Attachment 13 — Attestations

Applicant Name: _____

Authorizing Signature: _____

Printed Name: _____

Instructions: For each attestation, Applicant will check "yes," or "no." A "yes" answer is normal, and an explanation will be furnished if Applicant's response is "no". Applicant must respond to all attestations. If an attestation has more than one question and Applicant's answer is "no" to any question, check "no" and provide an explanation.

These attestations must be signed by a representative of Applicant.

Unless a particular item is expressly effective at the time of Application, each attestation is effective starting at the time of Readiness Review and continuing throughout the term of the Contract. Each section of attestations refers to a questionnaire in an Attachment, which may furnish background and related questions.

A. General Questions Attestations (Attachment 6)

1. Contract

a. Is Applicant willing to enter into a Contract for 2020 in the form of Appendix B?

☐ Yes ☐ No

If "no" please provide explanation: _____

b. Is Applicant willing to satisfy Readiness Review standards by September 30, 2019?

☐ Yes ☐ No

If "no" please provide explanation: _____

2. Subcontracts

a. Is Applicant willing to hold written agreements with Subcontractors that clearly describe the scope of work?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to provide to OHA an inventory of all work described in this Contract that is delegated or subcontracted and identify the entity performing the work?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to provide to OHA unredacted copies of written agreements with Subcontractors?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

3. Third Party Liability and Personal Injury Lien

a. Is Applicant willing to identify and require its Subcontractors and Providers to identify and promptly report the presence of a Member's Third Party Liability?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to document all efforts to pursue financial recoveries from third party insurers?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to report and require its Subcontractors to report all financial recoveries from third party insurers?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to provide and require its Affiliated entities and Subcontractors to provide to OHA all information related to TPL eligibility to assist in the pursuit of financial recovery?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

4. Oversight and Governance

a. Is Applicant willing to provide its organizational structure, identifying any relationships with subsidiaries and entities with an ownership or Control stake?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

B. Provider Participation and Operations Attestations (Attachment 7)

1. General Questions

a. Will Applicant have an individual accountable for each of the operational functions described below?

- Contract administration
- Outcomes and evaluation
- Performance measurement
- Health management and Care Coordination activities
- System coordination and shared accountability between DHS Medicaid-funded LTC system and CCO
- Behavioral Health (mental health and addictions) coordination and system management
- Communications management to Providers and Members
- Provider relations and network management, including credentialing
- Health information technology and medical records
- Privacy officer
- Compliance officer
- Quality Performance Improvement
- Leadership contact for single point of accountability for the development and implementation of the Health Equity Plan
- Traditional Health Workers Liaison

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Will Applicant participate in the Learning Collaboratives required by ORS 442.210?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Will Applicant collect, maintain and analyze race, ethnicity, and preferred spoken and written languages 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?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Will Applicant (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?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

e. Will Applicant 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?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

f. Will Applicant ensure that all Provider, facility, and supplier contracts or agreements contain the required contract provisions that are described in the Contract?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

g. Will Applicant have executed Provider, facility, and supplier contracts in place to demonstrate adequate access and availability of Covered Services throughout the requested Service Area?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

h. Will Applicant have all Provider contracts or agreements available to OHA in unredacted form?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

i. Will Applicant's contracts for administrative and management services contain the OHA required Contract provisions?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

j. Will Applicant establish, maintain, and monitor the performance of a comprehensive network of Providers to ensure sufficient access to Medicaid Covered Services, including comprehensive behavioral and oral health 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.

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

k. Will Applicant have executed written agreements with Providers (first tier, downstream, or related entity instruments) structured in compliance with OHA regulations and guidelines?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

l. Will Applicant have executed written agreements with Local Mental Health Authorities throughout its Service Area, structured in compliance with OHA regulations and guidelines?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

m. Will Applicant develop a comprehensive Behavioral Health plan in collaboration with the Local Mental Health Authority and other Community partners?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

n. Will Applicant coordinate and collaborate on the development of the Community health improvement plan (CHP) under ORS 414.627 with the Local Mental Health Authority's comprehensive local plan for the delivery of mental health services (ORS 430.630)?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

o. Will Applicant, through its contracted Participating Provider Network, along with other specialists outside the network, Community resources or social services within the CCO's Service Area, provide ongoing primary care, Behavioral Health care, oral health care, and specialty care as needed and will guarantee the continuity of care and the integration of services as described below?

- Prompt, convenient, and appropriate access to Covered Services by Members 24 hours a day, 7 days a week;
- The coordination of the individual care needs of Members in accordance with policies and procedures as established by the Applicant;
- Member involvement in decisions regarding treatment, proper education on treatment options, and the coordination of follow-up care;
- Effectively addressing and overcoming barriers to Member compliance with prescribed treatments and regimens; and
- Addressing diverse patient populations in a linguistically diverse and culturally competent manner.

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

p. Will Applicant establish policies, procedures, and standards that:

- Ensure and facilitate the availability, convenient, and timely access to all Medicaid Covered Services as well as any supplemental services offered by the CCO;
- Ensure access to medically necessary care and the development of medically necessary individualized care plans for Members;
- Promptly and efficiently coordinate and facilitate access to clinical information by all Providers involved in delivering the individualized care plan of the Member while following Timely Access to Services standards;
- Communicate and enforce compliance by Providers with medical necessity determinations; and
- Do not discriminate against Medicaid Members, including providing services to individuals with disabilities in the most integrated Community setting appropriate to the needs of those individuals.

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

q. Will Applicant 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?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

r. Will Applicant provide all services covered by Medicaid and comply with OHA coverage determinations?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

s. Will Applicant have an Medicare plan to serve Fully Dual Eligibles either through contractual arrangement or owned by Applicant or Applicant parent company to create integrated Medicare-Medicaid opportunities during the contract period? [Plan can be a Dual Special Needs Plan or MA plan that offers low premiums and integrated Part D medications options].

☐ Yes ☐ No

If "no" please provide explanation:

t. Will Applicant, Applicant staff and its Affiliated companies, subsidiaries or Subcontractors (first tier, downstream, and related entities), and Subcontractor staff 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).

