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**April 13, 2012**

**RFA 3402**

**Addendum #8**

1. This is Addendum # 8 to Request for Application (RFA) 3402, Coordinated Care Organizations (CCOs).
2. RFA #3402 is hereby amended to provide answers to questions received by OHA via: question and answers received by email and the Webinars conducted by OHA on March 22, 2012, March 27, 2012 and April 4, 2012 (not including answers provided in Addendum 2 or Addendum 4 to this RFA). The following are OHA's official answers:

### **Insurance and Reinsurance**

There has been discussion about the state providing some sort of risk management tool in the form of reinsurance. There are a variety of other ways that could happen, potentially a package of tools that would reduce the risk of the high cost catastrophic cases. We just want to take this opportunity to let you know that we are working on that and we would like to hear from the Applicants. If you have any particular views about that we would welcome your comments.

**Question 1.** Whom would we send comments regarding reinsurance to?

**Answer 1.** All comments should be sent to Sole Point of Contact-Tammy Hurst at [RFA.FormalQuestion@dhs.oregon.gov](mailto:RFA.FormalQuestion@dhs.oregon.gov) as listed in the RFA and she will distribute appropriately.

**Question 2.** In order to name the State of Oregon as an additional insured for commercial liability, it is necessary to use an address. Which address should we use?

**Answer 2.** 500 Summer Street NE, Salem, Oregon 97301

### **Public Presentation by Applicant Questions**

**Question 3.** When should Applicants invite OHA to attend stakeholder meetings in the communities?

**Answer 3.** The public presentation meetings need to happen before the certification process is finalized. For the first wave, August 1<sup>st</sup> start up, the certification process will be finalized by May 28<sup>th</sup>. The public presentation meetings need to happen in advance of that date. Addendum 7 amended the RFA, section 5.4, to add guidelines for those public presentations. Under section 5.4.1, the public presentation needs to happen in a community forum within the Applicants service area and OHA has to be invited to attend. This means for Applicants applying to provide service in multiple geographic areas; they will have to do multiple public presentations.

**Question 4.** So in the case of a CCO that consist of several counties, will one stakeholder meeting be sufficient or does one have to occur in every county?

**Answer 4.** You wouldn't necessarily need to have a public presentation in every county, but would have to have a public presentation in every service area and it would need to be reasonably geographically accessible. What we are asking for is coverage of all of the service areas that you intend to apply in and it be done in a reasonable way from the stand point of both the Applicant and stakeholders in that community.

**Question 5.** Can you please expand on the intent and expectation of the public presentation given the deadline being prior to award certification?

**Answer 5.** Addendum 7 described the intent and the expectation. There is no expectation that it's going to be an extensive, detailed presentation.

### **Benefits/Services/Providers Questions**

**Question 6.** Do you expect the CCO applicants to have executed provider contracts for all providers at the time of filing the Technical Application (for 1<sup>st</sup> wave applicants, on April 30)? Or on date CCO contract is effective (for 1<sup>st</sup> wave applicants, 8.1.12)?

**Answer 6.** OHA would expect Applicant to have the executed provider contracts by the Readiness Review.

**Question 7.** Appendix B Section 2 Standard #1 is the Table B-1 (Participating Provider Table) due at the application due date or at the readiness review?

**Answer 7.** Table B-1 is due on Readiness Review date, and does not need to be submitted with the Application.

### **Medicare/Medicaid Alignment Demonstration Questions**

Due to the decision of considering moving start date to 2014, OHA has extended the public comment period to April 13<sup>th</sup>. Original comment period would have ended April 4<sup>th</sup>.

**Question 8.** Is there any new information on the Dual Demonstration Project - such as start date?

**Answer 8.** In light of the concerns raised by Applicants, and the responses which OHA received in response to a request for feedback from Applicants, the decision has been made to request a start date of January 2014 for the Medicare/Medicaid Alignment Demonstration. This was announced to Applicants in Addendum 6. A memo was sent to Applicants regarding this decision, which can also be found at: <https://cco.health.oregon.gov/Documents/M-MAlignmentdemo-2014memotoCCOApplicants4-5-12.pdf>.

