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March 15, 2019

RFP 4690

Addendum #5

1. This is Addendum # 5 to Request for Application (RFA) 4690, Coordinated Care Organizations (CCOs) 2.0.

2. OHA amends the RFA as follows:

a. Section 2.3 "Scope of Work" paragraph 1 of the RFA Document, is amended as follows, language to be deleted or replaced is ~~struck through~~; new language is **underlined and bold**:

Work to be performed under the Contracts awarded through this RFA is to provide Coordinated Care Services for the CCO's Members, in accordance with the objectives of Health System Transformation, as described in this RFA. Additional information is in the CCO Administrative Rules (~~Section 1.5 and~~ Appendix C), the Attachments and Tables of the RFA, the RFA Questionnaires (Attachments 1 through 16), the Definitions (Appendix A) and the Contract Template (Appendix B).

b. Section 4.2 "Pre-Application Conference" of the RFA Document is hereby amended to remove the duplicated sub-bullet "Health Information Technology".

c. Section 4.7 "Application Due" of the RFA Document is amended as follows, language to be deleted or replaced is ~~struck through~~; new language is **underlined and bold**:

4.7 Application Due

~~a.~~ An Application (including all required submittal items) must be **received by the SPC** ~~uploaded into ORPIN~~ before Closing. All Application modifications or withdrawals must be received prior to Closing. **Late Application** ~~The ORPIN system~~ will not **be** accept**ed** ~~late Applications~~. Applications must be **submitted on a USB drive hard copies will not be accepted.** ~~uploaded in order to be considered.~~

b. Community Letters of Support

The community letters of support described in the Applicant's Community Engagement Plan (see Attachment 10) must be uploaded by May 15, 2019. If a community letter of support described in the Applicant's Community Engagement Plan is unavailable on that date, Applicant shall submit an amendment to its RFA Community Engagement Plan updating its plan for submitting community letters of support.

d. Section 4.15.g. "Goals of the Public Presentation" is hereby amended to remove the duplicated sub-bullet "Health Information Technology".

e. Attachment 7 "DHS Provider Report Protocol is hereby added and incorporated into the RFP with this reference.

f. Attachment 12 "Cost and Financial Questionnaire" Section L., is hereby amended to change the title from "Exhibits to this Attachment 11" to "Exhibits to this Attachment 12".

g. Section 1.2 "Schedule": The Required Applicant Conference is scheduled for May **30** ~~20~~, 2019 on the Schedule of Events timeline

h. Attachment _8 has been updated, online, to the correct title of "Year 1 VBP Data Template." Similarly, Attachment_8_Required has been updated with correct title of "RFA VBP Data Template."

i. Section 5.9. "State Funded Programs" has been corrected to read: "The Contract is for Medicaid Recipients **and is funded through** ~~is receives~~ federal financial participation."

j. Section 1.2 "Schedule" is amended to add the event **"Community Letters of Support Due" with the due date of May 15th, 2019.**

k. Attachment 10 "Social Determinants of Health and Health Equity," Section A, "Community Engagement," Subsection 2, "Required Documents" (see Addendum 3) is amended by adding the following final bullet:

- Community letters of support from key stakeholders identified in Applicant's Community Engagement Plan (due May 15, 2019)**.**

3. In accordance with the RFA, OHA provides the following questions and answers:

General Questions

Question 1. Summary of Public Feedback Included in the Final CCO 2.0 RFA, page 2: Will there be an opportunity to submit questions after the technical assistance conference for applicants on February 7?

Answer 1. OHA extended the question period specific to the Rates TA, until 2/11/2019. OHA may open further topic-specific Q&A periods. Addenda will be posted as necessary.

Question 2. To how many CCOs does the OHA hope/intend to award contracts under this RFA? Last time there were 16 until FamilyCare dropped out. I've read that Willamette Valley Community Health apparently will not participate this time. (Is that the OHA's present understanding about WVCH?)

Answer 2. The Letters of Intent received for this RFA are posted on the CCO 2.0 website. Please visit the website for more information about those organizations.

Question 3. Will the OHA consider applications from conventional insurance carriers doing business in the state of Oregon?

Answer 3. The State will consider applications from all entities meeting the requirements set forth in RFA Section 3.1.

Question 4. Attachment 7, 8 and 9 provides both a page limit for the total questionnaire and also recommended page limits for each section/question. Can OHA please confirm that the "recommended page limit" is a recommendation only and that the Applicant can choose to use this suggested recommendation or not as long as the total Provider Participation and Operations Questionnaire does not exceed 40 pages (outside of excluded items)?

Answer 4. Yes, it is a recommendation and do not exceed 40 pages total (outside of excluded items)

Question 5. In Attachment 6 and additional attachments, there are Informational Questions and Evaluation Questions. Can OHA clarify whether answers to Informational Questions are required and whether they are scored? Can OHA also clarify whether Informational Questions count towards page limits?

Answer 5. Applicants must receive a passing score on all evaluation questions to receive a notice of award. The informational questions are intended to gather information to inform OHA's implementation efforts. (from answer 85). Responses to informational questions are required, and they do count towards page limits. The labelling of questions as informational or evaluative is preliminary and may be refined during the evaluation process.

Main RFA Document

Question 6. Section 1.1 "Introduction": What is the maximum number of renewal option years?

Answer 6. There is no firm maximum number of renewal terms, but the State anticipates re-soliciting contracts in five years.

Question 7. Section 1.2 "Schedule":

- When will we be notified of the date and time for the Pre-Application Conference?
- Is the "Required Applicant Conference" noted in Section 1.2 the same as the mandatory Compliance Conference noted in Attachment 13 – Attestations page 9, Section B. Provider Participation and Operations Attestations, question 3. B.? If so what is the correct date for the conference, May 20th or May 30th?
- Based on the scope of the RFA will the OHA allow and respond to additional questions/requests for clarification beyond the 2/5/19 deadline?

Answer 7. The Pre-Application conference has been announced via addendum. It will take place on 3/22/2019. Yes, these are the same conference, the correct date is May 30th. We will correct the RFA schedule in 1.2.

Question 8. Section 2.2.b "Description of Oregon's Integrated and Coordinated Health Care Model": the RFA states that CCOs will be required to enter into a companion contract covering state funded services.

What is the intent and goal of adding OEBB and PEBB?

Answer 8. The reference to companion contract for state funded services refers to state-only funded programs that are operated under the Oregon Health Plan but are not federally funded. This currently refers to Cover All Kids. CCOs will be required to enter into a companion contract to serve this population. There could be future populations added if the Legislature expands the Oregon Health Plan to new groups. In addition, PEBB and OEBB are undertaking a review of their programs and exploring potential innovations they could undertake to align with state health system transformation goals and implement the coordinated care model to improve care and lower costs. It is possible that at a future date CCOs may be invited or required to participate in PEBB/OEBB markets or other markets, and/or collaborate with other payers to align transformation efforts across markets. OHA does not have any additional details at this time.

Question 9. Section 2.2.b "Description of Oregon's Integrated and Coordinated Health Care Model": the RFA states that CCOs will be required to enter into a companion contract covering state funded services.

Can OHA elaborate on how the CCO program would need to be modified or altered to support OEBB and PEBB?