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

u. Is it true that 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, subsidiaries, or entities with an ownership stake, 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?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

2. Network Adequacy

a. Is Applicant willing to monitor and evaluate the adequacy of its Provider Network?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to remedy any deficiencies in its Provider Network within a specified timeframe when deficiencies are identified?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to report on its Provider Network in a format and frequency specified by OHA?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to collect data to validate that its Members are able to access care within time and distance requirements?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

e. Is Applicant willing to collect data to validate that its Members are able to make appointments within the required timeframes?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

f. Is Applicant willing to collect data to validate that its Members are able to access care within the required timeframes?

☐ Yes ☐ No

g. Is Applicant willing to arrange for Covered Services to be provided by Non-Participating Providers if the services are not timely available within Applicant's Provider Network?

☐ Yes ☐ No

3. Fraud, Waste and Abuse Compliance

a. Is Applicant willing to designate a Compliance Officer to oversee activities related to the prevention and detection of Fraud, Waste and Abuse?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to send two representatives, including the Applicant's designated Compliance Officer and another member of the senior executive team to attend a mandatory Compliance Conference on May 30, 2019?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

C. Value-Based Payment (VBP) Attestations (Attachment 8)

1. Have you reviewed the VBP Policy Requirements set forth in the VBP Questionnaire?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

2. Have you reviewed the VBP reference documents linked to the VBP Questionnaire?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

3. Can you implement and report on VBP as defined by VBP Questionnaire and the Health Care Payment Learning and Action Network's (LAN's) "Alternative Payment Model Framework White Paper Refreshed 2017" (https://hcp-lan.org/apm-refresh-white-paper/) and the OHA Value-Based Payment Roadmap Categorization Guidance for Coordinated Care Organizations?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

4. Will you begin CCO 2.0 – January 2020 – with at least 20% of your projected annual payments to your Providers under contracts that include a Value-Based Payment component as defined by the Health Care Payment Learning and Action Network's (LAN's) "Alternative Payment Model Framework White Paper Refreshed 2017" (https://hcp-lan.org/apm-refresh-white-paper/), Pay for Performance category 2C or higher and the OHA Value-Based Payment Roadmap Categorization Guidance for Coordinated Care Organizations?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

5. Do you permit OHA to publish your VBP data such as the actual VBP percent of spending that is LAN category 2C or higher and spending that is LAN category 3B or higher, as well as data pertaining to your care delivery areas, Patient-Centered Primary Care Home (PCPCH) payments, and other information about VBPs required by this RFA? (OHA does not intend to publish specific payments amounts from an Applicant to a specific rovider.)

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

6. Do you agree to develop mitigation plans for adverse effects VBPs may have on health inequities, health disparities, or any adverse health-related outcomes for any specific population (including racial, ethnic and culturally-based communities; LGBTQ people; persons with disabilities; people with limited English proficiency; and immigrants or refugees and Members with complex health care needs, as well as populations at the intersections of these groups) and to report on these plans to OHA annually?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

7. Do you agree to the requirements for VBP targets, care delivery areas and PCPCH clinics for years 2020 through 2024, as set forth in the VBP Questionnaire?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

8. Do you agree to the requirements for VBP data reporting for years 2020 through 2024, as set forth in the VBP Questionnaire?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

9. Should OHA contract with one or more other CCOs serving Members in the same geographical area, will you participate in OHA-facilitated discussions to select performance measures to be incorporated into each CCO's VBP Provider contracts for common Provider types and specialties?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

10. If, after the discussion described in the previous question, OHA informs you of the Provider types and specialties for which the performance measures apply, will you incorporate all selected measures into applicable Provider contracts?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

D. Health Information Technology (HIT) Attestations (Attachment 9)

1. HIT Roadmap

a. Does Applicant agree to participate in an interview/demonstration and deliver an HIT Roadmap with any refinements/adjustments agreed to with OHA during Readiness Review, for OHA approval?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Does Applicant agree to provide an annual HIT Roadmap update for OHA approval to include status/progress on CCO-identified milestones, and any adjustments to the HIT Roadmap; as well as participate in an annual interview with OHA?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

2. HIT Partnership

a. Does Applicant agree to participate in the HIT Commons beginning 2020, including agreeing to do all of the following:

- Maintaining an active, signed HIT Commons MOU and adhering to its terms,
- Paying annual HIT Commons assessments, and
- Serving, if elected, on the HIT Commons Governance Board or one of its committees?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Does Applicant agree to participate in OHA's HIT Advisory Group, (HITAG), at least once annually?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

3. Support for EHR Adoption

a. Will Applicant support EHR adoption for its contracted physical health Providers?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Will Applicant support EHR adoption for its contracted Behavioral Health Providers?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Will Applicant support EHR adoption for its contracted oral health Providers?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

d. During Year 1, will Applicant report on the baseline of EHR adoption among its contracted physical health Providers, set Improvement Targets, and provide supporting detail about its implementation approach?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

e. During Year 1, will Applicant report on the baseline of EHR adoption among its contracted Behavioral Health Providers, set Improvement Targets, and provide supporting detail about its implementation approach?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

f. During Year 1, will Applicant report on the baseline of EHR adoption among its contracted oral health Providers, set Improvement Targets, and provide supporting detail about its implementation approach?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

g. Will Applicant report to the state annually on which EHR(s) each of its contracted physical health Providers is using, by means of definitions and data sources agreed upon during Readiness Review? Will reports include product and vendor name, version, and, if applicable, certification year the ONC Certification (CHPL) number for Certified EHR Technology? See https://chpl.healthit.gov/ and https://www.healthit.gov/topic/certification-ehrs/2015-edition for more information about Certified EHR Technology.

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

h. Will Applicant report to the state annually on which EHR(s) each of its contracted Behavioral Health Providers are using, by means of definitions and data sources agreed upon during Readiness Review? Will reports include product and vendor name, version, and, if applicable, certification year the ONC Certification (CHPL) number for Certified EHR Technology? See https://chpl.healthit.gov/ and https://www.healthit.gov/topic/certification-ehrs/2015-edition for more information about Certified EHR Technology.

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

i. Will Applicant report to the state annually on which EHR(s) each of its contracted oral health Providers is using, by means of definitions and data sources agreed upon during Readiness Review? Will reports include product and vendor name, version, and, if applicable, certification year the ONC Certification (CHPL) number for Certified EHR Technology? See https://chpl.healthit.gov/ and https://www.healthit.gov/topic/certification-ehrs/2015-edition for more information about Certified EHR Technology.

