal contractual relationship with any DCO that serves Members of the CCO in the area where they reside.

- A.3.6.e.** Describe the Applicant's 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 oral health needs, prevention and wellness as well as facilitating appropriate referrals to dental.

### **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 Members, with the PCPCH or primary care provider and the member in central treatment planning roles.

### **A.3.7. DHS Medicaid-funded Long Term Care Services**

CCOs will be responsible for the provision of health services to Members receiving DHS Medicaid-funded LTC services provided under the DHS-reimbursed LTC program. DHS Medicaid-funded LTC services include, but are not limited to, in-home supports/services, Adult Foster Care, Residential Care Facilities, Assisted Living Facilities, DHS Medicaid-funded 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 areas where contracted to transportation brokerages) and PACE state plan (including Medicare benefits).

- A.3.7.a.** Describe how the Applicant
- Will effectively provide health services to Members receiving DHS Medicaid-funded LTC services whether served in their own home, community-based care or nursing facility and coordinate with the DHS Medicaid-funded LTC delivery system in the Applicants service area, including the role of type B AAA or the APD office;
  - Will use best practices applicable to individuals in DHS Medicaid-funded LTC settings including best practices related to care coordination and transitions of care;
  - Will use, or participate in, any of the following models for better coordinating care between the health and DHS Medicaid-funded 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 healthcare settings or co-locating behavioral health specialists in health or other care settings where Members live or spend time,
    - Team approaches: care coordination positions jointly funded by the DHS Medicaid-funded LTC and health systems, or team approaches such as a multi-disciplinary care team including DHS Medicaid-funded LTC representation,
    - Services in Congregate Settings: DHS Medicaid-funded LTC and health services provided in congregate settings, which can be limited to one type of service, 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: 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.** Describe how the Applicant will perform the following UM activities tailored to address the needs of diverse populations including members receiving DHS Medicaid-funded LTC services, members with special health care needs, members with intellectual disability and developmental disabilities, adults who have serious mental illness and children who have serious emotional disturbance.

- How will the authorization process differ for acute and ambulatory levels of care
- Describe the methodology and criteria for identifying over- and under-utilization of services

## **Section 4 - Health Equity and Eliminating Health Disparities**

Health equity and identifying and addressing health disparities are an essential component of HST. 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.** CCOs 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. Describe how the Applicant and its providers will achieve this objective.

**A.4.2.** Describe how the Applicant will track and report on quality measures by these demographic factors that includes race, ethnicity, primary language, mental health and substance abuse disorder data.

## **Section 5 - Payment Methodologies that Support the Triple Aim**

**A.5.1.** Demonstrate how Applicant's payment methodologies promote or will promote the Triple Aim and in particular, how the Applicant will:

- Provide comprehensive coordination or create shared responsibility across provider types and levels of care and creates incentives for using such delivery systems such as PCPCHs;
- Provide financial support, differentially based on the tier level achieved, to PCPCHs for meeting the PCPCH standards;
- Align financial incentives for evidence-based and best emerging practices.

## **Section 6 - Health Information Technology**

**A.6.1. Health Information Technology (HIT), Electronic Health Record Systems (EHRs) and Health Information Exchange (HIE)**

**A.6.1.a.** Describe the Applicant's current capacity and plans to improve HIT in the areas of data analytics, quality improvement, patient engagement through HIT (using tools such as email, personal health records, etc.) and other HIT.

**A.6.1.b.** What are the Applicant's strategies to track and increase adoption rates of federal ONC certified EHRs?

**A.6.1.c.** Describe how the Applicant will facilitate meaningful use and HIE and also ensure that every provider in its network is either:

- 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
- 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.

