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April 25, 2012

RFA 3402

Addendum #13

1. This is Addendum # 13 to Request for Application (RFA) 3402, Coordinated Care Organizations (CCOs).
2. RFA #3402 is hereby amended as follows:
 - a. A 1st wave Applicant may correct its Technical Application no later than one week after the date of this Addendum 13, to the extent such corrections result from the changes made by this Addendum 13. The 1st wave applicant shall make such corrections by submitting any corrected document by email to the Sole Point of Contact, with the corrections marked in the submission.”
 - b. Attachment 8, Table F-2 “Estimated Costs and Capitation Rates” spreadsheet, is replaced in its entirety with Attachment 1 to this Addendum 13.
 - c. In accordance with Section 4.4 of the RFA, OHA provides answers to questions received by OHA via: email to the SPC and the Webinars conducted by OHA on March 22, 2012, March 27, 2012, April 4, 2012, and April 12, 2012 (not including answers provided in Addendum 2, Addendum 4 or Addendum 8 to this RFA). The following are OHA’s official answers:

Governance/Organizational Requirements Questions

Question 1. Can you please clarify the State’s expectations around the timing of the formation of the Community Advisory Council?

Answer 1. The Community Advisory Council (CAC) must be formed and named no later than the time of Contract execution.

Question 2. Please clarify if you expect names for the governance board or just positions or titles? This would require the Community Advisory Council (CAC) to be formed prior to Application.

Answer 2. Both the governance board and the CAC must be formed at the time of Contract execution. Names of the governance board or the CAC will not be required at the time the Application is submitted, but names will be required by the time of Contract signing. At Application, describe the processes that are being used to develop the appropriate governance and CAC membership.

Enrollees/Covered Populations Questions

Question 3. If we set our maximum capacity for 10,600 does this mean the State can auto assign up to 120% of this maximum (12,720). If this is the case then I will cap my maximum at 9000 or its current limit (10,800) with 120% auto assign by the State.

Answer 3. OHA does auto assign up to 110% of capacity.

Provider Questions

Question 4. Appendix B: Attachment 6, please define these two assurances:
As a CCO how will we have knowledge of “potential members”?
Define Trading partner standard.

7. Medicaid Assurance #7 - Potential Member Informational Requirements
12. Medicaid Assurance #12 - Trading Partner Standard

Answer 4. A Potential Member means an OHP Client who is subject to mandatory Enrollment or may voluntarily elect to enroll in a CCO, but is not yet enrolled with a specific CCO.

The term trading partner refers to the relationship between the CCO and the Authority in conducting electronic data transactions (EDI) such as encounter data submission that are governed by the HIPAA Transactions Standards. OHA’s website has useful information about the EDI requirements at <http://health.oregon.gov/OHA/edi/index.shtml>

Question 5. Line 15 of this table asks for credential verification. Mental Health providers hold Certificate of Approvals to provide mental health services. The individual therapists at the agencies are credentialed but we do not hold individual contracts with the individual therapists (unless they are psychiatrists). How should I complete Line 15? The Certificate of Approval date for the Mental Health providers or a list of the individual therapists and there credentialed date or both?
Thanks

Answer 5. Both.

Question 6. I have a question regarding Table B-1 of the CCO RFA. I would like some clarification on whether or not it would be appropriate to list the participating providers by clinic and include specialty codes within each clinic. This, as opposed to listing each provider, would be much more efficient. What are your thoughts?

Answer 6. Within each clinic is fine as long as we have assurance that each provider is accounted for.