Answer 9. The reference to companion contract for state funded services refers to state-only funded programs that are operated under the Oregon Health Plan but are not federally funded. This currently refers to Cover All Kids. CCOs will be required to enter into a companion contract to serve this population. There could be future populations added if the Legislature expands the Oregon Health Plan to new groups. In addition, PEBB and OEBB are undertaking a review of their programs and exploring potential innovations they could undertake to align with state health system transformation goals and implement the

coordinated care model to improve care and lower costs. It is possible that at a future date CCOs may be invited or required to participate in PEBB/OEBB markets or other markets, and/or collaborate with other payers to align transformation efforts across markets. OHA does not have any additional details at this time.

Question 10. Section 2.2.b "Description of Oregon's Integrated and Coordinated Health Care Model": the RFA states that CCOs will be required to enter into a companion contract covering state funded services.

How would the offering align or differ from the current offerings, including current carrier contracts, benefits and coverage, provider network, supplemental programs, etc.?

Answer 10. As cited in the RFA, for 2020 and future years, the differences between the CCO Contract and the State Funded Contract will be similar to the differences between the 2019 Cover All Kids contract and the 2019 CCO contract, except that additional population groups may be covered. There could be populations added in the future if the Legislature expands the Oregon Health Plan to cover new groups. OHA does not have any further information or plans regarding additional populations at this time.

Question 11. Section 2.2.b "Description of Oregon's Integrated and Coordinated Health Care Model": the RFA states that CCOs will be required to enter into a companion contract covering state funded services.

How would OEBB and PEBB be administered and governed? Currently there is an OEBB Board, a PEBB Board and the Joint Innovation Workgroup, and the programs are administered by the Oregon HCA staff.

Answer 11. The reference to companion contract for state funded services refers to state-only funded programs that are operated under the Oregon Health Plan but are not federally funded. This currently refers to Cover All Kids. CCOs will be required to enter into a companion contract to serve this population. There could be future populations added if the Legislature expands the Oregon Health Plan to new groups. In addition, PEBB and OEBB are undertaking a review of their programs and exploring potential innovations they could undertake to align with state health system transformation goals and implement the coordinated care model to improve care and lower costs. It is possible that at a future date CCOs may be invited or required to participate in PEBB/OEBB markets or other markets, and/or collaborate with other payers to align transformation efforts across markets. OHA does not have any additional details at this time.

Question 12. Section 2.2.b "Description of Oregon's Integrated and Coordinated Health Care Model": the RFA states that CCOs will be required to enter into a companion contract covering state funded services.

How would reimbursement and budgeting requirements differ for OEBB and PEBB versus the Medicaid population?

Answer 12. The reference to companion contract for state funded services refers to state-only funded programs that are operated under the Oregon Health Plan but are not federally funded. This currently refers to Cover All Kids. CCOs will be required to enter into a companion contract to serve this population. There could be future populations added if the Legislature expands the Oregon Health Plan to new groups. In addition, PEBB and OEBB are undertaking a review of their programs and exploring potential innovations they could undertake to align with state health system transformation goals and implement the coordinated care model to improve care and lower costs. It is possible that at a future date

CCOs may be invited or required to participate in PEBB/OEBB markets or other markets, and/or collaborate with other payers to align transformation efforts across markets. OHA does not have any additional details at this time.

Question 13. Section 2.3 “Scope of Work” paragraph 1: Regarding the sentence: "Additional information is in the CCO Administrative Rules (Section 1.5 and Appendix C), the Attachments and Tables of the RFA… " Can OHA please clarify where Section 1.5 is located? We only see three subsections in Section 1 of the Main RFA Document. Is "Section 1.5" in another RFA Attachment or Addendum? Please clarify.

Answer 13. See Section 2. at the beginning of this document, which amends the sentence in question to remove the reference to Section 1.5.

Question 14. Section 2.3 “Scope of Work” Subsection a. “Contract Template” 2nd paragraph: References future plans that may require CCOs to participate in other health insurance markets, such as OEBB/PEBB and the Marketplace. Our question is whether the CCO itself will be required to participate in other markets, or if an affiliate of the CCO will be able to participate in other markets and still comply with this section?

Answer 14. The reference to companion contract for state funded services refers to state-only funded programs that are operated under the Oregon Health Plan but are not federally funded. This currently refers to Cover All Kids. CCOs will be required to enter into a companion contract to serve this population. There could be future populations added if the Legislature expands the Oregon Health Plan to new groups. In addition, PEBB and OEBB are undertaking a review of their programs and exploring potential innovations they could undertake to align with state health system transformation goals and implement the coordinated care model to improve care and lower costs. It is possible that at a future date CCOs may be invited or required to participate in PEBB/OEBB markets or other markets, and/or collaborate with other payers to align transformation efforts across markets. OHA does not have any additional details at this time.

Question 15. Section 2.3 “Scope of Work” Subsection c. “Transformation Scope Elements”: paragraph 3 states “Applicant will use the RFA submission to describe and demonstrate to OHA how it proposes to accomplish the Work, and how it plans to meet progressive goals.” Please elaborate on what OHA is expecting to see in the response related to “progressive goals.”

Answer 15. OHA would expect to see progressive goals consistent with the requirements and policies contained in the RFA.

Question 16. Section 3.2.c. “Service Area Exceptions and Negotiations” The RFA states, "Applicant must submit a document titled “Full County Coverage Exception Requests” at time of Application if it would like OHA to consider allowing it to serve less than a full County". Can OHA please define "less than a full County"? For example, does the definition of "less than a full County" apply to a CCO proposed service area that may include members who reside in a congruent zip code in a border or neighboring county but receive their services in the CCO proposed service area?

Answer 16. A full county is all zip codes within a county’s borders. An applicant must agree to cover enrollees residing in all zip codes in a county. If the applicant requests to exclude a zip code, then the applicant would be requesting to cover “less than a full county.” If the applicant intends to cover a full county plus additional border zip codes, then the applicant is seeking to cover less than a full county in the neighboring county.

Question 17. Section 3.3 “Minimum Submission”: The RFA provides particular page limits throughout for crafting narrative, but within each Applicant’s narrative, the RFA does not address how to format narrative and whether the RFA questions and instructions should be restated in that narrative. We respectfully request clarification regarding how to format required narrative, given the page limits. Should applicants restate questions using headings to format the narrative and improve readability? Should applicants refer only to subsection references in headings?

Answer 17. Questions must be restated and include the section, attachment, etc. that is being answered.

Question 18. Section 3.3.a. “Application Submissions” and Section 3.4 “Application Requirements” Section 3.3.a Application Submissions and Section 3.4 Application Requirements provide a listing of required items, however, the order of documents in these sections is slightly different. Can OHA please confirm that the Application shall follow the order listed in Section 3.4 Application Requirements.

Answer 18. Please follow the list as described in Section 3.4.

Question 19. Section 3.3.b “Application Format and Quantity” Paragraph 5: Please confirm that OHA is requesting that each "submission document" be submitted separately (e.g. Attachment 6 - General Questions and Attachment 7 - Provider Participation and Operations Questionnaire submitted as separate files) and labeled according to the instructions in Section 3.3.b.

Answer 19. Each submitted document must be one file, together saved to one thumb drive, Applicants should not submit multiple thumb drives.

Question 20. Section 3.3.b. “Application Format and Quantity” Paragraph 8: Will OHA allow for a smaller font size of 10-point font for tables and graphics within the narrative response?

Answer 20. Yes, you may use smaller font on tables and graphics

Question 21. Section 3.3.b. “Application Format and Quantity” Clarify the font style is required for the response besides size 12pt

Answer 21. Please use serif fonts.

Question 22. Section 3.3.b. “Application Format and Quantity” Clarify if entire response is paginated, or by attachment/section.