## APPENDIX B – Provider Participation and Operations Questionnaire

This questionnaire consists of three sections:

- Section 1:** Service Area and Capacity
- Section 2:** Standards Related To Provider Participation
- Section 3:** Assurances of Compliance with Medicaid Regulations and Requirements

The information requested in this questionnaire is focused on the essential provider participation and operations elements that are necessary for an Applicant to demonstrate its ability to meet Medicaid requirements, and achieve Health System Transformation. Applicant should submit its information in the requested format or in narrative form that clearly identifies the standard or assurance being addressed.

### Section 1 - Service Area and Capacity

List the service area(s) the Applicant is applying for and the maximum number of Members the Applicant is proposing to accept in each area based upon the Applicant's community health assessment and plan for delivery of integrated and coordinated health, mental health, and chemical dependency treatment services and supports (and Dental Services when Applicant has a contract with a DCO).

OHA reserves the right to set the maximum number of Members an Applicant may contract to serve and the area(s) an Applicant may serve based upon OHA's evaluation of the Applicant's ability to serve Members, including dually eligible Members. Applicants may apply for partial or entire service area(s). These full or partial service areas must be identified by zip code. Applicants should submit this information in an Excel or similar format to incorporate all the service area(s) it is applying for; however, the structure and information cited in this form must remain the same as indicated.

**Service Area Table**

<b>Service Area Description</b>	<b>Zip Code(s)</b>	<b>Maximum Number of Members-Capacity Level</b>

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 will 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 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 health 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 health assessment and plan for delivery of integrated and coordinated health, mental health, and chemical dependency treatment services and supports (and Dental Services when Applicant has a contract with a DCO), 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
- Assertive Community Treatment
- Chemical dependency treatment providers
- Community Health Workers
- Community prevention services
- Dialysis services
- Federally qualified health centers
- Health Care Interpreters (qualified/certified)
- Health education, health promotion, health literacy
- Home health
- Hospice
- Hospital
- Imaging
- Intensive Case Management
- 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
- Supported Employment

- Tertiary hospital services
- Tribal and Urban Indian Health Services
- Urgent care center
- Others not listed but included in the Applicant’s integrated and coordinated service delivery network.

**INSTRUCTIONS:** As part of the readiness review process, submit the information in Table B-1 (Participating Provider Table) about each provider or facility using the format in Excel for each category of service provider or facility listed above. For example, all Addiction 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.

Note: As part of the readiness 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.

## **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 health 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 DCO, include the dental providers who meet this standard.

#### **Required Response**

As part of the readiness review process, 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.

**Publicly Funded Health Care and Service Programs Table**

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 #7A– Mental Illness Services**

- (a) Describe how the Applicant will provide community-based mental health services to Members, including Members receiving home and community-based services under the State’s 1915(i) SPA.
- (b) Describe how the Applicant will screen all eligible Members for mental illness to promote prevention, early detection, intervention and referral to mental health treatment – especially at initial contact or physical exam, initial prenatal exam, when a Member shows evidence of mental illness, or when a Member over-utilizes services.

## **Standard #7B – Chemical Dependency Services**

- (a) Describe how the Applicant will provide community-based chemical dependency services to Members, including Members receiving home and community-based services under the State’s 1915(i) SPA.
- (b) Describe how the Applicant will screen all eligible Members for chemical dependency to promote prevention, early detection, intervention and referral to mental health treatment – especially at initial contact or physical exam, initial prenatal exam, when a Member shows evidence of mental illness, or when a Member over-utilizes 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.
- (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) 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 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.
- (g) Describe Applicant’s ability to engage and utilize 340B enrolled providers and pharmacies as a part of the CCO.
- (h) Describe Applicant’s ability and intent to use Medication Therapy Management (MTM) as part of a Patient Centered Primary Care Home
- (i) Describe Applicant’s ability to utilize E-prescribing and its interface with Electronic Medical Records (EMR).

**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, and less intensive interventions 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 innovative strategies that could be employed to decrease unnecessary hospital utilization.