**Question 9.** The Dual Demo project proposal stated that the plan for CCOs is to force every CCO onto a statewide Preferred Drug List. This is highly concerning to us. Did I miss this in the legislation somewhere? Will we have an opportunity to present why we believe this is not in the best interest of members?

**Answer 9.** This was included in the draft Medicare/Medicaid Alignment Demonstration proposal based on a preliminary policy understanding, but this requirement will not be included in the final Demonstration proposal, and is not part of the requirements for CCOs.

## OHA Technical Assistance/RFA Q&A

**Question 10.** Is it expected that we submit individual and executed attestations, assurances, and representations that coordinate with those listed within Appendix A - CCO Criteria or is the filled out, signed and dated Appendix A enough?

**Answer 10.** Attachment 6 lists the attestations and provides a column for “yes or no” or qualified “yes” and explanations if necessary and includes the requirement for an authorized signature.

### Miscellaneous Questions

**Question 11.** I asked last time if the core contract attached to the final RFA was the final core contract and we were told that no, the core contract was still open for comment. The written answers that were posted indicated that the core contract posted is actually the final version. We submitted a small number of what we considered to be highly important comments. It doesn't look like those were taken into account. Is the contract in its final form and will we ever see answers to our comments?

**Answer 11.** Please re-send your comments to the SPC. We will consider the comments and we can revise the core contract if necessary.

**Question 12.** Appendix B Section 2 Standard #1 Please explain what is required in the paragraph that starts with "Based upon the Applicant's community health assessment..... What is OHA expecting to see?

**Answer 12.** In section 2, we have provided a list of service providers, and the health assessment in the community could narrow or expand the list. The list is representative of types of service providers that would be required in a comprehensive delivery system. If your health assessment shows that you have particular needs or health concerns in one area, an Applicant will need to show that it has the service providers or some sort of arrangement that can deal with those concerns and show access within the community served.

**Question 13.** Will we be required to have some type of licensure with OID?

**Answer 13.** The statute and OHPB implementation proposal do mention the possibility of a license. That question would be something for the future and will probably need to be addressed by the next session of the legislature as exactly what that licensure would look like relative to other licenses issued by DCBS. At this point, there will be a legislative concept drawn up, go through the process and the legislature will decide exactly how they want to handle that. If there is a special license for CCO's, that will not happen at the earliest until mid-year next year.

**Question 14.** Were there any Protests to the LOI's? These were due April 4<sup>th</sup>

**Answer 14.** Clarification on this question, the LOIs was due April 2<sup>nd</sup>, there is no protest option to the LOI. This question may really relate to protests to the RFA that were due April 4<sup>th</sup> and if so, then “No” we did not receive any protests to the RFA.

## Global Budget and Cost Template Questions

OHA has determined that Applicants that have submitted a letter of intent may request utilization data for their proposed geographic area. This data is being provided specifically to allow Applicants to build their own profile and resource for proposed covered population to support the development of their application only.

Applicants must acknowledge understanding of the data use agreement found in order to receive this dataset. The data is being provided to the Applicant in the format that it was submitted to MMIS with personal identifiers excluded.

Please note: Advanced data experience with claims data will be required to manipulate these data sets. OHA will work directly with designated contacts from the legal entity for secure transmittal of the data.

Applicants have been sent correspondence that outlined the following:

1. Terms and conditions of Web Portal
2. Outlining the general data that will be made available to applicants
3. Data use Agreement that will need to be signed and returned
4. Requirements for clarification of data request, for example:
  - a. Does the Applicant intend to include Dental service
  - b. The intended zip codes that will be covered

CCO Cost Template Process Overview:

The OHA Actuaries produced a Version 2 of the CCO Cost Template, which was made available to applicants by Addendum 5.

OHA is requesting that Applicants complete CCO Cost Template Steps 1-3 and submit a draft CCO Cost Template for Actuarial Review. At this time ASU will populate the template with the expansion FFS population risk factors and send the CCO Cost Template back to the Applicant along with any comments and questions. This process will take less than five working days from the time of Applicant draft submission. The sooner the Applicant can submit their draft CCO Cost Template the sooner ASU can return the worksheet to the Applicant.