Answer 22. It is preferred that pagination is by attachment and each attachment is a separate file. Responses must be numbered the same as requests for those responses.

Question 23. Section 3.3.b. “Application Format and Quantity” Paragraph 9: Are Applicants required to use the provided attachment templates (e.g. Attachment 9 - Health Information Technology) to submit their Application? If yes, will OHA provide Word documents to allow for responses to be placed under each section/question so the responses will adhere to the parameters of the RFA requirements (i.e.: 1" margins, etc.)?

Answer 23. Applicants are not required to use the exact document as a template for their application materials.

Question 24. Section 3.3.b Application Format and Quantity states that, "Except for notarized signatures, all submissions must be electronic." Can OHA please clarify if the notarized copy of Attachment 3 shall be hand delivered or mailed to OHA or if it is part of the electronic submission.

Answer 24. For the purpose of this RFA, electronic signature means a scanned image of a signature and the notary certification, where applicable. Hard copies of the RFA have not been requested nor will they be accepted.

Question 25. Section 3.3.b. RFA Document states "… must be clearly named with RFA #4690-19, the Applicant's name (which may be abbreviated), and the document identification including applicable numbering. Page 12, second paragraph of RFA Document shows "RFA4690-(Name or Acronym of Applicant)-Att(X)(Name of Submission Document)"

Answer 25. The name example is correct.

Question 26. Headers and Footers, page 12, third paragraph of RFA_Document

Desired headers and footers" is not defined

Answer 26. There is no requirement on Headers and Footers. However it is preferred that a header has the RFA # and the name of the Applicant and the footer has the name of the Attachment that is the document is in response to.

Question 27. Section 3.4 "Application Requirements" Within several attachments, OHA has provided background, requirements, contract obligations and response parameters, (i.e.: Attachment 9 – Health Information Technology, etc.). Please confirm whether Applicants should restate the RFA language (e.g. background/requirements/deliverables) under the contract/parameters or questions before their responses. If yes, please confirm that the restatement of the RFA language does not count against the page limits.

Answer 27. Questions must be restated and include the section, attachment, etc. that is being answered.

Question 28. Section 3.4 "Application Requirements": Please confirm that the following Attachments listed below in Section 3.4 Application Requirements are incorrectly labeled and should be labeled:

- Application Checklist (Attachment 2)

- Application and Information Certification (Attachment 3)

- Disclosure Certificate Exemptions (Attachment 4)

Answer 28. The titles to each document are correct, however the footers can be labeled as mentioned above.

Question 29. Section 3.4. "Application Requirements": Are attachments permitted outside of those explicitly required within each Questionnaire?

Answer 29. Yes applicants may include supporting attachments in addition to, but not in lieu of, the required attachments.

Question 30. Please clarify if attachments count toward the page limit for each section?

Answer 30. Attachments count toward the page limit unless otherwise noted in the question.

Question 31. Section 3.4.e. "References**":** The instructions state that the page limit for references is one page each.

a. Does this mean that we need to submit only the references' contact information? Alternatively, does this mean that we need to submit a one-page narrative from the reference, with their contact information included?

Answer 31. For references, please submit one page for each reference that includes contact information, a statement of similar projects performed within the last 5 years that can speak to and verify the quality of the work you delivered to them, and how those projects are related to the Work under the Sample Contract.

Question 32. Section 3.4.e. "References**":** The instructions ask for references from current client firms and former client firms.

a. Where the Applicant is currently a certified CCO, what "client firms" would the OHA like Applicants to reference? Alternatively, could the Applicant include a reference from an Affiliate's client firm?

Answer 32. Yes, references from an Affiliate's client firm are acceptable. Where the Applicant is currently a certified CCO, references from community providers or stakeholders are acceptable. Please do not use any part of OHA as a reference.

Question 33. Section 3.4.e. "References" Subsection (1): If an existing CCO is reapplying for their existing service area and has no other lines of business there are no "client" references to provide. Please clarify the expectation for this question in this case.

Answer 33. See answer 32.

Question 34. Section 4.2. "Pre-Application Process" Regarding the sub-bulleted list with these items (which is in both Sections 4.2 and 4.15.g):

o Value-Based Payments

o Health Information Technology

o Social Determinants of Health and Health Equity

o Behavioral Health

o Health Information Technology

Did OHA mean the last bullet to indicate another item (since "Health Information Technology" is duplicated in the first and last item)?

Answer 34. This is a duplicate.

Question 35. Section 4.2. "Pre-Application Process" and Section 4.15.g "Goals of Public Presentation": "Health Information Technology" is listed twice in several areas under RFA 's focal area; is there supposed to be a 5th focal area?

Answer 35. This is a duplicate.

Question 36. Section 4.3 "Questions/Requests for Clarification" Will OHA consider allowing Applicants to submit follow up or clarifying questions from OHA's published Answers to Questions / Requests for Clarification Issued?

Answer 36. OHA may open further topic-specific Q&A periods. Addenda will be posted as necessary.

Question 37. Section 4.3 "Questions/Requests for Clarification" Given the number of reference documents released in Addendum #2 (published January 31, 2019) was after the initial RFA release date, will OHA consider adding a second round of Questions / Requests for Clarification for Applicants?

Answer 37. OHA may open further topic-specific Q&A periods. Addenda will be posted as necessary.

Question 38. Section 4.7 "Application Due": Please provide instructions or direction as to how to upload required submittal items into ORPIN. Currently when we try to use the "respond online" option we receive a message "This document does not allow Electronic Bid Responses". Will the system be modified to allow bid responses to be uploaded or will this requirement be removed/modified?

Answer 38. See Section 2. at the beginning of this document, which amends Section 4.7 with updated instruction for submitting Applications.

Question 39. Section 4.12 "Evaluation Criteria" Paragraph 2: Can OHA please define "pass" and "fail" as described in Section 4.12 of the RFA? Additionally, can OHA please provide the scoring criteria the evaluators will utilize to assign a "pass" or a "fail" for an evaluation criteria so Applicants are able to provide a complete response?

Answer 39. Answers will be determined to "pass" or "fail" if OHA concludes that the response acceptably meets the policy and operational objectives of OHA. The State will not provide scoring criteria in advance of the application due date.

Question 40. Section 4.12 "Evaluation Criteria" Can OHA please define "evaluation criterion" as described in Section 4.12 of the RFA. For example does OHA consider a complete questionnaire (e.g. Attachment 10) to be "evaluation criterion" or is OHA referring to the specific questions within an attachment (e.g. "evaluation questions" or "informational questions")?

Answer 40. Simply having a completed questionnaire is not sufficient to meet the evaluation criteria. The substance of the responses for all evaluation questions must be deemed acceptable by OHA.

Question 41. Section 4.12 "Evaluation Criteria" of the RFA Document provides an overview of the evaluation process. In addition to this overview, can OHA provide Applicants with the associated point allocation or weight given to each "evaluation criteria" of the RFA response to ensure Application are able to appropriately answer and address the priority areas for the CCO 2.0 program?

Answer 41. All evaluation questions will be scored on a "pass" or "fail" basis. There are no point values attributed to specific questions. Applicants must pass all elements in order to receive an RFA award.

Question 42. Section 4.13 "Program Integrity Conference" and Section 1.2 "Schedule": The Required Applicant Conference is scheduled for May 20, 2019 on the Schedule of Events timeline. However, on page 17, Section 4.13(1), the RFA states that the Program Integrity Conference is referred to as an "Applicants Conference" and is scheduled for May 30, 2019.