### **Section 3 - Assurances of Compliance with Medicaid Regulations and Requirements**

Attachment 6 has fourteen assurances of Compliance with Medicaid Regulations and Requirements. These Assurances address specific Medicaid regulatory requirements that must be met in order for the Applicant to qualify for Certification as a CCO. 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. This section of Questionnaire B asks the Applicant to provide a brief narrative of how the Applicant meets the applicable Assurance. The Applicant must provide supporting materials available to the OHA upon request – which may occur before or after approval.

Please describe in a brief narrative how Applicant meets the standards and complies with the Medicaid requirements cited in the Medicaid Assurances in Attachment 6:

1. Medicaid Assurance #1 - Emergency and Urgent Care Services
2. Medicaid Assurance #2 - Continuity of Care
3. Medicaid Assurance #3 - Medical Record Keeping
4. Medicaid Assurance #4 - Quality Improvement
5. Medicaid Assurance #5 - Accessibility
6. Medicaid Assurance #6 - Grievance System
7. Medicaid Assurance #7 - Potential Member Informational Requirements
8. Medicaid Assurance #8 - Member Education
9. Medicaid Assurance #9 - Member Rights and Responsibilities
10. Medicaid Assurance #10 - Intensive Care Coordination
11. Medicaid Assurance #11 - Billing and Payment Standard
12. Medicaid Assurance #12 - Trading Partner Standard
13. Medicaid Assurance #13 - Encounter Data Submission and Validation Standard – Health Services and Pharmacy Services
14. Medicaid Assurance #14 - Enrollment and Disenrollment Data Validation Standard

## APPENDIX C – Accountability Questionnaire

This questionnaire consists of two sections:

**Section 1:** Accountability Standards

**Section 2:** Quality Improvement Program

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 HST. 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 (2013), CCOs accountability will be for reporting only. In year 2 (2014) and beyond, 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. 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 Attachment 8, Table C-1 (Year-one CCO Accountability Metrics), 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.

*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 DHS Medicaid-funded LTC:* DHS 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 DHS Medicaid-funded LTC system will need to coordinate care and share accountability. A set of CCO-DHS Medicaid-funded 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 DHS Medicaid-funded 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.

## **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.

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 DCOs, 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 Applicant’s governance and organizational structure will achieve best clinical practices.

## **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 System 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.
- 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.

## APPENDIX D – Medicare/Medicaid Alignment Questionnaire

This Appendix consists of the following sections:

**Section 1:** Background Information

**Section 2:** Participation in the Demonstration (Pending CMS approvals)

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

The OHA is preparing a formal proposal to CMS for a Demonstration to integrate care for individuals dually eligible for Medicare and Medicaid (Medicare/Medicaid Alignment Demonstration). 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. Interested CCOs may apply for the Demonstration; CCOs will not be required to participate. .

Oregon's proposal to CMS was released for a 30-day public comment period on March 5, 2012, and can be viewed online at: <http://cco.health.oregon.gov/DraftDocuments/Pages/Duals-Proposal.aspx>. Following that public comment period, the proposal will be submitted to CMS, with a current target date of mid-April, at which time CMS will have their own 30 day public comment period. If Oregon's proposal receives federal approval, following the CMS public comment period, CMS and Oregon will negotiate remaining requirements and finalize payment rates for CCOs participating in the Demonstration. These details will be part of a memorandum of understanding (MOU) between CMS and OHA targeted to be signed in summer 2012. The timeline of the CMS process means that plans will be initially certified to become CCOs by OHA, and then the Certification of interested CCOs for the Medicare/Medicaid Alignment Demonstration will take place in summer 2012. The target date for CCOs to begin providing Medicare services through the Demonstration 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. In order to participate in the Three-Way Contracts and offer Medicare benefits, interested CCOs will be asked to provide additional information as part of the CMS certification process and will need to meet additional requirements. On January 25, 2012, CMS 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 January 25 CMS guidance linked above outlines some of the key areas of plan requirements where there will be additional CMS requirements or where additional requirements will be negotiated between CMS and the state. CMS expects to release further guidance after this RFA is posted, describing Medicare plan requirements in more detail.

