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April 27, 2012

RFA 3402

Addendum #15

1. This is Addendum # 15 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 15, to the extent such corrections result from the changes made by this Addendum 15. 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. The OHA “Bucket Book” is hereby attached to this Addendum 15 as Attachment 1.
 - c. The OHA-DHS “Policy for DHS and OHA Divisions on Collecting Race, Ethnicity and Language Data” is hereby attached to this Addendum 15 as Attachment 2.
 - d. The OHA “Global Budget Announcement” is hereby attached to this Addendum 15 as Attachment 3.
 - e. 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, April 12, 2012 and April 19, 1021 (not including answers provided in Addendum 2, Addendum 4, Addendum 8 or 13 to this RFA). The following are OHA’s official answers:

Governance/Organizational Requirements Questions

Question 1. Must the Community Advisory Council (CAC) be in place by April 30th? The RFA language includes language about the proposed CAC, but also how the CAC was selected.

Answer 1. The CAC must be in place, with a description of the selection process and names of CAC members identified, by Contract signing, which will be June 14th for 1st wave applicants submitting on April 30.

Question 2. Clinical Advisory Panel – do we need to say whether we plan on having one but don’t yet have one?

Answer 2. Yes.

Provider Questions

Question 3. May current contracts that you may have through an MCO or MHO agreement be transferred over to the CCO or do they need to be new contracts?

Answer 3. They need to be changed in the appropriate legal way so that the contract is with the CCO and meet the new requirements.

Question 4. One more question about the "Exhibit K" provider list: Since PCPCH is at a clinic level, we will only have Y in the clinic level record in Exhibit K and no docs will be marked as PCP's. Is that correct?

Answer 4. PCPCH is a clinic/practice level indicator and docs in the clinic/practice would not need to be designated PCPs

Question 5. We understand that an existing FCHP contract will not replace the requirement for new CCO contracts. However, can an FCHP ask a provider for a legal "assignment" of that contract, coupled with appropriate amendments that include any new CCO requirements that may not have been part of the original FCHP provider contract?

Answer 5. Yes, as long as the amendments reflect appropriate name changes and the additional responsibilities associated with health systems transformation identified in the CCO contract with OHA

Mental Health Questions

Question 6. Do the MOUs (AAA, mental health, etc.) need to be with the CCO itself, or can they be with subcontracted entities?

Answer 6. ORS 414.153(4) requires "a written agreement between each coordinated care organization and the local mental health authority in the area served by the coordinated care organization, unless cause can be shown why such an agreement is not feasible under criteria established by the Oregon Health Authority." The section goes on to describe the need to maintain the mental health safety net system and to maintain efficient and effective management of a specific set of responsibilities.

Readiness Review

Question 7. What options do we have besides deferring to keep possible competitors from seeing all of our answers to the RFA when they are in later waves? This seems to give them an advantage when the readiness review is prior to their application submission.

Answer 7. Transparency requires that OHA post this information. However, the advantage of later implementing CCOs seeing earlier implementing CCO's information will

likely be outweighed by the advantages of beginning sooner the enrollment of new eligibles and recertifying eligibles.

Question 8. General question concerns the actual date on which this information must be committed and confirmed. Is this or can this be part of our “deferred submission documents” and thus part of our readiness review under section 6.7.1?

Answer 8. Yes.

Question 9. The timeline doesn't list the desk review date.

Answer 9. Expectation is that it will be the end of June, beginning of July.

Question 10. Who is going to be conducting the readiness review?

Answer 10. We have not yet decided.

Miscellaneous Questions

Question 11. Has the deadline for comments on the contract been changed from 3 pm to 5 pm? Do you want those contract comments uploaded as part of the documents or emailed straight to the single point of contact?

Answer 11. Yes the deadline has been moved, but the earlier you can get them in the better. Please send them to the sole point of contact.

Question 12. Where do you go in the Oregon Health Authority for technical assistance around facilitation and mediation?

Answer 12. All requests for that go through a sole point of contact, Tammy Hurst.