- **a.** Are these conferences the same? If they are, which date is the correct date of the conference?

Answer 42. The correct date is May 30th, 2019. See Section 2 at the beginning of this document, which amends the date from May 20 to May 30.

Question 43. Section 4.13 “Program Integrity Conference” and Section 1.2 “Schedule”: The required Applicant Conference is shown on two different dates in May in these sections. Please clarify the dates for all meetings and/or conferences.

Answer 43. The correct date is May 30th, 2019. See Section 2 at the beginning of this document, which amends the date from May 20 to May 30.

Question 44. Section 4.15 “Public Presentation by Applicant”: How will the public presentation be incorporated into the RFA evaluation process? What is the expected timeframe for the public presentation to occur under the Schedule of Events as outlined in Section 1.1?

Answer 44. The Public Presentation by Applicant will be made after evaluation and award. It is part of the Readiness Review process.

Question 45. Section 5.3.d. “Pay Equity Certification” and 5.3.e. “Nondiscrimination in Employment”: If a CCO has no employees and delegates all administrative services to their CCO partners please clarify the expectation for providing a pay equity compliance certification and the Nondiscrimination in Employment certification.

Answer 45. Please provide the information for the “CCO partners” and identify their relationship to the CCO.

Question 46. Section 5.8. “Member Enrollment”: Can OHA please define "normal Member choice procedures" as described in 5.8?

Answer 46. Federal Medicaid rules require that after a beneficiary is auto-enrolled into a plan, that beneficiary must be permitted to change plans during the 90 day period after the later of the date of the member’s enrollment or the date the State sends the beneficiary notice of that enrollment. See 42. C.F.R. § 438.56.

Question 47. Section 5.8. “Member Enrollment”: Please describe the process for assigning enrollees to CCOs that operate within the same Member Service Area if they enroll after the initial open enrollment period.

Answer 47. After the initial open enrollment period, all beneficiaries would be given the opportunity to select a CCO. If they fail to select a CCO, they would be auto-assigned in a manner generally consistent with the approach articulated in Section 5.8 for a “choice area.”

Question 48. Section 5.9. “State Funded Programs” Regarding the sentence: "The Contract is for Medicaid Recipients is receives federal financial participation." We assume this sentence should read: "The Contract is for Medicaid Recipients who receive federal financial participation." Are we correct in our assumption? If we are not correct, please clarify.

Answer 48. The sentence should read: "The Contract is for Medicaid Recipients and is funded through federal financial participation." See Section 2 at the beginning of this document, which amends this sentence

Question 49. Section 5.9. “State Funded Programs”: last paragraph, the document states, “For 2020 and future years, the differences between the CCO Contract and the State Funded Contract will be similar to the differences between the 2019 CAK contract and the 2019 CCO Contract, except that additional population groups may be covered.” Can OHA elaborate on what is meant by “additional population groups”?

Answer 49. There could be populations added in the future if the Legislature expands the Oregon Health Plan to cover new groups. OHA does not have any further information or plans regarding additional populations at this time.

Question 50. Section 6.1. “Certified Firm Participation”: Please provide a link to the intended version of the document “Certified Disadvantaged Business Outreach Plan (Attachment 9)”.

Is this Plan required with the Application or during the Readiness Review/Contract Negotiation?

Answer 50. This Plan is not required with the Application but may be required during Readiness Review and Contract negotiation?

Attachment 6

Question 51. Attachment 6 is limited to five pages in response. However, given the number of questions and sub questions, will OHA consider expanding the page limit to ensure Applicants can adequately respond to each section and provide enough information for the OHA to evaluate the response?

Answer 51. Limit remains 5 pages. Reminder - many items are supplemental and note where the attachments don't count against page limits.

Question 52. Attachment 6, Section A.1.h.: The question asks the Applicant if they have a current Dual Special Needs Coordination of Benefits Agreement with OHA to serve Fully Dual Eligible Members.

a. Is this question asking if the Applicant has a D-SNP plan with CMS? Or is this question asking if the Applicant has a COBA agreement with the OHA? We note that elsewhere in the RFA, it provides that applicants can fulfill coordination requirements via a Medicare Advantage plan or a D-SNP plan. If the intent is to mandate only a D-SNP plan, we respectfully request clarification in other sections of the RFA.

Answer 52. The question is intended to determine if the Applicant has experience as a Medicare Advantage contractor serving Fully Dual Eligible OHP members through the DSNP model. Applicants are not required to offer DSNP plans at this time.

Question 53. Attachment 6, page 3, Section D.1.a. Please define “delegates”

Answer 53. Please use Merriam-Webster dictionary for the definition.

Question 54. Attachment 6, Section D.1.a.: Can OHA please define "business functions" as it relates to question D.1.a?

Answer 54. Business functions are functions about which the RFA inquires.

Question 55. Attachment 6, Section D.1.b: Will OHA please clarify the threshold for "major" subcontracts as it relates to this question?

Answer 55. Major subcontracts are subcontracts for business functions about which the RFA inquires.

Question 56. Attachment 6 “Subcontractors and Delegated Entities Report” Please confirm that "Attachment-6-Subcontractors-and-Delegated-Entities-Report" is aligned with Attachment 6 - General Questions, Question 1.b "major subcontracts Applicant expects to have".

Answer 56. Confirmed.

Attachment 7

Question 57. Section 3 "Transforming Models of Care: This section is comprised of seven questions across two categories (PCPCH and Other Models of Patient-Centered Primary Health Care). Would OHA consider increasing the recommended page limit for this section from 1 page to 3 pages (with a concomitant increase to the overall page limit for the Attachment 7 response) to allow for a more complete response?

Answer 57. The page limit for Attachment 7 in its entirety is 40 pages. Applicants may flex the page length of their responses within that 40 page limit.

Question 58. Section 3.2.c. of the RFA Document and Section 11 of Attachment 7: Applicants planning to submit a request to serve a partial county are instructed to complete a document titled "Full County Coverage Exception Request." Applicants are also instructed to separately provide a Service Area table and respond to Question 11 of Attachment 7. The required description of the Applicant's rationale for proposing a partial county Service Area are the same in each of these locations. Can OHA provide guidance on the difference between these two sections and confirm whether Applicants are required to provide two separate responses regarding partial county Service Areas?

Answer 58. A single response in Attachment 7 is sufficient.

Question 59. Section 4. "Network Adequacy" Subsection b. "Requested Documents": Can OHA clarify expectations regarding the provider network, i.e. are signed contracts required at application submission or are letters of intent sufficient with signed contracts provided during the readiness review?

Answer 59. Letters of intent are sufficient with signed contracts due at Readiness Review.

Question 60. Section 6 **"**Coordination, Transition and Care Management": Does the 5-page limit listed next to the heading "Coordination, Transition and Care Management" only apply to item 6.a.?

Answer 60. The page limit for Attachment 7 in its entirety is 40 pages. Applicants may flex the page length of their responses within that 40 page limit.

Question 61. Section 6 **"**Coordination, Transition and Care Management": Can OHA please provide a page limit for subsection a and d?

Answer 61. The page limit for Attachment 7 in its entirety is 40 pages. Applicants may flex the page length of their responses within that 40 page limit.

Question 62. Section 6 **"**Coordination, Transition and Care Management": What is the page limit for item 6.d. Utilization Management?

Answer 62. The page limit for Attachment 7 in its entirety is 40 pages. Applicants may flex the page length of their responses within that 40 page limit.