- Question 7.** Regarding RFA Attachment 8 – this format is very similar to the FCHP Exhibit K, with one exception – the current Exhibit’s last column is for “Service Area”, while the Exhibit 8 lists “Contract Start Date” and “Contract End Date”. As an existing FCHP, can we use the service area, rather than start and end dates? Was this an oversight in the application, and was the intent to match the exhibit from the existing contract?
- Answer 7.** We need both since the new CCO is different from the FCHP and will have a new Contract with OHA. Similarly, the service area may change.
- Question 8.** Line 8: Provider Type: Provider Type codes provided in Table B-1. What do we categorize our non-licensed providers (QMHP, QMHA, Behavioral health Aide, Peer Support Spec)? The current table does not have a listing for these individuals.
- Answer 8.** Non-licensed providers employed by an organization with a Certificate of Approval, Letter of Approval, or License from OHA/AMH are not entered into the MMIS individually thus do not have an Oregon specified provider type code. The non-licensed providers are not required to have an NPI but some do. When listing these individual clinical staff of a provider agency, identify the role of the individual (QMHA, QMHP, Peer Spec.), and if they have an NPI include that.
- Question 9.** Date Applicant verified or certified Provider's credentials? Will you accept the effective date of licensure? What about those who are Master's level clinicians?
- Answer 9.** No. Effective date of licensure is not the same as date Applicant verified or certified provider’s credentials. Non-licensed providers have requirements for the role they play that are often specified in Oregon Administrative Rules and policies of the agency/organization that employs them. The Applicant should be able to verify the extent to which non-licensed clinical staff meets the requirements of their role. See Appendix G – Core Contract, Exhibit B, Statement of Work, 16, Credentialing b. (1), (a) and (b).
- Question 10.** Brief description of any sanctions, fines or disciplinary actions that are currently active from the appropriate licensing boards? We generally do not hire clinicians who have any disciplinary action against them due to working with a "vulnerable" population. How do you locate "sanctions" on a non-licensed provider? Could we possibly use the date of passing the DHS criminal background check?
- Answer 10.** Passing a criminal background check is not the only verification that should be done. At a minimum the Applicant should verify the individuals do not appear on a federal exclusions or do-not-contract list. See Appendix G – Core Contract, Exhibit B, Statement of Work, 16, Credentialing f.
- Question 11.** Is there more documentation that provides more clarity around the provider type codes around TCM providers and other case management services.

- Answer 11.** Targeted Case Management providers are type 64, Targeted Case Management. Within that, there are several subprograms, designated by specialty codes:
- 512- Asthma Healthy Homes
 - 509 - Babies First
 - 515 -Early Intervention/Early Childhood Special Education
 - 508 -HIV/AIDS
 - 513 -Substance Abusing Pregnant Women & Substance Abusing Parents with Children Under Age 18
 - 505 -Tribal [not required to be in Global Budget]
 - 506- Child Welfare Foster Care
 - 507- Child Welfare In-Home Care
 - 510- Self Sufficiency JOBS-Teens
 - 511-Self Sufficiency JOBS-Adults

There are also two TCM programs run through Developmental Disabilities: DD Comprehensive Waiver and Model Waivers, and DD Self Directed Support Services Waiver Only. These are currently billed through eXPRS and do not have provider type and specialty code.

- Question 12.** We have providers (Detox Staff) who work in an environment where the funds are blended (Medicaid and general state funds) at the state level. This agency is contracted through us, where clients must be 60% Medicaid. Will this staff need to be included with our overall Provider Table?

Answer 12. Yes

Mental Health Questions

- Question 13.** There are several requests in the application for a description of how we will coordinate care for members served under the 1915i waiver. There has been no information about this waiver provided to the mental health system at this point so that we have no idea what these services will be or how they will be provided. How do we respond to these questions?

Answer 13. During implementation, individuals meeting the criteria for 1915(i) Home and Community Based Services State Plan Amendment will primarily be receiving the 1915(i) services in residential treatment settings. The services provided within the adult mental health residential system are not included in the global budget at implementation. Please focus your response on the care coordination that will be available to individuals receiving services within the adult mental health residential system to ensure they are being served in a setting that provides them with the most independence possible and to continue their recovery in settings providing greater independence.