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

4. Support for HIE

a. Will Applicant ensure access to timely Hospital event notifications for its contracted physical health Providers? If there are costs associated with ensuring access to timely Hospital event notifications for contracted Providers, will the Applicant be responsible for those costs?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Will Applicant ensure access to timely Hospital event notifications for its contracted Behavioral Health Providers? If there are costs associated with ensuring access to timely Hospital event notifications for contracted Providers, will the Applicant will be responsible for those costs?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Will Applicant ensure access to timely Hospital event notifications for its contracted oral health Providers? If there are costs associated with ensuring access to timely Hospital event notifications for contracted Providers, will the Applicant will be responsible for those costs.

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Will Applicant use Hospital event notifications within the CCO, for example to support Care Coordination and/or population health efforts?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

e. Will Applicant support access to health information exchange that enables sharing patient information for Care Coordination for its contracted physical health Providers?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

f. Will Applicant support access to health information exchange that enables sharing patient information for Care Coordination for its contracted Behavioral Health Providers?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

g. Will Applicant support access to health information exchange that enables sharing patient information for Care Coordination for its contracted oral health Providers?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

h. During Year 1, will Applicant report on the baseline of HIE access and use among its contracted physical health Providers (inclusive of Hospital event notifications and HIE for Care Coordination), set Improvement Targets, and provide supporting detail about its implementation approach?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

i. During Year 1, will Applicant report on the baseline of HIE access and use among its contracted Behavioral Health Providers (inclusive of Hospital event notifications and HIE for Care Coordination), set Improvement Targets, and provide supporting detail about its implementation approach?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

j. During Year 1, will Applicant report on the baseline of HIE access and use among its contracted oral health Providers (inclusive of Hospital event notifications and HIE for Care Coordination), set Improvement Targets, and provide supporting detail about its implementation approach?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

k. Will Applicant report to the state annually on which HIE tool(s) each of its contracted physical health Providers is using, using definitions and data sources agreed upon during Readiness Review?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

l. Will Applicant report to the state annually on which HIE tool(s) each of its contracted Behavioral Health Providers is using, using definitions and data sources agreed upon during Readiness Review?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

m. Will Applicant report to the state annually on which HIE tool(s) each of its contracted oral health Providers is using, using definitions and data sources agreed upon during Readiness Review?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

5. Health IT for VBP and Population Management.

a. For the initial VBP arrangements, will Applicant have by the start of Year 1 the HIT needed to administer the arrangements (as described in its supporting detail)?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

b. For the planned VBP arrangements for Years 2 through 5, does Applicant have a roadmap to obtain the HIT needed to administer the arrangements (as described in its supporting detail)?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

c. By the start of Year 1, will the Applicant provide contracted Providers with VBP arrangements with timely (e.g., at least quarterly) information on measures used in the VBP arrangement(s) applicable to the Providers?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

d. By the start of Year 1, will the Applicant provide contracted Providers with VBP arrangements with accurate and consistent information on patient attribution?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

e. By the start of Year 1, will the Applicant identify for contracted Providers with VBP arrangements specific patients who need intervention through the year, so they can take action before the year end?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

f. By the start of Year 1, will the Applicant have the capability to risk stratify and identify and report upon Member characteristics, including but not limited to past diagnoses and services, that can inform the targeting of interventions to improve outcomes?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

g. By the start of each subsequent year for Years 2 through 5, will the Applicant CCO provide risk stratification and Member characteristics to your contracted Providers with VBP arrangements for the population(s) included in the arrangement(s) in place for each year?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

E. Social Determinants of Health and Health Equity (SDOH-HE) Attestations (Attachment 10)

1. Social Determinants of Health and Health Equity Spending, Priorities, and Partnership

a. Is Applicant willing to direct a portion of its annual net income or reserves, as required by Oregon State Statute and defined by OHA in rule, to addressing health disparities and SDOH-HE?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to enter into written agreements with SDOH-HE partners that describe the following: any relationship or financial interest that may exist between the SDOH-HE partner and the CCO, how funds will be distributed, the scope of work including the domain of SDOH-HE addressed and the targeted population, whether CCO will refer Members to the SDOH-HE partner, the geographic area to be covered, how outcomes will be evaluated and measured, and how the CCO will collect and report data related to outcomes?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

c. When identifying priorities for required SDOH-HE spending, is Applicant willing to designate, define and document a role for the CAC in directing, tracking and reviewing spending?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to align its SDOH-HE spending priorities with the priorities identified in the Community Health Improvement Plan and its Transformation and Quality Strategy, and to include at least one statewide priority (e.g. housing-related services and supports, including Supported Housing) in addition to its Community priorities?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

2. Health-related Services

a. Is Applicant willing to align HRS Community benefit initiatives with Community priorities from the CCO's Community Health Improvement Plan?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to align HRS Community benefit initiatives with a designated statewide priority should OHA require it?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to designate, define and document a role for the CAC when determining how Health-Related Services Community benefit initiatives decisions are made?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

3. Community Advisory Council membership and role

a. Is the Applicant willing to provide to OHA an organizational chart that includes the Community Advisory Council, and notes relationships between entities, including the CAC and the Board, how information flows between the bodies, the CAC and Board connection to various committees, and CAC representation on the board?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

4. Health Equity Assessment and Health Equity Plan

a. Is Applicant willing to develop and implement a Health Equity Plan according to OHA guidance, which includes a plan to provide cultural responsiveness and implicit bias education and training across the Applicant's organization and Provider Network? See Sample Contract and Cultural Responsiveness Training Plan Guidance Document.