In particular, Applicants interested in participating in the Medicare/Medicaid Alignment Demonstration will be required to meet CMS criteria in the following areas:

- **Past Medicare performance:** Applicant may not be under enrollment and/or marketing sanction by CMS. In addition, CCOs that have not met specific Medicare performance expectations, to be described by CMS in its forthcoming guidance, will not be eligible for passive enrollment until the entity meets performance expectations.
- **Demonstration Application:** A Demonstration Application will be due to CMS May 24, 2012, including specific attestations and supporting documentation related to the Medicare elements of the Demonstration. The Demonstration Application will be submitted via the CMS Health Plan Management System (HPMS). HPMS supports contract management for Medicare health plans and

prescription drug plans, and supports data and information exchanges between CMS and health plans. Demonstration Application information due May 24 will include, but is not limited to, the following areas:

- Part D
- Solvency/Licensure
- Fiscal Soundness
- Administrative and Financial Arrangements
- Network Adequacy: Medical Services and Prescription Drugs
- Model of Care

In addition to the forthcoming CMS guidance, further requirements will be negotiated between CMS and OHA and will be announced by addendum to this RFA. At that time, further attestations and supplemental information will be required. Attestations will include, but not be limited to, the following areas:

- Quality Reporting Requirements
- Marketing
- Appeals
- Service Area/Capacity
- Beneficiary Participation on Governing and Advisory Boards
- Encounter Reporting
- Customer Service
- Privacy
- Credentialing

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

There are a number of key CMS deadlines that interested Applicants must meet in order to participate in the Demonstration/Three-Way Contracts and offer Medicare benefits, for those Applicants that choose to apply. The January 25<sup>th</sup> 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 Applicants 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
- May 24, 2012 – Demonstration Application to CMS
- 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

**D.2.1.** Has the Applicant submitted the required CMS Notice of Intent to Apply prior to the April 2<sup>nd</sup> deadline? If so, a copy must be submitted with the Applicant's Letter of Intent to OHA.

**D.2.2.** Has the Applicant submitted the required CMS User ID connectivity form? Interested Applicants will need to submit a CMS User ID connectivity form to CMS no later than April 9, 2012 to ensure user access to the CMS Health Plan Management System (HPMS). This is used for submission of

the Demonstration Application to CMS, as well as formulary and plan benefit package information.

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.

**D.2.3.** Does Applicant or any Affiliate or subcontractor of Applicant currently have a contract with or have submitted an application to CMS to serve Medicare beneficiaries in 2013? If so, describe if it is:

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

**D.2.4.** Describe the length of time and contract history with CMS or its intermediaries for any Medicare line of business for Applicant or any Affiliate or subcontractor of Applicant.

Formulary development is an extensive body of work, particularly for plans that have not previously offered a Part D plan. CMS has encouraged Applicants interested in participating in the Demonstration 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 Applicants on the Medicare Part D requirements and has provided an email address for any questions: [CMSMMCOcapsmodel@cms.hhs.gov](mailto:CMSMMCOcapsmodel@cms.hhs.gov).

**D.2.5.** For Applicants who are interested in participating in the Demonstration only:

**D.2.5.a.** How does the Applicant intend to meet the CMS Part D requirements, including the formulary requirement?

**D.2.5.b.** Has the Applicant previously offered a Part D benefit?

**D.2.5.c.** 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?

## APPENDIX E – 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

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

#### E.1.1. Corporate Organization and Structure

- E.1.1.a.** Provide a certified copy of the Applicant’s articles of incorporation as filed with the Oregon Secretary of State.
- E.1.1.b.** Provide listing of ownership or sponsorship, including the percentage Control each owner has over the organization.
- E.1.1.c.** Provide a description of any licenses the corporation possesses.
- E.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.
- E.1.1.e.** 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. Affiliate contracts are excluded in this item and should be included under item E.1.2.b.