Question 63. Section 6 **"**Coordination, Transition and Care Management": This section is comprised of 19 questions. Would OHA consider increasing the recommended page limit for this section from 5 pages to 10 pages (with a concomitant increase to the overall page limit for the Attachment 7 response) to allow for a more complete response?

Answer 63. The page limit for Attachment 7 in its entirety is 40 pages. Applicants may flex the page length of their responses within that 40 page limit.

Question 64. Section 6. **"**Coordination, Transition and Care Management" Subsection b. "Care Integrations": This section is comprised of 6 questions across two categories (Oral Health and Agreements for Hospital and Specialty Services). Would OHA consider increasing the recommended page limit for this section from 1.5 pages to 3 pages (with a concomitant increase to the overall page limit for the Attachment 7 response) to allow for a more complete response?

Answer 64. The page limit for Attachment 7 in its entirety is 40 pages. Applicants may flex the page length of their responses within that 40 page limit.

Question 65. Section 9 "Quality Improvement Program" This section is comprised of four questions across multiple categories including asking for "innovative strategies in all areas of Health System Transformation". Given the emphasis on Health System Transformation outlined in Section 2: Authority, Overview and Scope in the principle RFA document, would OHA consider increasing the recommended page limit for this section from 1 page to 3 pages (with a concomitant increase to the overall page limit for the Attachment 7 response) to allow for a more complete response?

Answer 65. The page limit for Attachment 7 in its entirety is 40 pages. Applicants may flex the page length of their responses within that 40 page limit.

Question 66. Section 12.a. "Standard #1 - Provision of Coordinated Care Services": The third paragraph states "describe Applicant's comprehensive and integrated care management network and delivery system network serving Medicaid and dually eligible Members for the following categories of services or types of service Providers that has agreed to provide those services or items to Members, whether employed by the Applicant or under subcontract with the Applicant." (Emphasis added.) Then, the "INSTRUCTIONS" section on page 12 states to submit the information using the DSN Provider Report Template.

a. Do we need to submit a narrative to describe the care management and delivery system network for each of the provider types listed? Or a summative narrative? There are no fields within the DSN Template to provide this explanation.

b. If the intent was not to seek narrative to "describe," we respectfully request clarification to these instructions.

Answer 66. A narrative response to Section 12.a. and a completed DSN report are required.

Question 67. Section 12.a. "Standard #1 - Provision of Coordinated Care Services": Can OHA please confirm that the "recommended page limit 5 pages" listed next to "12. Standards Related to Provider Participation" is for the response to Section 12.a Standard #1 - Provision of Coordinated Care Services

Answer 67. The page limit for Attachment 7 in its entirety is 40 pages. The page limits for each section are recommended, not required, limits. Applicants may flex the page length of their responses within that 40 page limit.

Question 68. Section 12.d. “Standard #4 – Services for the American Indian/Alaska Native Population (AI/AN)” The suggested page limit for this section is 1/2 page. Would OHA consider extending the page limit for this section from 1/2 page to 1 page for Applicants to be able to adequately address our experience and ability to provide culturally relevant Coordinated Care Services for the AI/AN population.

Answer 68. The page limit for Attachment 7 in its entirety is 40 pages. The page limits for each section are recommended, not required, limits. Applicants may flex the page length of their responses within that 40 page limit.

Question 69. Section 12.e. “Standard #5 – Indian Health Services (IHS) and Tribal 638 facilities” Section 12.e states, "From among the Providers and facilities listed in the DSN Provider Report Template, please identify any that are Indian Health Service or Tribal 638 facilities." Can we indicate this information within the DSN Provider Report Template and then affirm we did so in this section? Or is OHA looking for the Applicant to also provide the list of providers in this section. If yes, can OHA confirm the list of providers does not count toward the page limit for this section?

Answer 69. Applicants may satisfy this requirement with a completed DSN report that identifies IHS or Tribal 638 facilities

Question 70. Section 12.f. “Standard #6 – Pharmacy Services and Medication Management” This section is comprised of ten questions including three questions with subcomponents. Would OHA consider increasing the recommended page limit for this section from 5 pages to 8 pages (with a concomitant increase to the overall page limit for the Attachment 7 response) to allow for a more complete response?

Answer 70. The page limit for Attachment 7 in its entirety is 40 pages. The page limits for each section are recommended, not required, limits. Applicants may flex the page length of their responses within that 40 page limit.

Attachment 8

Question 71. Excel workbooks Attachment_8 versus Attachment_8_Required

Similar but not exact excel workbooks, are both required? Is one for year 1 and the other for years 2-4?

Answer 71. Attachment _8 has been updated, online, to the correct title of "Year 1 VBP Data Template." Similarly, " Attachment_8_Required has been updated with correct title of "RFA VBP Data Template."

Question 72. Section B "VBP Reporting" page 2 please clarify whether applicants should address Item B. Required Reporting, in the application response or whether this section is informational for purposes of the RFA.

Answer 72. Section B is informational only

Question 73. Section A "Value-Based Payment (VBP) Requirements": Please clarify whether the VBP percentages will be applied to all categories of services or will exclude pharmacy expenditures, which cannot reasonably be expected to be paid under the Alternative Payment Model Framework.

Answer 73. The VBP percentages will be applied to all categories of services.

Question 74. Section A "Value-Based Payment (VBP) Requirements" "Patient-Centered Primary Care Home (PCPCH) VBP requirements": If a CCO has already made a significant financial invest in PCPCH's we don't agree that a mandate should exist to increase payments each year over the five-year contract. We are hoping to work with OHA to clarify or allow exceptions to the annual increase if current PMPMs are significant and adequate, or if our valued based payment models provide additional compensation for meeting cost or quality metrics, or for serving higher risk members and/or achieving a higher PCPCH certified status.

Answer 74. OHA will require that the PCPCH payments increase by some amount each year.

Question 75. Section B "Data Reporting: 2021": In the first quarter of 2021 CCOs must submit Year 1 VBP Data Template, which includes summary data stratified by LAN categories that describes 2020 payment arrangements. Although the CCO will likely be unable to report exactly all adjudicated payments made for 2020, OHA will require the reporting of fee-for-service payments that are associated with a VBP in order to assess the CCO's preliminary progress towards meeting the VBP targets.

Answer 75. Thank you for your feedback.

Question 76. Section B "Data Reporting: 2021": The above section says that all fee-for-service dollars associated with the risk model will be counted as VBP. This requirement is in conflict to Appendix C – Administrative Rule Concepts, which implies that only the risk settlement dollars will be counted as VBP:

- "OHA will consider the absolute value of all risk settlements (which would turn a negative payment to a positive payment) and use that absolute value for the numerator. The denominator would remain the same: total Member expenditures as reported in Exhibit L."

  ☐ (OHBP #10 (VBP): Increase CCOs' use of Value-Based-Payments (VBP) with their contracted Providers – Appendix C – Administrative Rule Concept – p. 2 of 52.)

Please clarify OHA's position and intent on this definition as the discrepancy in the descriptions could have big implications.

Answer 76. The intent is that fee-for-service payments associated with a risk model, including any risk settlements, would be considered as a VBP. If a negative payment was made – or a risk settlement – then the absolute value of that payment would be added to any other components of the payment such as fee-for-service, and all would be considered a VBP.