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to include in its Health Equity Plan at least one initiative using HIT to support patient engagement?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to adopt potential health equity plan changes, including requirements, focus areas and components, based on OHA plan review feedback and, when applicable, based on guidance provided by the Oregon Health Policy Board's Health Equity Committee?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to designate a single point of accountability within the organization, who has budgetary decision-making authority and health equity expertise, for the development and implementation of the Health Equity Plan?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

e. Is Applicant willing to faithfully execute the finalized Health Equity Plan?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

f. Is Applicant willing to a) ask vendors for cultural and linguistic accessibility when discussing bringing on new HIT tools for patient engagement and b) when possible, seek out HIT tools for patient engagement that are culturally and linguistically accessible?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

5. Traditional Health Workers (THW) Utilization and Integration

a. Is Applicant willing to develop and fully implement a Traditional Health Workers Integration and Utilization Plan?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to work in collaboration with the THW Commission to implement the Commission's best practices for THW integration and utilization?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to fully implement the best practices developed in collaboration with the THW Commission?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to develop and implement a payment strategy for THWs that is informed by the recommendations from the Payment Model Committee of the THW Commission?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

e. Is Applicant willing to designate an individual within the organization as a THW Liaison as of the Effective Date of the Contract?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

f. Is Applicant willing to engage THWs during the development of the CHA and CHP?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

g. For services that are not captured on encounter claims, is Applicant willing to track and document Member interactions with THWs?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

6. Community Health Assessment and Community Health Improvement Plan

a. Is Applicant willing to partner with local public health authorities, non-profit Hospitals, any CCO that shares a portion of its Service Area, and any Tribes that are developing a CHA/CHP to develop shared CHA and CHP priorities?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to align CHP priorities with at least two State Health Improvement Plan (SHIP) priorities and implement statewide SHIP strategies based on local need?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to submit its Community Health Assessment and Community Health Improvement Plan to OHA?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to develop and fully implement a community engagement plan?

☐ Yes ☐ No

If "no" please provide explanation:

F. Behavioral Health Attestations (Attachment 11)

1. Behavioral Health Benefit

a. Will Applicant report performance measures and implement Evidence-Based outcome measures, as developed by the OHA Metrics and Scoring Committee, and as specified in the Contract?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Will Applicant work collaboratively with OHA and its partners to implement all of the requirements in Exhibit M of the Contract?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Will Applicant be fully responsible for the Behavioral Health benefit for Members beginning in CY 2020?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Will Applicant manage the Global Budget (as defined in ORS 414.025) in a fully integrated manner? Fully integrated manner means that Applicant will not sub-capitate any Provider or entity for Behavioral Health services separately from physical health services nor will Applicant enter into any Value-Based Payment arrangements under which Behavioral Health spending is tracked separately from physical health services.

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

e. Will Applicant report on the information and data specified in the Performance Expectations section as specified in the Contract and submit an annual report to OAH for review and approval?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

f. Will Applicant have sufficient resources, including technological, financial, Provider and workforce, to integrate the Behavioral Health benefit with oral and physical health care benefits?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

g. Will Applicant ensure the provision of cost-effective, comprehensive, person-centered, Culturally Responsive, and integrated Community-based Behavioral Health services for Members?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

h. Will Applicant provide oversight, Care Coordination, transition planning and management of the Behavioral Health needs of Members to ensure Culturally Responsive and linguistically appropriate Behavioral Health services are provided in a way that Members are served in a most natural and integrated environment possible and that minimizes the use of institutional care?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

i. Will Applicant follow Intensive Care Coordination standards as identified in OAR 410-141-3160/70?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

j. Will Applicant ensure Members have access to Referral and screening at multiple health system or health care entry points?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

k. Will Applicant use a standardized Assessment tool, to adapt the intensity and frequency of Behavioral Health services to the Behavioral Health needs of the Member?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

l. Will Applicant work collaboratively to improve services for adult Members with SPMI as a priority population? Will Applicant make significant commitments and undertake significant efforts to continue to improve treatment and services so that adults with SPMI can live and prosper in integrated Community settings?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

m. Will Applicant ensure Members have timely access to all services under the Behavioral Health benefit in accordance with access to service standards as developed in Appendix C, the Administrative Rules Concept Document, under OHPB #17?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

n. Will Applicant have an adequate Provider Network to ensure Members have timely access to Behavioral Health services and effective treatment in accordance with the Delivery System and Provider Capacity section of the Contract?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

o. Will Applicant establish written policies and procedures for Prior Authorizations, in compliance with the Mental Health Parity and Addiction Equity Act of 2008, and be responsible for any inquiries or concerns and not delegate responsibility to Providers?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

p. Will Applicant establish written policies and procedures for the Behavioral Health benefit and provide the written policies and procedures to OHA by the beginning of CY 2020?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

q. Will Applicant require mental health and substance use disorder programs be licensed or certified by OHA to enter the Provider Network?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

r. Will Applicant require Providers to screen Members for adequacy of supports for the Family in the home (e.g., housing adequacy, nutrition/food, diaper needs, transportation needs, safety needs and home visiting)?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

s. Will Applicant ensure Applicant's staff and Providers are trained in recovery principles, motivational interviewing, integration, and Foundations of Trauma Informed Care (https://traumainformedoregon.org/tic-intro-training-modules/)?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

t. Will Applicant ensure Providers are trained in Trauma Informed approaches and provide regular periodic oversight and technical assistance to Providers?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

u. Will Applicant require Providers, in developing Individual Service and Support Plans for Members, to assess for Adverse Childhood Experiences (ACEs) and trauma in a Culturally Responsive and Trauma Informed framework and approach?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

v. Will Applicant ensure Behavioral Health services are Culturally Responsive and Trauma Informed?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

w. Will Applicant assume responsibility for the entire Behavioral Health residential benefit by the beginning of CY 2022?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

x. Will Applicant include OHA approved Behavioral Health homes (BHHs) in Applicant's network as the BHHs qualify in Applicant's Region?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

y. Will Applicant assist Behavioral Health organizations within the delivery system to establish BHHs?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

z. Will Applicant utilize BHHs in their network for Members to the greatest extent possible?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

aa. Will Applicant provide a full psychological evaluation and child psychiatric consultation for children being referred to the highest levels of care (day treatment, subacute or PRTS)?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

2. MOU with Community Mental Health Program (CMHP)

a. Will Applicant enter into a written memorandum of understanding (MOU) with the local Community Mental Health Program (CMHP) in Applicant's Region by beginning of CY 2020, in accordance with ORS 414.153?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Will Applicant develop a comprehensive Behavioral Health plan for Applicant's Region in collaboration with the Local Mental Health Authority and other Community partners (e.g., education/schools, Hospitals, corrections, police, first responders, Child Welfare, DHS, public health, Peers, families, housing authorities, housing Providers, courts)?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Will Applicant coordinate and collaborate on the development of the Community health improvement plan (CHP) under ORS 414.627 with the local Community Mental Health Program (CMHP) for the delivery of mental health services under ORS 430.630