- Question 14.** We have not been able to engage our local mental health authority as they have not made themselves available to discuss potential contract arrangements. Other than a good faith effort to meet with the local mental health authority, is there anything else an applicant should do to try to satisfy the mental health related requirements of the RFA.

Answer 14. The Applicant should talk with the county mental health director and discuss the critical need for the MOU with the LMHA based on the requirements in HB 3650 amending ORS 414.153. The new material added to the statute explains the importance of the MOU in maintaining the mental health safety net and managing and funding crisis services and the flow between levels of care such as the state hospital, adult residential services and the Medicaid funded, CCO contracted, intensive psychiatric services for children and adolescents. The Mental Health Director may be able to arrange the necessary conversations with the LMHA or may be delegated by the MHA to develop the MOU.

Dental Care Questions

Question 15. If a DCO wants to start early can a CCO applicant keep the DCO from joining the CCO?

Answer 15. Oral health is not a required benefit to be covered by CCOs at certification.

Question 16. Legislative intent appeared to include a DCO as a “major component of the health care delivery system” thus eligible to be on the governance of the CCO. Is this true? Many CCO formation groups are confused about this. Clarification would be helpful.

Answer 16. Dental Care Organization (DCO) representation is eligible to be on the CCO governing board if the DCO is engaged as a part of the CCO’s delivery system.

Medicare/Medicaid Alignment Demonstration Questions

Question 17. Do we still need to submit responses for Appendix D by the 4/30 deadline now that there is a January 1, 2014 start date for the Medicare/Medicaid Alignment Demonstration? I haven't seen an Addendum on this yet.

Answer 17. Appendix D was significantly revised in RFA Addendum 10, related to the change to a January 1, 2014 start date for the Medicare/Medicaid Alignment Demonstration. The response to Appendix D will now be due at the same time as the financial application for the first round of applications, and not with the rest of the technical application. Appendix D has been updated to reflect the 2014 start date for the demonstration, to remove the questions that were originally included, which were replaced with a single new question.

Now that the demonstration is voluntary and will start in 2014, there have been questions about whether and how CCOs will be required to serve dually eligible individuals.

- Addendum 10 clarifies that CCOs will be required to be able to serve dually eligible individuals for Medicare, either by participating in the demonstration or by offering Medicare benefits through an owned, affiliated, or contracted Medicare plan, no later than January 2014; there will be an exceptions process available for CCOs that are not fully able to meet this requirement on that timeline. The new question in Appendix D is about the Applicant’s ability to meet this requirement to serve dually eligible individuals for Medicare.

- Addendum 10 also clarifies that CCOs will be required to provide covered Medicaid services for dually eligible Members whether or not the Member is enrolled in a Medicare Advantage plan that is owned, affiliated or contracted by the CCO- meaning that plans will no longer be allowed to request the disenrollment of a dually eligible Member that is not enrolled in the owned, affiliated, or contracted Medicare Advantage plan.

There will be a separate procurement for the demonstration which will start in November 2012, and as such in Addendum 10 all references in the RFA to certification for participation in the demonstration or other related procurement process issues were removed. This new timeline will allow time for OHA to negotiate a Memorandum of Understanding with CMS around the terms for the demonstration, and for those terms to be known by plans, before a Notice of Intent to Apply for the demonstration needs to be submitted to CMS. The rest of the procurement process will follow similar steps to the one that was originally in place for a 2013 demonstration. As a reminder, only CCOs will be eligible to apply to participate in the demonstration and participation in the demonstration will remain voluntary for CCOs.

Long Term Care Memorandum of Understanding Questions

Question 18. When will the final guidance for the MOU for Long Term Care be released or posted and available on the web site?

Answer 18. We posted guidance on DHS web site (<http://www.oregon.gov/DHS/hst/apd-cco-info.shtml>) and it was listed in addendum 11 on RFA web site.