#### E.1.2. Corporate Affiliations, Transactions, Arrangements

- E.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 code 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.

- E.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.

### E.1.3. General Questions

**E.1.2.a.** Is Applicant deferring submission of any supporting documents, tables, or data that are part of its Technical Application until its readiness review under Section 6.7.1? Please list all deferred submission documents.

**E.1.2.b.** Describe Applicant's demonstrated experience and capacity for:

- Managing financial risk and establishing financial reserves
- Meeting the minimum financial requirements for restricted reserves and net worth in OAR 410-141-3350.

### Section 2: Demonstration of Financial Solvency

The following standard applies as of the CCO's Medicaid effective date and/or the CCO's Medicare/Medicaid Alignment Demonstration 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.

#### **E.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

**E.2.1.a.** Applicant shall establish and maintain restricted reserve funds per OAR 410-141-3350(A). 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

**E.2.1.b.** Applicant shall maintain, at all times, a level of net worth, per OAR 410-141-3350 (B) and (C). 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.

- E.2.1.c.** An Applicant must also have sufficient working capital above the minimum, as required by OAR 410-141-3350(D), in order to maintain the minimum net worth requirement at all times.

### **Required Response**

- E.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 410-141-3340(6) using the format set forth in Table E-1: Pro Forma Projections for the First Five Years. 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, using Table E-1: Pro Forma Projections for the First Five Years. 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.

- E.2.1.e.** Provide a developmental budget delineating all expenses prior to beginning operation using Table E-2: Monthly Developmental Budget.

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.

- E.2.1.f.** Provide an operational budget covering the initial two years of operation using Table E-3: Monthly Operational Budget as a model.

The budget should factor in projected utilization levels by key categories of service, and projected expenditures reflecting HST 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 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).

- E.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 Attachment 8, Table E-4: Monthly Staffing Plan as a model. Express the staffing requirements in Full-Time-Equivalents (FTEs).

If the staffing resources required to provide services to 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.

**E.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 using Table E-1: Pro Forma Projections for the First Five Years. The pro forma financial statements should reflect corporate-wide activity. Pro forma financial statements should be prepared using Statutory Accounting Principles. The amounts and expenses included in the monthly staffing budgets from D.2.1.g 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 pro forma financial statements to form an overall account of the projected required capital for the CCO's development and first five years of operation

## **E.2.2. Measurement Standard (Applies to Existing and Newly Formed Insurers)**

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

### **Required Response**

- E.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.
- E.2.2.b.** Provide quarterly developmental budget delineating any additional expenses the insurer will incur to fulfill its obligations as a CCO. See required response E.2.1.e above for instructions.
- E.2.2.c.** Provide quarterly operational expenses the insurer will incur to fulfill its obligations as a CCO. See required response E.2.1.f above for instructions.
- E.2.2.d.** Provide monthly staffing plan related to fulfillment of the insurer's CCO operations. See required response E.2.1.g above for instructions.
- E.2.2.e.** Provide pro forma financial statements as outlined in E.2.1.h above. The pro forma financial statements should reflect corporate-wide activity.

## Section 3 - Demonstration of Ability to Achieve the Financial Goals

### E.3.1. General Questions Relating to Financial Management

**E.3.1.a.** Describe how the Applicant uses best practices in the management of finances, contracts, claims processing, payment functions and provider network administration.

**E.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; and
- 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, and
  - Administrative cost allocation across books of business (including Medicaid, Medicare, and commercial). Describe in detail any cost allocation arrangements with Affiliates.