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

3. Provisions of Covered Services – Behavioral Health

a. Will Applicant provide services as necessary to achieve compliance with the mental health parity requirements of 42 CFR§ 438, subpart K and ensure that any quantitative treatment limitations (QTLs), or non-quantitative treatment limitations (NQTLs) placed on Medically Necessary Covered Services are no more restrictive than those applied to fee-for-service medically necessary covered benefits, as described in 42 CFR 438.210(a)(5)(i)?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Will Applicant assume accountability for Members that are civilly committed and are referred to and enter Oregon State Hospital; be financially responsible for the services for Members on waitlist for Oregon State Hospital after the second year of the Vontract, with timeline to be determined by OHA; and be financially responsible for services for Members admitted to Oregon State Hospital after the second year of the Vontract, with timeline to be determined by OHA?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Will Applicant reimburse for covered Behavioral Health services rendered in a primary care setting by a qualified Behavioral Health Provider, and reimburse for covered physical health services in Behavioral Health care settings, by a qualified medical Provider?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Will Applicant ensure Members receive services from Non-Participating Providers for Behavioral Health services if those services are not available from Participating Providers or if a Member is not able to access services within the timely access to care standards? Will Applicant remain responsible for coordinating Behavioral Health services with Non-Participating Providers and reimbursing for services?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

e. Will Applicant ensure continuity of care throughout episodes of care and provide Intensive Care Coordination and general Care Coordination as specified in the Contract?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

4. Covered Services Component – Behavioral Health

a. Will Applicant establish written policies and procedures for an emergency response system, including post-stabilization care services and Urgent Services for all Members on a 24-hour, 7-day-a-week basis consistent with OAR 410-141-3140 and 42 CFR 438.114? Will the emergency response system provide an immediate, initial or limited duration response for emergency situations or potential Behavioral Health emergency situations that may include Behavioral Health conditions?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Will Applicant ensure access to Mobile Crisis Services for all Members in accordance with OAR 309-019-0105, OAR 309-019-0150, 309-019-0242, and 309-019-0300 to 309-019-0320 to promote stabilization in a Community setting rather than arrest, presentation to an Emergency Department, or admission to an Acute psychiatric care facility?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Will Applicant establish written policies and procedures for a Quality Improvement plan for the emergency response system?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Will Applicant collaboratively work with OHA and CMHPs to develop and implement plans to better meet the needs of Members in Community integrated settings and to reduce recidivism to Emergency Departments for Behavioral Health reasons?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

e. Will Applicant work with Hospitals to provide data on Emergency Department (ED) utilization for Behavioral Health reasons and length of time in the ED? Will Applicant develop remediation plans with EDs with significant numbers of ED stays longer than 23 hour?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

f. Will Applicant establish a policy and procedure for developing a management plan for contacting and offering services to each Member who has two or more readmissions to an ED in a six-month period?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

g. Will Applicant make a reasonable effort to provide Covered Services on a voluntary basis and consistent with current Declaration for Mental Health Treatment as provided at: http://www.oregon.gov/oha/amh/forms/declaration.pdf in lieu of involuntary treatment?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

h. Will Applicant establish written policies and procedures describing the appropriate use of Emergency Psychiatric Holds consistent with ORS 426 and alternatives to involuntary psychiatric care when a less restrictive voluntary service will not meet the Medically Appropriate needs of the Member and the behavior of the Member meets legal standards for the use of an Emergency Psychiatric Hold?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

i. Will Applicant assure that any involuntary treatment provided under the Contract is provided in accordance with administrative rule and statute, and coordinate with the CMHP Director in assuring that all statutory requirements are met? Will Applicant also work with the CMHP Director in assigning a civilly committed Member to any placement and participate in circuit court hearings related to planned placements, if applicable?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

j. If Applicant identifies a Member, over age 18 with no significant nursing care needs due to a general medical condition, Acute medical condition or physical disorder, is appropriate for Long Term Psychiatric Care (State Facility level of care), will Applicant request a LTPC determination from the OHA LTPC reviewer?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

k. If Applicant identifies a Member, age 18 to age 64, with no significant nursing care needs due to a general medical condition, Acute medical condition or physical disorder of an enduring nature, is appropriate for LTPC, will Applicant request a LTPC determination from the applicable HSD Adult Mental Health Services Unit, as described in Procedure for LTPC Determinations for Members 18 to 64, available on the Contract Reports Web Site?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

l. If Applicant identifies a Member, age 65 and over, or age 18 to age 64 with significant nursing care needs due to a general medical condition, Acute medical condition or physical disorder of an enduring nature, is appropriate for LTPC, will Applicant request a LTPC determination from the State hospital-NTS, Outreach and Consultation Service (OCS) Team as described in Procedure for LTPC Determinations for Member Requiring Neuropsychiatric Treatment, available on the Contract Reports Web Site?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

m. For the Member age 18 and over, will Applicant work with the Member to assure timely discharge and transition from LTPC to the most appropriate, independent and integrated Community-based setting possible consistent with Member choice?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

n. Will Applicant authorize and reimburse Care Coordination services, in particular for Members who receive ICC, that are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are provided to Members receiving care through licensed Community treatment programs? Will Applicant authorize and reimburse for ICC services, in accordance with standards identified in OAR 410-141-3160-70?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

o. Will Applicant ensure that any involuntary treatment provided under the Contract is provided in accordance with administrative rule and statute and coordinate with the CMHP Director in assuring that all statutory requirements are met? Will Applicant work with the CMHP Director in assigning a civilly committed Member to any placement and participate in circuit court hearings related to planned placements, if applicable?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

p. Will Applicant provide Acute Inpatient Hospital Psychiatric Care for Members who do not meet the criteria for LTPC?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

q. Will Applicant ensure that all Members discharged from Acute Care Psychiatric Hospitals are provided a Warm Handoff to a Community case manager, Peer bridger, or other Community provider prior to discharge, and that all such Warm Handoffs are documented?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