Question 13. At the last webinar, it was stated that we are to upload the RFA responses individually, via the format outlined in Attachment 7. Will there be anything stated in writing to confirm this method? Sect. 5.1 is unclear.

Answer 13. We will have a checklist. There is a handout that will be made available. When you upload the document there will be a column with a drop down menu. There will be some additional features around to manage your submissions.

Question 14. Are the questions on Appendix E&F due with the technical application or the financial application

Answer 14. They are due with the Financial Application.

Question 15. Will the 1st wave applications be available to the public while the 2nd and subsequent wave applications are being completed and prior to their due date?

- Answer 15.** First wave Technical Applications will be posted before the second and subsequent are completed.
- Question 16.** Concern: First wave of applicants post information some of which is not really proprietary will be published for future applicants to see, which would give them an advantage in the process.
- Answer 16.** At this time we are being directed to post those Applications they are received.
- Question 17.** Will first wave applicants be able to amend application until what date?
- Answer 17.** You can amend your Applications right up to the due date if you post your Applications in advance of the due date. You certainly can amend it, but once it is past the due date you cannot, except where the change is due to an addendum posted during the week before the due date.
- Question 18.** Could we change definition of terms during the negotiation process potentially?
- Answer 18.** We may be able to negotiate definitions found in the Contract only, not the definitions that are defined in regulation, rule or statute.
- Question 19.** After the contract is executed and the CCO goes into operation first wave August 1st or whatever, could you go back and reopen your contract for some sort of an amendment that would change the terms of the contract?
- Answer 19.** The Contract will be reviewed every year. If there is a situation of concern the Contractor would need to bring that to the attention of the Contract Administrator and a decision would be made on a case by case basis.
- Question 20.** Race, language, ethnicity policy OHA policy which has not been published on the web site or incorporated into the RFA as an addendum.
- Answer 20.** See Attachment 2 of this Addendum 15.
- Question 21.** If the policy doesn't get published soon enough for the contents to be considered and incorporated to the response to the application, than would the application make reference to the policy that they haven't been received but would be incorporated once they did receive the responses?
- Answer 21.** See answer 20.
- Question 22.** Appendix H which is optional, could it be deferred to readiness review?
- Answer 22.** We would like to have the discussion during contract negotiations. If you've got elements of Appendix H that really resonate with how you attend to approach this work, we would like to get it in your statement of course.
- Question 23.** So the question was: is it correct that an applicant could pick questions from Appendix H and respond to just those questions if they chose to do so?

Answer 23. The answer is yes, you can do that and it is again, not required so it won't affect the CCO certification process.

Question 24. Is there an available list of consultants to assist applicants with the RFA?

Answer 24. No.

Financial Solvency Questions

Question 25. Page 82 section E.2.2 – The word insurer was included in that section and the question was – what does insurer mean in this context?

Answer 25. It means DCBS-licensed insurance company or health care service contractor. So if you're a licensed insurance company then that would apply to you. But if you are an MHO that is not a licensed insurance company it would not apply to you.

Question 26. MCO and MHO come together as a CCO entity and the question is; In filling out the financial information, do you split out the administrative services to report separately the MCO's administrator and the MHO's administration if they come together to become a CCO?

Answer 26. OHA's expectation is what we will see is a set of administrative expenses not from various entities involved, but a single entity that has applied to become a CCO will have administrative expenses and that should be what we see not separately but together – consolidated so to speak.

Question 27. Q: 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 appears to be more like the NAIC and be more rigid?

Answer 27. Existing MCO organizations that are becoming CCO's will be able to rely on the current financial solvency risk capital requirements initially. The actual rules of financial solvency spell out what the requirements are going to be in the beginning and how they will change over time so that ultimately the CCO's will be responsible for the same requirements that the NAIC recommends.

Question 28. I understand there is going to be a revised table E1 and I believe that would be the performance right?

Answer 28. Yes, see Addendum 12.

Question 29. Would an existing MCO need to fill out the E-1 (Pro forma)?

Answer 29. Yes, they would.