Question 77. Page 4, Section C. "VBP Questions" Paragraph 1: Section C.1 states "Submit two variations of the information in the supplemental baseline RFA VBP Data template." There were two VBP Data templates ("RFA VBP data template" and "Year1 VBP data template") included as attachments to the RFA, can OHA please clarify which data template CCOs should use to submit the VBP data.

Answer 77. The document titled "Year 1 VBP Data Template" has been removed from ORPIN as that is a requirement for the Contract.

Question 78. Section C.2.a and C.2.b Can OHA please confirm if C.2.a and C.2.b should be included as part of the VBP Data Template, or separately.

Answer 78. Section C2a and b should be responded to separately from the RFA VBP Data Template

Question 79. Page 5, Section D "VBP Reference Documents" Can OHA please confirm that the "Year 1 VBP Data Template" is optional and not required as part of the RFA submission. Additionally, can OHA confirm that as an optional submission only, the "Year 1 VBP Data Template" will not be evaluated per the evaluation process outlined in Section 4.12 of the main RFA document.

Answer 79. The document titled "Year 1 VBP Data Template" 1 has been removed from ORPIN as that is a requirement for the Contract.

Question 80. "VBP Data Template" Please revise cell G22 to be formatted as a percent.

Answer 80. Change have been made and posted.

Question 81. "Year 1 VBP Data Template" Please revise cell G22 to be formatted as a percent.

Answer 81. Change have been made and posted.

Attachment 9

Question 82. Section Titled “RFA HIT Questionnaire” 3rd bullet: Regarding the sentence: "For example, a response in component 2 that does not address Behavioral Health Providers will not be considered complete. "Can OHA clarify what/where "component 2" is in terms of Attachment 9?

Answer 82. Thank you for your question. This question will be answered in a different addendum that will be posted approximately March 22nd, 2019

Question 83. Section Titled “Other HIT-related deliverables under the Contract:” Regarding this sentence: "Performance Expectations (see Appendix B, Sample Contract, Exhibit M) including…" Given the context of this section of Attachment 9, is the reference to Exhibit M (Behavioral Health) correct or did OHA intend the reference to be to another Exhibit (e.g. Exhibit J (HIT))? Please confirm or clarify.

Answer 83. This reference should be updated to specify Exhibit J, not Exhibit M.

Question 84. We respectfully request clarification regarding various HIT Roadmap references in Attachment 9. Given the phrasing here and in the proposed 2020 contract, it is unclear if this is a proprietary template that each applicant should develop or if the RFA is requesting a prescriptive format of some kind. For example, on page 1, the RFA provides that “[d]ue to the critical nature of HIT to support CCO obligations, failure to complete an approved HIT Roadmap may delay completion of Readiness Review.” Elsewhere, the RFA provides for the following elements of a roadmap: current/future plans, activities, milestones, timelines, targets, EHR adoption (by care domain), and HIE access (by care domain). Section B.1, Support for EHR Adoption, in Attachment 9 makes reference to a narrative and a roadmap, which suggests that the narrative response to Attachment 9 is not, itself, a roadmap. We can envision a variety of formats here. Does Attachment 9 call for a particular format or will the OHA release a format in readiness review that has no impact on formatting the narrative required in Attachment 9?

Answer 84. Thank you for your question. We will not be providing any further detail at this time as the information is not critical to the Application process. There will be opportunities for contract revision, and negotiation in the future

Question 85. Section A. “HIT Partnership”, Section B. “Support for EHR Adoption”, Section C. “Support for Health Information Exchange”, and Section D. “Health IT For VBP and Population Health Management” Several areas in Attachment 9 - Health Information Technology, ask Applicants to respond to: Informational Questions and Evaluation Questions. There does not appear to be a definition or description of these two question types. For Applicant response purposes, are Informational Questions and Evaluation Questions identical or is there a distinction in terms of how responses to these question types will be evaluated by OHA? Please clarify on the distinction.

Same question applies for Attachment 10 - Social Determinants of Health and Health Equity.

Answer 85. Applicants must receive a passing score on all evaluation questions to receive a notice of award. The informational questions are intended to gather information to inform OHA’s implementation efforts.

Question 86. Section B.1. “Evaluation Questions” paragraph 1: Regarding this sentence: "When answering the evaluation questions, please include in a narrative as well as a roadmap that includes activities, milestones and timelines." Does the roadmap in the above sentence count towards the overall page limit of Attachment 9 or is the roadmap excluded from the Attachment 9 page limit? Please clarify.

Answer 86. The roadmap may be provided as a supplemental attachment; it will not be included in the page limits.

Question 87. Section C.1. “Evaluation Questions” opening paragraph: Regarding this sentence: "When answering the evaluation questions, please include in a narrative as well as a roadmap that includes activities, milestones and timelines." Does the roadmap in the above sentence count towards the overall page limit of Attachment 9 or is the roadmap excluded from the Attachment 9 page limit? Please clarify.

Answer 87. The roadmap may be provided as a supplemental attachment; it will not be included in the page limits.

Question 88. Section D.2. “Evaluation Questions” Subsection a.: Regarding this sentence: "Include in your description, plans for enhancing or changing HIT if enhancements or changes are needed to administer VBP arrangements over the 5-year contract, including activities, milestones, and timelines." We assume that the Applicant's description of "activities, milestones, and timelines" must be contained within the overall page limit of Attachment 9. Are we correct in our assumption? Please clarify if we are not correct.

Answer 88. The Applicant's description of "activities, milestones, and timelines" must be contained within the total 36 page limit of Attachment 9.

Attachment 10

Question 89. Section A "Community Engagement" Subsection 1. "Evaluation Questions" paragraph b.:

b. "Plan will include strategies for…and developing shared CHAs and CHIP priorities and strategies."

Does this mean sharing in the joint development of the CHA and CHIP or sharing the results or both?

Answer 89. Both. OHA expects that CCOs will jointly develop CHAs and CHIP with specified partners. Sharing results is an important part of the development process to support further refinement of the CHAs and CHIPs.

Question 90. Section B "Social Determinants of Health and Health Equity (SDOH-HE) Spending, Priorities, and Partnership": Under the paragraph titled "Risk adjustment for social factors"—is OHA intending to use the data it is currently collecting through the pediatric health/social complexity data it is currently collecting in the risk adjustment?

Answer 90. Thank you for your questions regarding Behavioral Health, and Social Determinants of Health and Health Equity. In the areas of Behavioral Health and Social Determinants of Health and Health Equity, the RFA focuses on outcomes as opposed to structures. It is our intent to foster innovation and local collaboration around solutions rather than prescribe acceptable interventions. It our expectation that these innovations will be evidence-based interventions that are linked to lowered cost and improved health status, and that applicants will clearly identify and describe how outcomes intend to be tracked and achieved through the structures they propose. We look forward to collaborating with successful Applicants to explore potential approaches in these areas but have no further detail to share at this time regarding preferred approaches to services, billing or plans for data collection.

Question 91. Section B "Social Determinants of Health and Health Equity (SDOH-HE) Spending, Priorities, and Partnership" Regarding this sentence: "This statutory requirement – ORS 414.625(1)(b)(C) – will be operationalized through Oregon Administrative Rule, as described in the rule concepts accompanying this RFA." We assume that the above citation (ORS 414.625(1)(b)(C) is a 2018 amendment that is: [CCOs must:] (C) Expend a portion of the annual net income or reserves of the coordinated care organization that exceed the financial requirements specified in this paragraph on services designed to address health disparities and the social determinants of health consistent with the coordinated care organization's community health improvement plan and transformation plan and the terms and conditions of the Medicaid demonstration project under section 1115 of the Social Security Act (42 U.S.C. 1315). If we are not correct, please clarify.