Starting next week ASU will also begin scheduling 1:1 technical meetings with the Applicants. If you wish to schedule a technical conference with ASU please contact David Rohrer at (503) 945-6923 or email at [david.l.rohrer@state.or.us](mailto:david.l.rohrer@state.or.us)

**Question 15.** Tables E1-E4 are those considered due as part of the RFA on the Technical Application deadline (for 1<sup>st</sup> wave applicants, April 30) or Financial Application deadline (for 1<sup>st</sup> wave applicants, May 14)?

**Answer 15.** Tables E1-E4 are due on the Financial Application deadline (for 1<sup>st</sup> wave applicants, May 14<sup>th</sup>).

**Question 16.** Do we have any updated information regarding "early adopter" money or the money coming in from CMS?

**Answer 16.** No, this is still to be determined. Once we hear we will let you know, it may be a matter of weeks.

**Question 17.** When will we be told what the relative risk of Fee for Service members is?

- Answer 17.** Once you complete CCO Cost Template Steps 1-3 and submit the draft CCO Cost Template we will return the template to the Applicant within 5 business days with the relative FFS risk.
- Question 18.** I have heard the financial application process described as a "lowest cost estimate" and as a "base line cost submission"? Which if either of those is it? Are the submitted costs supposed to be "actuarially sound"? Should the plans have their submissions be certified as actuarially sound? Or will the state certify the rates as being actuarially sound? Is the state seeking a waiver from CMS to actuarially sound rates in the future after fixed budgets are implemented in future years?
- Answer 18.** What you report in the CCO Cost Template is up to the Applicant; we left that open. We want actual-based costs and what assumptions you can make on your contracting and data ideas on how you're going to manage your population. We expect the costs to be actual; we do not expect the Applicant to certify the costs as being actuarially sound. OHA will be responsible to certify the rates as being actuarially sound. We are not currently seeking a waiver from CMS on general actuarial soundness.
- Question 19.** What FFS claims history is available, by county and rate category, for use in estimating the adjustment to cover FFS?
- Answer 19.** The data set that we will be providing will include FFS data, which will be provided at a claims level if you would like to conduct your own analysis. Regarding the CCO Cost Template, that adjustment will be done based on our analysis and will be part of the CCO Cost Template that we send back to you as the procedure explained earlier (in the introduction under "Global Budget and Cost Template Questions"). So you could essentially conduct your own analysis, but how it's handled in the CCO Cost Template is essentially an adjustment that will be done by OHA actuary. That can be part of our discussion or questions, and we would be happy to discuss that. Just a reminder that the data we are sending out is very technical in nature and difficult to manipulate. Our actuaries spent months organizing and formatting it for use in actuary purposes. While we are happy to talk to you, we have a timeline and we will not be able to spend a whole lot of time talking format.
- Question 20.** If the baseline costs include costs that were lowered only to meet the "targeted budget reduction" amounts for October 2011, and the providers (physicians and hospitals) are asking to have those previous rates restored during negotiations, would those increases be added to the "inflation" or "trend" columns of the baseline cost submission?
- Answer 20.** At this point we are not telling you what assumptions to make, so you can make those assumptions. If that is what you believe is part of your network and your service provider submission, that would be appropriate. There may be discussions and additional instructions in the future about it, but not at this time.
- Question 21.** The CCOs will require new administrative services (and related costs) that were not required under FCHPs (and thus not part of the baseline costs). Has OHA provided a way for CCOs to identify, and summarize those new additional costs? At a previous Q&A meeting, the state actuary mentioned that they would expect the admin costs under CCOs to be close to the historical FCHP amounts of 8.08%. It does not seem reasonable that OHA would expect admin costs to be the same, given the many new CCO requirements (i.e. Health Navigators, Community Health Assessments, Community Advisory Councils, New Quality Metrics, etc.).
- Answer 21.** Generally speaking, this question falls under the purview of assumptions made by the CCO. The comment made by the actuary was a general comment and meant that there are pluses/minuses.

There are anticipated saving for CCO's such as savings in efficiency, size and integration of mental health. The exercise of creating CCO's is not meant to be an exercise that will substantially increase the admin costs, although that may be something that you present based on your particular practice pattern and of your particular submission area. Again that is in the purview of the Applicant.