r. Will Applicant ensure that all Members discharged from Acute Care Psychiatric Hospitals have linkages to timely, appropriate behavioral and primary health care in the Community prior to discharge and that all such linkages are documented, in accordance with OAR provisions 309-032-0850 through 309-032-0870?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

s. Will Applicant ensure all adult Members receive a follow-up visit with a Community Behavioral Health Provider within seven (7) days of their discharge from an Acute Care Psychiatric Hospital?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

t. Will Applicant reduce readmissions of adult Members with SPMI to Acute Care Psychiatric Hospitals?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

u. Will Applicant coordinate with system Community partners to ensure Members who are homeless and who have had two or more readmissions to an Acute Care Psychiatric Hospital in a six-month period are connected to a housing agency or mental health agency to ensure these Members are linked to housing in an integrated Community setting, Supported Housing to the extent possible, consistent with the individual's treatment goals, clinical needs and the individual's informed choice?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

v. Will Applicant ensure coordination and appropriate Referral to Intensive Care Coordination to ensure that Member's rights are met and there is post-discharge support? If Member is connected to ICC coordinator, will Applicant ensure coordination with this person as directed in OAR 410-141-3160-3170?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

w. Will Applicant work with OHA and the CMHPs to ensure that Members who are discharged from Acute Care Psychiatric Hospitals are discharged to housing that meets the individuals' immediate need for housing and work with Acute Care Psychiatric Hospitals in the development of each individual's housing assessment?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

x. Will Applicant establish a policy and procedure for developing a management plan for contacting and offering services to each Member who has two (2) or more readmissions to an Acute Care Psychiatric Hospital in a six-month period?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

y. Will Applicant work with OHA, other state agencies, and other state funded or operated entities to identify areas where treatment and services for adult Members with SPMI can be improved?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

z. Will Applicant coordinate services for each adult Member with SPMI who needs assistance with Covered or Non-covered Services?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

aa. Will Applicant provide oversight, Care Coordination, transition planning and management for Members receiving Behavioral Health services, including Mental Health Rehabilitative Services and Personal Care Services, in licensed and non-licensed home and Community-based settings, ensuring that individuals who no longer need placement in such settings are transitioned to a Community placement in the most integrated Community setting appropriate for that person?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

bb. Will Applicant provide Utilization Review and utilization management, for Members receiving Behavioral Health Services, including Mental Health Rehabilitative Services and Personal Care Services, in licensed and non-licensed home and Community-based settings, ensuring that individuals who no longer need placement in such setting transition to the most integrated Community setting, Supported Housing to the extent possible, consistent with the individual's treatment goals, clinical needs, and the individual's informed choice?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

cc. Will Applicant encourage utilization of Peer-Delivered Services (PDS) and ensure that Members are informed of their benefit to access and receive PDS from a Peer Support Specialist, Peer Wellness Specialist, Family Support Specialist, or Youth Support Specialist as applicable to the Member's diagnosis and needs?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

dd. Will Applicant ensure that Members with SPMI receive Intensive Care Coordination (ICC) support in finding appropriate housing and receive coordination in addressing Member's housing needs?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

ee. Will Applicant ensure Members with SPMI are assessed to determine eligibility for ACT?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

ff. Will Applicant ensure ACT services are provided for all adult Members with SPMI who are referred to and eligible for ACT services in accordance with OAR 309-019-0105 and 309-019-0225 through 309-019-0255?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

gg. Will Applicant ensure additional ACT capacity is created to serve adult Members with SPMI as services are needed?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

hh. Will Applicant, when ten (10) or more of Applicant's adult Members with SPMI in Applicant's Service Area are on a waitlist to receive ACT for more than thirty (30) days, without limiting other Applicant solutions, create additional capacity by either increasing existing ACT team capacity to a size that is still consistent with Fidelity standards or by adding additional ACT teams?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

If Applicant lacks qualified Providers to provide ACT services, will Applicant consult with OHA and develop a plan to develop additional qualified Providers? Will lack of capacity not be a reason to allow individuals who are determined to be eligible for ACT to remain on the waitlist? Will no individual on a waitlist for ACT services be without such services for more than 30 days?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

ii. Will Applicant ensure all denials of ACT services for all adult Members with SPMI are: based on established, evidence-based medical necessity criteria; reviewed, recorded and compiled in a manner that allows denials to be accurately reported out as appropriate or inappropriate; and follow the Notice of Adverse Benefit Determination process for all denials as described in the Contract?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

jj. Will Applicant be responsible for finding or creating a team to serve Members who have appropriately received a denial for a particular ACT team but who meet ACT eligibility standards?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

kk. Will Applicant be responsible for engaging with all eligible Members who decline to participate in ACT in an attempt to identify and overcome barriers to the Member's participation?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

ll. Will Applicant require that a Provider or care coordinator meets with the Member to discuss ACT services and provide information to support the Member in making an informed decision regarding participation? Will this include a description of ACT services and how to access them, an explanation of the role of the ACT team and how supports can be individualized based on the Member's self-identified needs, and ways that ACT can enhance a Member's care and support independent Community living?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

mm. Will Applicant provide alternative evidence-based intensive services if Member continues to decline participation in ACT, which must include coordination with an ICC?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

nn. Will Applicant report the number of individuals referred to ACT, number of individuals admitted to ACT programs, number of denials for the ACT benefit, number of denials to ACT programs, and number of individuals on waitlist by month?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

oo. Will Applicant ensure a Member discharged from OSH who is appropriate for ACT shall receive ACT or an evidence-based alternative?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

pp. Will Applicant document efforts to provide ACT to individuals who initially refuse ACT services, and document all efforts to accommodate their concerns?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

qq. Will Applicant offer alternative evidence-based intensive services for individuals discharged from OSH who refuse ACT services?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

rr. Will Applicant ensure a Member discharged from OSH who is determined not to meet the level of care for ACT shall be discharged with services appropriate to meet their needs?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

ss. Will Applicant coordinate with system partners as needed regarding Oregon State Hospital discharges for all adult Members with SPMI in accordance with OAR 309-091-0000 through 0050?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

tt. Will Applicant ensure access to Supported Employment Services for all adult Members eligible for these services, in accordance with OAR 309-019-0275 through 309-019-0295? ("Supported Employment Services" means the same as "Individual Placement and Support (IPS) Supported Employment Services" as defined in OAR 309-019-0225.)