Answer 91. Yes. That is correct.

Question 92. Section B. "Social Determinants of Health and Health Equity (SDOH-HE) Spending, Priorities, and Partnership" Please confirm that the availability of each CCO receiving additional funding under both the SDOH-HE program and the variable margin program for Social Determinants of Health are dependent upon that CCO's cost growth remaining under 3.4% (as any SDOH-HE bonus and variable margin will not be paid unless this threshold is met and individual CCO surplus may not be available unless this threshold is met)

Answer 92. The availability of additional funding under the SDOH-HE program is contingent on the cost growth of the entire *program* remaining under 3.4%. The variable margin will apply

to all CCOs, regardless of overall program cost growth. CCOs with lower cost growth are likely to have higher variable margins, all else equal.

Question 93. Section B. "Social Determinants of Health and Health Equity (SDOH-HE) Spending, Priorities, and Partnership" Assuming that additional funding for Social Determinants of Health is dependent upon cost growth remaining under 3.4%, please describe any consideration OHA or Optumas has made or will make to ensure that the additional funding flows to where it is needed most, for example, communities with persistent poverty or where extreme events contribute to cost trends beyond 3.4% (e.g. forest fires, measles outbreaks, infrastructure failures)

Answer 93. Additional funding for SDOH-HE will be structured as an incentive payment to the CCOs and therefore must be tied to the CCO's performance, not to needs in a specific region. That said, SDOH-HE funding will be spent in alignment with the CHP developed in conjunction with local partners and the CAC. Accordingly, OHA anticipates that SDOH-HE spending will align with local priorities.

Question 94. Section B. "Social Determinants of Health and Health Equity (SDOH-HE) Spending, Priorities, and Partnership": If additional funding will not be made available to regions with extreme changes in health needs or social determinants of health outside CCO control, please describe adjustments expected to be made to the 3.4% rate of growth targets and/or upward adjustments to the rate development to ensure that CCOs have the requisite funds to make investments in Social Determinants of Health required under the contract.

Answer 94. OHA intends to develop an incentive payment to support SDOH-HE spending in the initial contract years. The 3.4% rate of growth target will not be adjusted. Further, under federal rules, capitation payments to Medicaid managed care plans, like CCOs, may only cover services described in the State Plan and identified in the contract between the plans and the State. Accordingly, the State is not permitted to increase rates specifically to address SDOH-HE spending. SB 4018, as codified at ORS 414.625(1)(b)(C), requires CCOs to spend a portion of net income or reserves to support SDOH-HE spending.

Question 95. Section B. "Social Determinants of Health and Health Equity (SDOH-HE) Spending, Priorities, and Partnership": For the first two years of SDOH-HE spending, OHA has designated a statewide priority for spending on housing related services and supports. Is it expected that this spending will be funded by surplus and/or the SDOH-HE Bonus Fund? If these amounts are not available (due to cost increases exceeding the rate of growth target), will CCOs still be expected to fund these projects?

Answer 95. OHA anticipates that CCOs will fund these efforts in the first two years primarily with surplus dollars (derived from annual net income or excess reserves) or payments received for meeting metrics/milestones under the SDOH-HE Capacity-Building Bonus Fund. If CCOs have surplus, they will be required to spend a portion of that surplus on SDOH-HE, as is required under HB 4018. Housing-related services and supports must be one of the priorities selected for this spending in the first two years. If there is no surplus, then the CCOs would not be required to spend on SDOH-HE. However, OHA will continue to encourage CCOs to invest in SDOH-HE through opportunities such as health-related services to reduce costs and improve outcomes and will deploy tools in CCO 2.0 to reward CCOs that are efficiently doing so. CCOs will be encouraged to align spending wherever possible (e.g. health-related services, grant or other funding) with statewide priorities in SDOH-HE, including housing-related services and supports.

Question 96. Section B. "Social Determinants of Health and Health Equity (SDOH-HE) Spending, Priorities, and Partnership": The SDOH-HE Bonus Fund is a two year incentive arrangement with a target implementation during CY 2021. Does that mean it is for 2021 and 2022? What year's rate of growth will determine eligibility for bonus payments?

Answer 96. The rate of growth for the most recent year available will determine eligibility for bonus payments. OHA will continue to develop parameters related to the bonus fund and will announce those parameters prior to the start of the CY 2021 contract.

Question 97. Section B. "Social Determinants of Health and Health Equity (SDOH-HE) Spending, Priorities, and Partnership": Please confirm that CCOs will not be expected to spend on SDOH until 2021, based on a calculation of end of year surplus for 2020.

Answer 97. Confirmed.

Question 98. Section E **"**Health Equity Assessment and Health Equity Plan" Subsection 3. "Requested Documents": Please affirm that the requested documents in Section E.3 are not included in the page limits for this section: Policies and procedures describing language access services, practices, evaluation, and monitoring for appropriateness and quality and Policies and procedures related to the provision of culturally and linguistically appropriate services.

Answer 98. Requested documents for Attachment 10 are not included in the page limit.

Question 99. Section E **"**Health Equity Assessment and Health Equity Plan" Subsection 3. "Requested Documents": Are the policies and procedures requested part of the 10 page limit for SDOH-HE, or in addition to the 10 pages?

Answer 99. Requested documents for Attachment 10 are not included in the page limit.

Question 100. Section F "Traditional Health Workers (THW) Utilization and Integration" Subsection 2 "Evaluation Questions": paragraph (a) states a): "Please submit a THW Integration and Utilization Plan which describes:

> "How applicant proposes to utilize the THW Liaison position to improve access to Members and increase recruitment and retention of THWs in its operation."

Where is information concerning the THW Liaison position? We do not see it in the reference documents or in any other part of the RFA.

Answer 100. The THW liaison position is described in Appendix B, Exhibit N, Section 6(h).

Attachment 11

Question 101. Section A "Behavioral Health Benefit" page 1 and Attachment 13; Section F.1.d; page 21

We respectfully request clarification from the OHA on various aspects of the RFA that relate to behavioral health strategy and contracting. We are concerned that these elements seem to set forth competing or conflicting direction to applicants. For example, Attachment 11 indicates that applicants may enter into VBP arrangements, but Attachment 13 later provides that applicants "will not sub-capitate any provider or entity for behavioral health services separately from physical health services." May applicants propose to use any form of capitation to pay for behavioral health services, assuming the applicant proposes to retain ultimate responsibility for the behavioral health benefit? Is capitation appropriate only if an entity provides both physical health and behavioral health services? Attachment 13 provides that applicants may not "enter into any value-based payment arrangements under which behavioral health spending is tracked separately from physical health services." Exhibit M (page 172 of 207) of the proposed CCO contract provides that the CCO may enter into VBP arrangements "so long as those arrangements do not separate the performance metrics for physical and Behavioral Health services." We observe that tracking, spending and building appropriate performance metrics are key to sound financial management and oversight, and not an indicator of a lack of integration. Indeed, Exhibit M also requires the CCO to report to the OHA a variety of behavioral health-specific performance metrics. We respectfully request that the OHA clarify its intent as between Attachment 11, Attachment 13, and Exhibit M of the proposed CCO contract. We strongly support integration, but clarity and tools to track, manage, and increase behavioral health utilization are key.