**Question 22.** Once the baseline costs are submitted, what will be the process the OHA will implement to arrive at final payment rates? New CCOs will have to negotiate hundreds of provider contracts based on the eventual budgets and will need to understand the negotiating process and timeline if they are to have new contracts in place with providers.

**Answer 22.** The CCO Cost Template, base area costs and PMPM capitation rates refer to your estimates for the base area. This is distinct from the expansion area. The PMPM rates for expansion area are derived using base area PMPM rates and risk adjustment factors.

Therefore, in CCO Cost Template, baseline costs refer to base area, or one of two components in expansion area PMPM rates. It does not refer to interim rates. Your estimated PMPM rates are your final rates, provided you have gone through draft CCO Cost Template rates and finalized your CCO Cost Template.

**Question 23.** Will the data request form come to the application contact?

**Answer 23.** Tammy Hurst emailed instructions to all Key Contact person named in the LOIs on April 6<sup>th</sup>.

**Question 24.** On Step 4 of the CCO Cost Template, there is a line for PCPCH. Given the historical costs for this are \$0, the formula for projected costs is not going to work. How should we handle this?

**Answer 24.** For this particular field, you will need to estimate the projected PMPM and you enter the PMPM amount in the row leaving out the trend factors. So that would directly carry over from the actual PMPM for the contract period. You may ask: how do you project the PMPM? The general approach is project the total cost; you can use one of the features in the CCO Cost Template to have this quickly calculated for you, if you so choose. That feature is somewhat hidden in document. You go to the admin piece and select the total admin costs, then put you your estimated total projected costs in the place of total admin costs, and the PMPM will be calculated and you can use those PMPM then-perhaps capture on a piece of paper- and then enter it into the PCPCH row. We can talk about it more if you have questions. But to recap, you start with the total projected costs and then you get to the PMPM.

**Question 25.** Step 2: Member months, mid-period members, end of period members, of mid-period projected members?

**Answer 25.** For step 2, it's the total enrollment for the data period that you have chosen in step 1. That is discussed in the instruction tab. For example if you select a data period of 12 months from January 2010 to December 2010, you want to add up all the enrollment including fractional ones, and those member months as a total will be put into step 2. I want to add that this is different than Step 3. In step 3, it deals with the contract period and it is the estimated contract period member months and it asks for an average; it equates to a monthly figure.

**Question 26.** What is the most recent claims data that can be used for the cost template?

**Answer 26.** We want you to use a data period that has significant completed claims. We don't want you to use something that has just ended, although it is not prohibited. If you have a pretty good estimate of what the Incurred But Not Reported (IBNR) is, then you can still use months that are relatively recent. But we would recommend that you use a data period that up to the point that you have put your data or present time but there is relative amount of lapse time.

**Question 27.** Step 3: End of the month, mid point?

**Answer 27.** For step 3 we are asking you to use an average, which may be interpreted as a mid period, but we like to be technical and say "use the average". Say that your contract period is Aug 1, 2010 to December 2013, you would project your member months for this entire period and take the average.

**Question 28.** Would the date of service 9/30/2011 be acceptable for claims data?

**Answer 28.** That would probably be the most recent data that would be sufficient on our end because of our claims lag, but that depends on what your system claims lag.

**Question 29.** When I put member months in Step 2, it says I have a 21% penetration. I don't think that is true.

**Answer 29.** The penetration in step 2 is penetration into total eligibility, for example if the county that you are in has an FCHP in the same county or significant members on FFS. But if you believe you are the dominant player in that county, in general we expect 75-80% penetration. We can take a look at an example and sort of de-bug that situation if you like.

**Question 30.** The template does not allow data for a period that goes beyond 9/30/2011. Can the template be adjusted to allow data to 12/31/11?

**Answer 30.** This will need to be handled on an Applicant by Applicant basis as this would change the embedded enrollment model. Because we preload the enrollment by county this would require a specific workaround in the template with disabled enrollment features.

**Question 31.** It relates to the penetration question and do you want to de-bug it (# 29)

**Answer 31.** If you think that your 21% is incorrect based off of the explanation the actuary gave, send us your CCO Cost Template and we would be happy to look at it.