Global Budget and Cost Template Questions

Question 30. Without the "stick" of the "targeted budget reduction" that we had in September, and with the combination of inflation, the forced 11.25% budget reduction, and the possible 7% underfunding at the beginning of January 2011, it is very possible that the cost submissions will significantly exceed the current post Oct 2011 costs. What is the process the state will use to meet its budget realities if cost submissions exceed available funds? In October, we were simply told we would not be awarded a contract. How will the CCO process differ from the LCE process?

Answer 30. See Attachment 3 to this Addendum 15.

Question 31. What purpose does the 'utilization' component of the "5 year pro forma" serve and how is it to be filled out. How do the columns "utilization" and "expenditure" interact?

Answer 31. The purpose it serves is that with health system transformation, patterns of utilization will change over time and we want to track those. With Health Care Transformation including integration of Mental and Physical Health and the implementation of Patient Centered Primary Care Homes OHA expects reduced hospital and emergency room utilization. These pro forma reports outline the applicant's projections on how they will meet the reduced utilization expectations of the Health Authority,

Question 32. If we are planning to be active for only certain zip codes within a county, how do we determine what percentage of the FFS membership to attribute for that county?

Answer 32. We expect you to assume 100% of the population you are requesting. If your expectation is to cover ½ the county then the assumption is that you would anticipate ½ the available FFS population as well. We expect roughly 75% of the currently FFS population to be enrolled in the CCO's in the first round therefore a fair assumption would be ½ of 75% or roughly 37.5% of the current FFS population.

Question 33. OHA has asked applicants to submit steps 1-3 as quickly as possible to ASU through the portal so that we can provide FFS risk adjustments so that you can complete the application.

Answer 33. There is still a body of work being done on this risk adjustment, so the adjustment isn't going to be completed in just a few days as we originally anticipated. But we anticipate that work to be done this week. So if you were to submit your template today or this week. I would expect you to get a response late next week or early the following week. One thing I would like to highlight, this work does not impede your completion of the cost template in any way. You can be working on the template and take it right up to completion and this will just enhance it.

Question 34. Will the data set being provided allow you to populate the cost template?

Answer 34. Answer is no.

So the data is titled the utilization data set. It contains fee for service utilization data. It also includes paid and fill charts for fee for service, it does not include paid financial information. So you would not be able to use it directly to complete the template. But it should provide you with a lot of utilization data that will assist you in making some assumptions.

Question 35. Do you need one cost template for multiple counties?

Answer 35. You could do one cost template for multiple counties; you could also do it for each county. Correct.

Question 36. The calculations between 3A and 3B in the cost template result in an error.

Answer 36. We are working on a fix to this problem.

Question 37. If the template is going to be changed, and a plan has already largely completed filling out the template, will there be an alternate method to simply correct the OLD spreadsheet with the new fix?

Answer 37. No, unfortunately, however we are going to send some description about the changes that have been made so you can identify where the change actually impacts you. The new version will be called version 2b, and we will accept version 2 or 2b. This change only impacts CCOs that are using existing MCO enrollment for the forecasting/contract period. If you used one of the choices in step 3b, you would be impacted.

Attachment 1
Bucket Book
(Separate Document)

Attachment 2

Policy for DHS and OHA Divisions on Collecting Race, Ethnicity and Language Data

OFFICE OF EQUITY AND INCLUSION

Policy for DHS and OHA Divisions on Collecting Race, Ethnicity and Language Data

Overview

Description: This policy creates a standard for collecting race, ethnicity and language data for all programs and activities within the Department of Human Services (DHS) and Oregon Health Authority (OHA), and mandates the collection of such information by all DHS and OHA programs that collect demographic data.

This policy was developed as part of the work of the Office of Equity and Inclusion with divisions to develop meaningful indicators to monitor progress on closing gaps in need for, access to, and outcomes of services among racial and ethnic groups. It is a first stage in the development of comprehensive and practical policies for collecting, analyzing, and reporting meaningful race, ethnicity and language data across DHS and OHA.