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

uu. Will Applicant work with local law enforcement and jail staff to develop strategies to reduce contacts between Members and law enforcement due to Behavioral Health reasons, including reduction in arrests, jail admissions, lengths of stay in jails and recidivism?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

vv. Will Applicant work with SRTFs to expeditiously move civilly committed adult Members with SPMI who no longer need placement in an SRTF to a Community placement in the most integrated setting, Supported Housing to the extent possible, consistent with the individual's treatment goals, clinical needs, and the individual's informed choice?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

ww. Will Applicant provide Substance Use Disorder (SUD) services to Members, which include outpatient, intensive outpatient, medication assisted treatment including Opiate Substitution Services, residential and detoxification treatment services consistent with OAR Chapter 309, Divisions 18, 19 and 22, and OAR Chapter 415 Divisions 20, and 50?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

xx. Will Applicant comply with Substance Use Disorder (SUD) waiver program designed to improve access to high quality, clinically appropriate treatment for opioid use disorder and other SUDs, upon approval by Centers for Medicare and Medicaid Services (CMS)?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

yy. Will Applicant inform all Members using Culturally Responsive and linguistically appropriate means that Substance Use Disorder outpatient, intensive outpatient, residential, detoxification and medication assisted treatment services, including opiate substitution treatment, are Covered Services consistent with OAR 410-141-3300?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

zz. Will Applicant participate with OHA in a review of OHA provided data about the impact of these criteria on service quality, cost, outcome, and access?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

5. Children and Youth

a. Will Applicant develop and implement cost-effective comprehensive, person-centered, individualized, and integrated Community-based Child and Youth Behavioral Health services for Members, using System of Care (SOC) principles?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Will Applicant utilize evidence-based Behavioral Health interventions for the needs of children 0-5, and their caregivers, with indications of Adverse Childhood Experiences (ACEs) and high complexity?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Will Applicant provide Intensive Care Coordination (ICC) that is Family and youth-driven, strengths based and Culturally Responsive and linguistically appropriate and abide by ICC standards as set forth in Appendix C, Administrative Rules Concept under OHPB #24 and in accordance with the ICC section in the Contract? Will Applicant abide by ICC standards as forth in Appendix C, Administrative Rules Concept, under OHPB #24, and in accordance with the ICC section in the Contract?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Will Applicant provide services to children, young adults and families of sufficient frequency, duration, location, and type that are convenient to the youth and Family? Will Services alleviate crisis while allowing for the development of natural supports, skill development, normative activities and therapeutic resolution to Behavioral Health disorders and environmental conditions that may impact the remediation of a Behavioral Health disorder?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

e. Will Applicant adopt policies and guidelines for admission into Psychiatric Residential Treatment Services (PRTS), Psychiatric Day Treatment Services (PDTS) and/or Intensive Outpatient Services and Supports?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

f. Will Applicant ensure the availability of service, supports or alternatives 24 hours a day/7 days a week to remediate a Behavioral Health crisis in a non-emergency department setting?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

g. Will Applicant encourage utilization of Peer-Delivered Services (PDS) and ensure that Members are informed of their benefit to access and receive PDS from a Peer Support Specialist, Peer Wellness Specialist, Family Support Specialist, or Youth Support Specialist as applicable to the Member's diagnosis and needs?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

h. If Applicant identifies a Member is appropriate for LTPC Referral, will Applicant request a LTPC determination from the applicable HSD Child and Adolescent Mental Health Specialist, as described in Procedure for LTPC Determinations for Members 17 and Under, available on the Contract Reports Web Site?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

i. Will Applicant arrange for the provision of non-health related services, supports and activities that can be expected to improve a Behavioral Health condition?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

j. Will Applicant coordinate admissions to and discharges from Acute Inpatient Hospital Psychiatric Care and Sub-Acute Care for Members 17 and under, including Members in the care and custody of DHS Child Welfare or OYA? For a Member 17 and under, placed by DHS Child Welfare through a Voluntary Placement Agreement (CF 0499), will Applicant also coordinate with such Member's parent or legal guardian?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

k. Will Applicant ensure a CANS Oregon is administered to a Member who is a child or youth and the data is entered into OHA approved data system according to the eligibility and timeline criteria in the Contract?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

l. Will Applicant have funding and resources to implement, to fidelity, Wraparound Services?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

m. Will Applicant enroll all eligible youth in Wraparound and place no youth on a waitlist?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

n. Will Applicant screen all eligible youth with a Wraparound Review Committee in accordance with Wraparound Services as described in the OHA System of Care Wraparound Initiative (SOCWI) guidance document found at the link below and in Wraparound Service OARs? http://www.oregon.gov/oha/hsd/amh/pages/index.aspx.

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

o. Will Applicant establish and maintain a functional System of Care in its Service Area in accordance with the Best Practice Guide located at https://www.pdx.edu/ccf/best-practice-guide including a Practice Level Workgroup, Advisory Committee and Executive Council with a goal of youth and Family voice representation to be 51 percent?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

p. Will Applicant have a functional SOC governance structure by the beginning of CY 2020 that consists of a practice level work group, advisory council, and executive council?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

q. By end of CY 2020, will Applicant have written Charters and new Member handbooks for Practice Level Work group, Advisory Council and Executive Council?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

G. Cost and Financial Attestations (Attachment 12)

1. Rates

Does Applicant accept the CY 2020 Rate Methodology appended to Attachment 12?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

2. Evaluate CCO performance to inform CCO-specific profit margin

a. Does Applicant agree to performance and efficiency evaluation being used to set profit margins in CCO capitation rates?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Does Applicant agree to accept the CCO 2.0 capitation rate methodology as described in the Oregon CY20 Procurement Rate Methodology document and also accept the performance evaluation methodology and its use in setting CCO-specific profit margins?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Does Applicant agree to report additional data as needed to inform the performance evaluation process, including data on utilization of Health-Related Services?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to have OHA use efficiency analysis to support managed care efficiency adjustments that may result in adjustments to the base data used in capitation rate development to further incentivize reductions in Waste in the system?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