Readiness Review

Question 19. My question is in regards to what falls under the category of “deferment” as it relates to Readiness Review. Do you have a list of sections/responses that would qualify for deferment until the Readiness Review due date of July 3rd?

Specifically, in regards to Appendix B, Section 2: Instructions state that submission of the Participating Provider Table is part of the readiness review process, but at the end of the instructions, under *Note*, it state that the OHP Provider and Facility tables are a part of the initial Application submission.

These two statements seem to be contradictory. Can you please clarify whether the Participating Provider Table is to be submitted with the initial application or can be deferred to Readiness Review?

Answer 19. The OHA must be able to confirm that the Applicant has sufficient provider capacity in its network, not later than the Contract effective date. The OHP Provider and Facility Tables are part of the Application, and will be reviewed as part of the Application process. Readiness review is the final opportunity to demonstrate that the necessary provider capacity has been established. By requiring final review no later than the time of readiness review, the RFA provides the Applicants with the flexibility of continuing to develop its provider network after submitting its Technical Application.

Miscellaneous Questions

Question 20. What is the definition of “health care entity” as that term is used in ORS 414.635(4) – (7) and OAR 410-141-3268?

Answer 20. The term “health care entity” is not defined in statute or rule. Applicants should apply the plain meaning of the term.

Question 21. I have a question regarding State Licenses for the CCOs. CMS is requiring proof of licensure for the Medicare piece. Is the State also requiring one for the Medicaid portion? I ask because, as a Medicare plan, ATRIO has a State Insurance License. However, we will only be an affiliate of the CCO and we are not sure if our license would suffice. Once the applications are submitted, will there be opportunity for remediation to correct deficiencies? If so, what will the timeframes be?

Answer 21. An Insurance Division Certificate of Authority is not required for CCO certification at this time.

Financial Solvency Questions

Question 22. What are the risk and capital requirements of the CCO; those of the legislation or those of the RFA? The first appears to be OHP like requirements and be more lenient or the latter which seem to be like the NAIC and more rigid?

Answer 22. The risk and capital requirements of the CCO are the same as current requirements at the time of certification. OAR 410-141-3340 to 410-141-3395, posted at https://cco.health.oregon.gov/RFA/Documents/Rules_141-3340_to_3395_Financial.pdf, identifies the period of time CCOs will have to achieve the requirements applied by the Insurance Division.

Global Budget and Cost Template Questions

Question 23. In today’s CCO Application Webinar, David stated that we could get additional information on the FFS population upon request.

In order to facilitate our ability to submit realistic CCO applications, we are requesting demographic and utilization data for FFS members. We would like tables showing the follow breakdowns:

- 1- FFS members by county by DMAP PERC code
- 2- FFS cost by county by DMAP PERC code

Answer 23. The data set OHA has prepared for Applicants can be requested through the RFA Portal. This dataset includes both PERC and County and will allow you to create your own permutations on the data.

Question 24. Could the actuarial services department make available the most up to date Bucket Book to assist plans in preparing the CCO base cost template?

Answer 24. Yes we will be posting the ASU Bucket Book for applicant use. However, please note that the ASU Bucket Book is an internal tool and it is not a necessary component to completing the Cost Template. Additionally ASU will not have the time or resources to respond to technical questions regarding the Bucket Book.

Question 25. Are CCOs going to cover Non-Emergent Medical Transportation in 2013 under the global budget?

Answer 25. Yes Non Emergent Transportation will be transitioned into the Global Budget in 2013. There is currently an internal/external workgroup working on various issues related to the NEMT transition into the Global Budget.

Question 26. Please give us an overview of what changes to the CCO Cost Template will be made by ASU once we submit with Steps 1-3. Should we hold off Step 4 until after this review?

Answer 26. There will be no changes to the CCO Cost Template, we will simply be providing each applicant with a set of adjustment factors which can be applied to the template.

Attachment 1

Table F-2: Estimated Costs and Capitation Rates spreadsheet

(Separate Document)