This policy is built on the foundation of the U.S. Office of Management and Budget's (OMB) Directive 15 (revised 1997), and adds key elements that will improve the quality of the data gathered. This policy is in compliance with standards recently released by U.S. Department of Health and Human Services (DHHS) for the collection of race, ethnicity and English proficiency. DHHS standards for the collection of sex and disability data will be addressed in a separate policy from OHA and DHS.

Purpose/Rationale: A standardized race, ethnicity and language data collection methodology will assist DHS and OHA, stakeholders, elected officials, and other decision makers to promote policies that address disparities among racial and ethnic groups. The standardized methodology will allow DHS and OHA to demonstrate progress towards reductions in racial and ethnic disparities by increasing transparency in reporting indicators by race and ethnicity. In addition, it will allow DHS and OHA to be consistent with federal reporting expectations and facilitate comparison of Oregon's progress to address racial and ethnic disparities with national trends.

Applicability: This policy applies to all DHS and OHA programs and contractors that collect, record, or report demographic data (such as, gender, age, income, race, ethnicity or language). This policy does not override an individual's right to refuse to report his or her race or ethnicity in order to receive services. This policy does not supersede federal requirements for programs regarding the collection of race, ethnicity or language data.

Policy

1. Overview

- A. **Data must be self-reported:** Whenever possible individuals should self-report race, ethnicity and language information on written forms. This is not always possible, but the expectation is that programs and contractors will adhere as closely to self-reporting as circumstances allow. Self-reporting race, ethnicity and language improves the quality of data gathered. Ethnic and racial identity and preferred spoken language should not be assumed or judged without asking the individual.
- B. **Definition of race and ethnicity categories:** DHS and OHA recognize that the definition of race and ethnicity categories is inherently sensitive and complex and the collection of such data for the public good is a serious responsibility. This policy is based on OMB Directive 15, which states, "the categories

represent a social-political construct designed for collecting data on the race and ethnicity of broad population groups in this country, and are not anthropologically or scientifically based.”

- C. **Race and ethnicity questions must be separate:** Separate questions shall be used for collecting race and ethnicity data. The ethnicity question shall precede the race question.

DHS and OHA acknowledge that respondents do not necessarily differentiate between their race and ethnicity and thus, may find the two questions confusing. DHS and OHA do not seek to define “ethnicity” and “race” with this policy, and recognize that these concepts are not well defined by OMB nor is there consensus among the citizenry as to their meaning. As the American Anthropological Association notes in its response to OMB Directive 15, “Although popular connotations of race tend to be associated with biology and those of ethnicity with culture, the two concepts are not clearly distinct from one another.” Nonetheless, federal guidelines have mandated separate questions for race and ethnicity since 1997, and this policy seeks to find a balance among meeting federal reporting guidelines, honoring the complexity of identity of individuals, and being able to provide meaningful data for the purpose of serving DHS and OHA clients and the public.

- D. **Data granularity:** The ethnicity and race categories listed in this policy represent a required minimum standard. Whenever possible and appropriate, programs are encouraged to collect and record data with greater granularity (i.e., greater number of race, ethnicity, and language categories) than those presented in this policy. However, the program must be able to aggregate those data into the categories presented in this policy.

For examples of greater granularity see the [2010 U.S. Census](#), [DHHS Standards](#), [Oregon Health Care Quality Corporation](#) [C:\Users\Trish\AppData\Local\Temp\DHHS Hyperlink.doc](#) and [Boston Public Health Commission](#).

- E. **Confidentiality:** Nothing in this policy overrides existing policies to safeguard confidentiality, including HIPAA requirements.

2. Ethnicity Categories

The following are the minimum standard ethnicity categories to use as recommended by OMB directive 15 plus additional categories for “declined to answer” and “unknown” which are modifications of categories recommended by the Health Research and Educational Trust in their [Disparities Toolkit](#).

The following ethnicity categories shall be used be incorporated into all written or oral data collection efforts or intake forms, or if more fine grained ethnicity data is collected, it must be able to be collapsed into the following categories.