3. Qualified Directed Payments to Providers

a. Is Applicant willing to make OHA-directed payments to certain Hospitals within five Business Days after receipt of a monthly report prepared and distributed by OHA?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to report to OHA promptly if it determines payments to Hospitals will be significantly delayed?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to exclude the portion of OHA-directed payments for provider tax repayment when negotiating alternative or Value-Based Payment reimbursement arrangements?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to provide input and feedback to OHA on the selection of measures of quality and value for OHA-directed payments to Providers?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

4. Quality Pool Operations and Reporting

a. Does Applicant agree to having a portion of capitation withheld from monthly Capitation Payment and awarded to the Applicant based on performance on metrics based on the Quality Incentive Pool program?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Does Applicant agree to report to OHA separately on expenditures incurred based on Quality Pool revenue earned?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Does Applicant agree to report on the methodology it uses to distribute Quality Pool earnings to Providers, including SDOH-HE partners and public health partners?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Does Applicant have a plan to evaluate contributions made by SDOH-HE and public health partners toward the achievement of Quality Pool metrics?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

5. Transparency in Pharmacy Benefit Management Contracts

a. Will Applicant select and contract with the Oregon Prescription Drug Program to provide Pharmacy Benefit Management services? If yes, please skip to section 5. If not, please answer parts b-f of this question.

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Will Applicant use a pharmacy benefit manager that will provide pharmacy cost passthrough at 100% and pass back 100% of rebates received to Applicant?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Will Applicant separately report to OHA any and all administrative fees paid to its PBM?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Will Applicant require reporting from PBM that provides paid amounts for pharmacy costs at a claim level?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

e. Will Applicant obtain market check and audits of their PBMs by a third party on an annual basis, and share the results of the market check with the OHA?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

f. Will Applicant require its PBM to remain competitive with enforceable contract terms and conditions driven by the findings of the annual market check and report auditing?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

6. Alignment Preferred Drug Lists (PDLs) and Prior Authorization Criteria

a. Will Applicant partner with OHA on the goal of increasing the alignment of CCO preferred drug lists (PDL) with the Fee-For-Service PDL set every year by OHA?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Will Applicant align its PDL in any and all categories of drugs as recommended by the P&T committee and as required by OHA?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Will Applicant post online in a publicly accessible manner the Applicant's specific PDL with coverage and Prior Authorization criteria in a format designated by OHA and update the posting concurrently or before any changes to the PDL or coverage/PA criteria become effective?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

7. Financial Reporting Tools and Requirements

a. Is Applicant willing to partake of all financial, legal and technological requirements of the National Association of Insurance Commissioners (NAIC) in whatever capacity necessary to file its financial information with OHA under NAIC standards?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Will Applicant report its required financial information to OHA on the NAIC's Health Quarterly and Annual Statement blank ("Orange Blank") through the NAIC website as described in this RFA, under NAIC standards and instructions?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Will Applicant report its financial information to OHA using Statutory Accounting Principles (SAP), subject to possible exemption from SAP for 2020 as described in this RFA?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Will Applicant file the financial reports described in this RFA, including Contract Exhibit L and supplemental schedules with the instructions referenced in this RFA?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

e. Is Applicant willing to resubmit its pro forma financial statements for three years starting in 2020, modified to reflect the Enrollment expected assuming other CCOs that may operate in Applicant's Service Area?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

f. Does Applicant commit to preparing and filing a Risk Based Capital (RBC) report each year based on NAIC requirements and instructions?

☐ Yes ☐ No

If "no" please provide explanation: _____

g. Is Applicant willing to submit quarterly financial reports including a quarterly estimation of RBC levels to ensure financial protections are in place during the year?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

h. Is Applicant willing to have its RBC threshold evaluated quarterly using a proxy calculation?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

i. If Applicant's estimated RBC falls below the minimum required percentage based on the quarterly estimation, is Applicant willing to submit a year-to-date financial filing and full RBC evaluation?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

8. Accountability to Oregon's Sustainable Growth Targets

a. Does Applicant commit to achieving a sustainable growth in expenditures each calendar year (normalized by membership) that matches or is below the Oregon 1115 Medicaid demonstration project waiver growth target of 3.4%?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Does Applicant similarly commit to making a good faith effort towards achievement of future modifications to the growth target in the waiver?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Does Applicant agree that OHA may publicly report on CCO performance relative to the sustainable growth rate targets (normalized for differences in membership)?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Does Applicant agree that OHA may institute a Corrective Action Plan, that may include financial penalties, if a CCO does not achieve the expenditure growth targets based on the current 1115 Medicaid waiver?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

9. Potential Establishment of Program-wide Reinsurance Program in Future Years

a. Will Applicant participate in any program-wide reinsurance program that is established in years after 2020 consistent with statutory and regulatory provisions that are enacted?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Will Applicant use private reinsurance contracts on only an annual basis so as to ensure ability to participate in state-run program if one is launched at the start of a calendar year?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Does Applicant agree that implementation of program-wide reinsurance program will reduce capitation rates in years implemented as a result of claims being paid through reinsurance instead of with capitation funds?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

10. CCO Solvency Standards and OHA Tools to Regulate and Mitigate Insolvency Risk

a. Is Applicant willing to have its financial solvency risk measured by Risk Based Capital (RBC) starting in 2021?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to achieve a calculated RBC threshold of 200% by end of Q3 of 2021 and thereafter to maintain a minimum RBC threshold of 200%?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to report to OHA promptly if it determines that its calculated RBC value is or is expected to be below 200%?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to report to OHA promptly if it determines that its actual financial performance departs materially from the pro forma financial statements submitted with this Application?

☐ Yes ☐ No

If "no" please provide explanation: _____

e. Will Applicant maintain the required restricted reserve account per Contract?

☐ Yes ☐ No

If "no" please provide explanation: _____

11. Encounter Data Validation Study

a. Is Applicant willing to perform regular chart reviews and audits of its encounter claims to ensure the Encounter Data accurately reflects the services provided?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to engage in activities to improve the quality and accuracy of Encounter Data submissions?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____

H. Member Transition Plan (Attachment 16)

1. Is Applicant willing to faithfully execute its Member Transition Plan as described in Attachment 16?

☐ Yes ☐ No

If "no" please provide explanation: _____

_____