**Question 32.** As I populate the Step 4 matrix, what is driving the Column O Row 6-17 algorithm?

**Answer 32.** First, the column is titled January 2012 cap rate, which is a reference rate that is provided in the CCO Cost Template. As you populate the CCO Cost Template, it starts where your base population is and where it is located county by county. Because of that it is able to aggregate January 2012 rates from the county level up and is able to then calculate overall rate for you. It does have two components, one the so called base area and the other expansion area. That is also combined in how the weighted average is calculated and that is what goes into column O.

**Question 33.** So Column O is what we receive currently in premium?

**Answer 33.** Not exactly, Column O is a reference rate. The reason it may not be the premium you're receiving is because the constraint in the template means this reference rate has to be built from the county level and there may be other managed care plans in the area. It will not match exactly what you are receiving but it is a very good reference rate.

**Question 34.** Should we be concerned if our column N is more than column O?

**Answer 34.** Column N is your estimated proposed rate. I would say whatever you come up with in the first step is the starting point in the understanding of your rates. I am sure you are not going to get there in one step. You're probably going to have your own draft or working versions.

**Question 35.** Column O is what the State is currently paying overall or for FFS only?

**Answer 35.** It only includes what we are paying to current Managed Care Organizations. So that figure would be separate for any of the costs in the expansion area in that county.

**Question 36.** Dennis suggested using the total costs for PCPCH and the admin portion of the template to split the projected costs by rate category. Could you please do a walk-through of how that would work?

**Answer 36.** Referring to Step 4, for those familiar with last template we used, this has changed since October 2011. In the CCO Cost Template you have admin choices and different ways you can enter your admin figures. The most popular way is percent admin. You can choose percent and enter in whatever percentages you wanted to load admin with category by category and then you enter 8% by .08. You can also enter that as the PMPM, if you select PMPM at the top, that's column E-4. That is the 2<sup>nd</sup> way you enter your admin, what you enter below is actual dollar figure, then 2 columns after it will show you what kind of percentage you have effectively entered.

When you choose percent or PMPM, there is a large highlighted area that says "leave blank not applicable", that is something you leave blank. But, you can also use that cell to start with the overall cost. To do this go back to the top, select "N/A -use total admin cost". Once you select that you no longer put in percent or PMPM, those cells become not applicable and that's what the N/A means, you come back to the bottom, you know longer see "N/A leave blank", it says total admin costs. At that point you enter your total estimated admin costs, or in this case because you want to utilize this feature for PCPCH PMPM, you enter your PCPCH total costs. Let's say \$1 M, you can enter that \$ 1 M in the cell. What will happen is 2 columns that show you what admin PMPM and what admin percent would result from total cost. In this case it's not your admin but your PCPCH PMPM. You can enter this in the steps below. There are some assumptions that go into this approach. The assumption is when you use total cost, you assume your PCPCH cost will be distributed across the eligibility categories based on how expensive or how much each of these eligibility costs will be paid. In other words you do have to enter your PMPM cost figures first before you enter your PCPCH.

**Question 37.** We have arrangements with providers that are very similar to PCPCH. Can we put these base year costs in that bucket?

**Answer 37.** Yes these costs can be included in the base year costs.

**Question 38.** Is there an area to include medical related expenses that do not have claims data associated with them, such as an air conditioner for an Asthma patient?

**Answer 38.** Other- PCPCH

**Question 39.** How should the template be filled out regarding “data period claim costs”, if the CCO did not cover a given service (for example, Dental...) during the experience period, but will cover the service during the rate period?

**Answer 39.** For those Applicants who are in this situation, this is a perfect example of where ASU would like to work closely with the Applicant in being able to provide them the information that they need to be able to complete their CCO Cost Template. For those Applicants in this situation, contact ASU as quickly as possible so we can help.

**Question 40.** So Column N has a load for FFS in it?

**Answer 40.** No, it does not yet, however, it will once we have received steps 1-3 and have sent back your CCO Cost Template with the FFS risk adjustment population.

**Question 41.** If you type a number into cell F19 for the total admin costs, it does not appear to change anything - maybe this is fixed in version 2?

**Answer 41.** The reason for that is that you have to have first filled out all the cost information for it to function. This will allocate your total costs to different eligibility categories based on how expensive or how high each of these different PMPM. If you haven't done that and your cost estimate is still zero for all of the categories, then it won't calculate the PMPM for you yet.