## APPENDIX F – Global Budget Questionnaire

This Appendix consists of the following sections and tables (table are in a separate document):

- Section 1:** General Questions on Global Budgeting
- Section 2:** Coordinated Care Organization (CCO) Cost Estimate Procedures
- Table F-1:** Medicaid Program and Services for Inclusion in the CCO Global Budget
- Table F-2:** Estimated Costs and Capitation Rates spreadsheet

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, DCOs. 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-LTC Medicaid expenditures, exceptions to service or program inclusion in the global budgets should be minimal. However, consideration could be given to Applicant 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. Applicants 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 Applicants 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 DHS Medicaid-funded LTC 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 Contractor 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. Contractor's 1<sup>st</sup> 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, MHOs and, if included, DCOs; and
- An add-on component to the capitated portion for the remaining Medicaid services or programs not currently included in Capitation Payments.

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 Contractor 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 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. This approach provides a key role for Applicants 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 Applicants 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 an Applicant can accept in its "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 Contractor's capitation rates. If Applicant proposes to operate in geographic areas where it has 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.

Applicants will submit base costs to OHA on the schedule shown in Table F-2. OHA's Actuarial Services Unit will be available for technical assistance and work closely with Applicants to help them prepare and submit their base cost estimates. If an Applicant declines to provide a base cost template, OHA will not certifying the Applicant.

The Applicant's submitted rates will be reviewed by OHA's actuary and assessed for reasonableness based on documentation that the Applicant 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 area level, and will confer with the Applicant 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, OHA's 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 Contractor will 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, Contractor, 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 Contractor 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 that do not penalize CCOs for successfully lowering costs.

### **Section 1 - General Questions Regarding Global Budgeting**

- F.1.1.** Applicant must describe its 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 Attachment 8, Table F-1?
- F.1.6.** Which programs and services can the Applicant provide in Attachment 8, Table F-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.** Does Applicant 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 and with a completed Base Cost Template in Attachment 8, Table F-2 using internal cost data that is representative of a minimum base population, for 1<sup>st</sup> year global budgets to include:
  - Per Member per month payments for services currently **provided through the OHP physical health plans, MHOs and, if included, DCOs.**

### **Section 2 - Coordinated Care Organization (CCO) Cost Estimate Procedures**

The CCO Cost Estimate Template is attached to the RFA as Table F-2. This Template will allow the Applicants to begin development of their 2012-13 Contract Year Base Cost Estimate. Using their existing data Applicants will complete the template for their base cost areas. This Base Cost Template will be used to develop the basis of the CCO Capitation Rate. Using a risk adjustment methodology, OHA Actuarial Services Unit (ASU) will adjust the base cost for the expansion areas and expansion populations. Then using Applicant's submitted costs and encounter data, ASU will calculate adjustments for certain select services such as Maternity Case Rates that will be used to develop a comprehensive CCO Capitation Rate. The Applicants will then have an opportunity to review these rates and methodologies as part of the Contract negotiation process.

The RFA requires Applicants to submit letters of intent that stipulate the areas that they wish to cover and their expected enrolled capacity. Once the letter of intent is submitted, ASU encourages Applicants to submit Steps 1-3 in the Cost Template. These steps comprise the basic cost and enrollment functions of the template, and completion of these sections will allow ASU to update the CCO Templates with Applicant specific expansion area and population risk adjustment profiles. In the event that multiple CCO's apply for the same service area, a standard algorithm will be applied to estimate an appropriate

division of the enrollable population. This may or may not reflect the final approved population; however, this will allow OHA and the Applicant to make general assumptions about the associated risk of the population in question.

Once the CCO Templates are updated, ASU will return the Templates to the Applicant within 5 working days so the Applicant may continue the RFA Application Process. Starting the first week in April and continuing through the financial Application deadline ASU will host weekly technical meetings open to all Applicants to provide technical assistance and answer questions. All questions and responses will be posted to the RFA Website and available to all Applicants. Upon request and subject to staff availability ASU will also schedule and conduct one on one technical assistance meetings with potential Applicants. All questions and responses that do not divulge proprietary information will be part of the RFA process and posted accordingly.

**APPENDIX G – Core Contract**

**RFA# 3402**

*[See separate document]*

**APPENDIX H – Transformation Scope Elements**

**RFA# 3402**

*[See separate document]*