Individuals are to select only ONE of the following:

- A. **Hispanic or Latino:** A person of Cuban, Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race.
- B. **Not Hispanic or Latino.**
- C. **Declined to Answer:** This category should be used when the individual is actively choosing to not provide information on their ethnicity. They should not be asked again for the information.

D. **Unknown:** This category should be used when the information is missing for some reason other than the individual actively declining, such as, (1) the individual or responsible caregiver is unable to provide an answer for some reason (e.g., they are cognitively unable) or (2) there is no available family member or responsible caregiver to respond for the individual. Individuals or their caregivers may be asked again for the information when appropriate.

3. Race Categories

The following race categories are the minimum standard categories to use and follow the OMB guidelines for minimum granularity to offer individuals and participants. The three categories “declined to answer,” “unknown” and “other” have been added, which are modifications of categories recommended by the Health Research and Educational Trust in their Disparities Toolkit.

The following race categories shall be used on written or oral data collection efforts or intake forms, or if more fine grained race data is collected, it must be able to be collapsed into the following categories.

Individuals should be instructed that they may choose more than one race category. All of the respondent’s selections shall be recorded and retained.

- A. **American Indian or Alaska Native:** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
- B. **Asian:** A person having origins in any of the original peoples of the East Asia, Southeast Asia, or South Asia including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- C. **Black or African American:** A person having origins in any of the black racial groups of Africa.
- D. **Native Hawaiian or Other Pacific Islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- E. **White:** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
- F. **Declined to Answer:** This category should be used when the individual is actively choosing to not provide information on their race identity. They should not be asked again for the information.
- G. **Unknown:** This category should be used when the information is missing for some reason other than the individual actively declining, such as, (1) the individual or responsible caregiver is unable to provide an answer for some reason (e.g., they are cognitively unable) or (2) there is no available family member or responsible caregiver to respond for the individual. Individuals or their caregivers may be asked again for the information when appropriate.
- H. **Other:** Use this category for those individuals who identify another race category not listed.

4. Primary Race Identity

A question asking clients for their primary race identity shall be incorporated into all written or oral data collection efforts, intake forms and systems for individuals who select multiple races.

Specifically, individuals shall be asked: “Which one of the following do you consider your primary race identity?” and then presented with the race categories listed in number 3 above plus a “no primary race identity” option.

This question is aligned with the approach taken in national surveys, such as the BRFSS (<http://www.cdc.gov/brfss/questionnaires/english.htm>).

Data from a primary race question allows individuals the freedom to indicate if they do have a primary race identity, rather than analysts making de facto decisions about race identity in the absence of this information. However, individuals should not feel pressured to select a primary race identity.

5. Preferred Language

A question asking for a client’s preferred spoken language shall be incorporated into all written or oral data collection efforts, intake forms and systems. Preferred spoken language is essential information for programs to possess to be able to address the needs of clients. Preferred language can also serve as a proxy for acculturation. Gathering preferred written language is recommended but not required by this policy.

The following languages are a minimum standard and shall be used on data collection or intake forms, including a field allowing the respondent to self-report a language that is not listed:

American Sign Language, (ASL)	Korean
Arabic	Lao/Laotian
Bosnian	Mandarin
Burmese	Mien
Cantonese	Romanian
Chinese (Other)	Russian
English	Spanish
Farsi	Somali
Hmong	Teochew
Khmer (Cambodian)	Vietnamese
Other (specify):	

Note:

The above list is comprised of the most common languages spoken among DHS clients. As the DHS and OHA client populations change, this list will need to be updated.

6. English Language Proficiency

The following question assessing English language proficiency shall be incorporated into all written or oral data collection efforts, intake forms and systems: *How well do you speak English? (5 years old or older)*

The following categories shall be for data collection:

- A. *Very well*
- B. *Well*
- C. *Not well*
- D. *Not at all*
- E. **Declined to Answer:** This category should be used when the individual is actively choosing to not provide information about the English language proficiency. They should not be asked again for the information.
- F. **Unknown:** This category should be used when the information is missing for some reason other than the individual actively declining, such as, (1) the individual or responsible caregiver is unable to provide an answer for some reason (e.g., they are cognitively unable) or (2) there is no available family member or responsible caregiver to respond for the individual. Individuals or their caregivers may be asked again for the information when appropriate.

The English language proficiency data standard represents a minimum standard and the question and answer categories cannot be changed. Additional questions on language may be added to any data collections forms or intakes as long as the minimum standard is included.

7. Data collection forms and training

- A. When replacing existing data collection or client intake forms that include requests for self-reported race, ethnicity, and language, programs must use cognitive and linguistic testing to review draft forms before implementation. Cognitive and linguistic testing done by a federal agency for standardized national forms will be accepted as meeting this requirement. Forms and translations should read at a 6th grade level at most.
- B. DHS and OHA employees shall receive training on accurately collecting and recording race, ethnicity, and language data; why these data are important to the work of DHS and OHA; and best practices for using the data responsibly and respectfully. At a minimum, a packet of resource materials for supporting data collection, analysis and reporting including training will be developed.

Contracting:

- A. This policy is applicable to all DHS and OHA contracts in which a contractor collects any demographic data (such as, gender, income, and age). Divisions shall require such contractors to collect race, ethnicity and language data according to the policy. Collection of these data will assist Divisions in understanding client populations, tailoring services, and evaluating potential disparities in need for services/programs, access to services/programs, customer service quality, and related outcomes by race/ethnicity. Contracts shall explicitly state the contractor's obligations to abide by this policy.
- B. As a minimum qualification requirement, potential contractors shall demonstrate efforts to continually improve methods for collecting race, ethnicity and preferred spoken language data.

- C. Contracts shall explicitly state that contractors for healthcare services, health insurance, pharmacy benefits management, third party healthcare claims administration, managed care, coordinated care and surveys including, but not limited to contracts for: PEBB, OEBC, MCOs, MHOs, OMIP, CCO and FHIAP are considered a “mandatory reporters” to OHA’s All Payer All Claims (APAC) Data Reporting Program.

Implementation:

Detailed timelines and budget for fully implementing this policy shall be filed with the **DHS/OHA Joint Operations Steering Committee.**

References:

- OMB Directive 15: <http://www.whitehouse.gov/omb/fedreg/ombdir15.html> and updates <http://www.whitehouse.gov/omb/inforeg/statpolicy.aspx>, under *Data on Race and Ethnicity*
- Census Summary File 2: <http://www.census.gov/prod/cen2000/doc/sf2.pdf>
- Health Research and Educational Trust (HRET) Disparities Toolkit: <http://www.hretdisparities.org/>
- American Anthropological Association Response to OMB Directive 15: <http://www.aaanet.org/gvt/ombdraft.htm>
- Behavioral Risk Factor Surveillance System: <http://www.cdc.gov/brfss/questionnaires/english.htm>
- U.S. Department of Health and Human Services Standards for collecting ethnicity, race, English proficiency, sex and disability data: <http://aspe.hhs.gov/datacncl/standards/ACA/4302/index.shtml>

Contact(s):

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Keywords:

Race, racial, ethnic, ethnicity, language, data, coding, category, OMB, Census, multiracial

Appendix A

Data Format and Coding:

Mandatory reporters to the All Payer All Claims (APAC) database must follow HIPAA transaction standards ASC X12 version 5010, which are given below. Other divisions and contractors collecting race, ethnicity and language data can view these standards as one possible example of a coding convention. OHA and DHS divisions and contractors that use other coding conventions are required to recode their data to the 5010 standards when merging datasets with APAC data. ***Note*** Race and ethnicity codes needed for the APAC database have not been finalized, so the following codes may need to change.

1. Ethnicity

- A. Format: Text, maximum length 5
- B. Coding: A single letter identifying the member's ethnicity or multiple letters delimited by an ampersand (example: H&N)

Code	Value
H	Hispanic / Latino
N	Non-Hispanic / Latino
R	Refused ("Decline to Answer" was selected)
U	Unknown (No answer was selected)

2. Race

- A. Format: Text, maximum length 13
- B. Coding: A single letter identifying the member's race or multiple letters delimited by an ampersand (example: I&P&W)

Code	Value
I	American Indian / Alaska Native
A	Asian
B	Black or African American
P	Native Hawaiian / Other Pacific Islander
W	White
O	Other
R	Refused ("Decline to Answer" was selected)
U	Unknown (No answer was selected)

3. Primary race

- A. Format: Text, maximum length 13
- B. Coding: A single letter identifying the member's primary race

Code	Value
I	American Indian / Alaska Native
A	Asian
B	Black or African American
P	Native Hawaiian / Other Pacific Islander
W	White
O	Other
R	Refused ("Decline to Answer" was selected)
U	Unknown (No answer was selected)

4. Preferred spoken language

- A. Format: Text, length 3
- B. Coding: The three-letter ANSI/NISO code identifying the member's preferred spoken language. Refer to most recent version of ANSI/NISO Z39.53 (Codes are for the Representation of Languages for Information Interchange); the 2001 version is freely available here: <http://www.niso.org/topics/ccm/ccmstandards/>.

Attachment 3

Global Budget Announcement

There have been a number of questions regarding the OHA budget situation and how that aligns with the CCO Cost Estimate. The final Budget picture is still not clear as we are continuing to have discussions with CMS regarding additional Federal support; as such, OHA is asking the Applicant's to develop their CCO Cost Templates assuming there are no funding cuts. Although it is still possible, this will change pending the final outcome of our discussions with federal officials, we felt it best at this time to begin the process as outlined. We will keep Applicants apprised of the situation.

Similar to the October Rate Setting Cycle, OHA will be implementing a bifurcated analysis of the CCO Cost Template where the Actuarial Services Unit (ASU) will conduct an independent analysis of the actuarial soundness of the Applicants submission, then OHA as part of the negotiation process will address any budgetary concerns with the Application. OHA is still finalizing the calculations however; we will be using the following methodology to communicate the actual Global Budget to each applicant:

- Step 1.** Each Applicant will receive a Global Budget based on their most current Letter of Intent (LOI). This Global Budget will be broken down by Rate Group and County and will have Dental and CAWEM Pre-natal options. This Global Budget will assume 100% of the requested enrollment in both Managed Care and Fee for Service (FFS) Expansion populations. The expectation is that this Global Budget will provide a landscape for the Applicant to develop their CCO Cost Template and will provide a base line to inform OHA in negotiations.
- Step 2.** Applicants submit their CCO Cost Templates as part of the Financial Application by May 14th and ASU will continue to have detailed discussions with each Applicant regarding their CCO Cost Template submission. At this point, the Applicant can make revisions and resubmit their CCO Cost Template at the direction of ASU. During this same period OHA will be negotiating with the Applicant on the non-actuarial portions of the Application including coverage area and covered populations and services.
- Step 3.** ASU will conduct actuarial soundness analysis by comparing Applicant CCO Cost Template submission to statewide rate ranges (developed internally by ASU) along with necessary risk adjustments and regional adjustments. ASU will make a recommendation of conditional acceptance of the Applicant CCO Cost Template submission, or ASU will make a recommendation to reject the Application. A conditional recommendation of acceptance is necessary pending the final determination of expansion and FFS populations.
- Step 4.** Once the final coverage area and covered populations have been decided, ASU will conduct a risk adjustment on the FFS expansion population to account for any variances between the assumed FFS enrollment and the final FFS enrollment.
- Step 5.** Applicants will have a final review of the proposed rates and once accepted ASU will make a final analysis of actuarial soundness.

Please keep in mind that the Global Budget numbers will not be final nor will they be binding but are meant as a guide to expedite the negotiation process. It is our intent to have these Global Budget calculations to each Applicant by Friday April 27, 2012. Questions regarding this methodology or the process should be submitted through the RFA Portal and put Global Budget in the subject line.