Answer 101. CCOs may enter into VBP arrangements with Behavioral Health providers, so long as those arrangements do not involve sub-capitation for Behavioral Health services. For example, CCOs may enter into contracts under which Behavioral Health providers receive shared savings/pay shared losses related to total cost of care. Similarly, CCOs may enter into bundled payment arrangements for a specific episode of Behavioral Health care. They also could sub-capitate a Behavioral Health provider for physical and Behavioral Health services for an attributed population. CCOs may track spending on Behavioral Health services, just like they might track spending on radiology services or prescription drugs, to inform strategies to improve the health of their enrolled population or encourage more efficient utilization patterns; CCOs may not, however, have a separate budget for Behavioral Health services that drives payment to certain providers or vendors.

Applicants will not be prohibited from sub capitating to pay for Behavioral Health services, assuming the Applicant proposes to retain ultimate responsibility for the Behavioral Health benefit (not solely with combined physical and behavioral health services). OHA strongly supports integration and VBP. Our goal is to assure that the CCO takes ultimate responsibility for the full benefit package it responsible for administering and does not cede all responsibility for oversight of those benefits. The CCO can enter into contracts, value based or not, with other entities, as long as the CCO continues to accept responsibility for the performance of that entity.

Question 102. Section A "Behavioral Health Benefit" Item 9: Please clarify the expectation of oral health providers related to conducting comprehensive physical and behavioral health screenings.

Answer 102. Oral Health providers, like physical and mental health providers, can conduct screenings that support multi-directional referrals to physical or Behavioral Health care. The expectation is that they use evidence-based screening tools to conduct those physical and Behavioral Health screenings that are within their scope of practice and billable within OHA rules

Question 103. Section D. "Provision of Covered Services" Item 1: please clarify what is expected in the response related to "a report on Behavioral Health needs" in Applicant's Service Area.

Answer 103. Thank you for your question. This question will be answered in a different addendum that will be posted approximately March 22nd, 2019.

Question 104. Section E. "Covered Services Components" Subsection 2 "Fewer readmissions to the same or higher level of care Prioritize Access for Pregnant Women and Children Ages Birth through Five Years" Item b: We observe that evidence-based practices for ACEs screening and tools validated for use in clinical care settings have not yet been developed. We respectfully request that the OHA clarify if screenings for ACEs conducted by the Applicant's case management program are adequate to meet this expectation.

Answer 104. Yes. Screenings for ACEs conducted by the Applicant's case management program are adequate to meet this expectation.

Question 105. "Section E. "Covered Services Components" Subsection 3 "Care Coordination" Item b: Can OHA please clarify if the work flow chart (if submitted) will count towards the overall page limits for this section?

Answer 105. The work flow chart is not included in the page limit for Attachment 11.

Question 106. Section E. "Covered Services Components" Subsection 3 "Care Coordination" Item m.: Please identify where this requirement is published: "Describe how Applicant will ensure ICC Care Coordinators will maintain the 15:1 caseload requirement."

Answer 106. We will include this requirement in Exhibit M of Appendix B.

Question 107. Section E. "Covered Services Components" Subsection 5 "Emergency Department" Item a.: It is unclear whether this section refers to any CCO member who has had two or more visits to an emergency department or some subset of members who meet criteria for having SPMI. In addition, we respectfully request the OHA to clarify the phrase "readmissions to an emergency department." Is this meant to communicate something other than "admissions" or "visits"?

Answer 107. This is for any CCO members who have two or more visits to an Emergency Department. Readmissions to an emergency department means an admission or visit to an Emergency Department after an earlier visit related to the purpose of that earlier visit.

Question 108. Section E. "Covered Services Components" Subsection 5 "Emergency Department": This section references "readmissions" to the emergency department. Typically, we do not refer to "admissions" to emergency departments. Does this mean "visits" or "ED visits that result in inpatient admissions"?

Answer 108. This means visits or ED visits.

Question 109. Section E. “Covered Services Components” Subsection 8 “Children’s System of Care” Item d: It is unclear whether the phrase "of at least 51 percent" applies to "youth and family voice" representation or the entirety of the representatives listed in that section. We respectfully request clarity.

Answer 109. All governance groups related to the system of care must have a majority of their members who quality as youth and Family voice representation.

Attachment 12

Question 110. Section C. "Quality Pool Operation and Reporting" When CCOs track their quality pool expenditures, please confirm that, while these expenditures should be tied to the earn-back of the quality pool withhold, this spending may not necessarily be over and above payment for services rendered, but may instead be in lieu of other spending (e.g. it may be a return of downside risk to the provider as well as to the CCO)

Answer 110. OHA cannot instruct CCOs on how to contract with Providers, per CMS rule, without a specific CMS-approved agreement under 438.6.

Question 111. Section F "Financial Reporting Tools and Requirements" References the NAIC Risk Based Capital tool. Does OHA intend to require CCOs to retain the same level of risk-based capital for the Medicaid population as is required of commercial carriers using the RBC Tool?

Answer 111. The specific RBC requirements will be developed through the "Oregon Administrative Rule" (OAR) process. As referenced in Attachment 13 Section 10.b. the expectation is that CCOs will "achieve a calculated RBC threshold of 200% by end of Q3 of 2021 and thereafter to maintain a minimum RBC threshold of 200%".

Question 112. Section H "Potential Establishment of Program-wide Reinsurance Program in Future Years": please clarify the evaluation criteria for this section. Are these questions informational or scored?

Answer 112. The questions are informational and will be part of the overall evaluation.

Question 113. Section L "Exhibits to this Attachment 11": Please clarify, is this for Attachment 11 or 12.

Answer 113. See correction in Section 2., at the beginning of this document, which provides clarification.

Question 114. "Rate Methodology" In the Background section at the top of page 3, item 1 notes that there will be CCO-specific VBP growth targets. Is this referring only to the required 70% VBP goal by 2024 across all CCOs, or does OHA intend to assign specific targets to individual CCOs? Please clarify.

Answer 114. Attachment 8 - Value-base Payment Questionnaire" outlines all VBP requirements and targets for 2020 - 2024.

Question 115. Attachment titled "Oregon CY20 Procurement Rate Methodology" On page 4, under Item 2, Rate Development Process, 2.01 Overview, Item 4, Social Determinants of Health Risk Differential, can OHA elaborate on how this will be measured, how reliability will be ensured, and how OHA will ensure actuarial soundness of this approach?

Answer 115. SDOH-HE is a new concept for OHA's CCO Program. As such OHA and Optumas are taking measures to ensure all methodologies and concepts are fully vetted. As we continue to work through the details of this methodology, OHA/Optumas intend to share data and pertinent details with all stakeholders to ensure this is developed in a transparent manner. As for actuarial soundness, ASOP 45- Health Based Risk Score will be considered as SDOH-HE is incorporated into any risk tool.

Question 116. Attachment titled “Oregon CY20 Procurement Rate Methodology” On page 5, under Item 2, Rate Development Process, 2.01 Overview item 9, Biennial rebasing, how will OHA ensure that this methodology does not exaggerate volatile variables like trend or SDOH impacts and improvements that are not recognized for 2 years?

Answer 116. Actuarial projection factors are always subject to projection error (volatile variables) whether the rate process is rebasing or just applying a rate update. A rate update should not be interpreted as having less rigor, in fact there would likely be more rigor applied to trend, SDOH-HE and other risk factors given the time saved from not having to rebase. All applicable actuarial standards will be followed with and without rebasing when developing projection factors.

Question 117. Attachment titled “Oregon CY20 Procurement Rate Methodology” Base Data page 5: With regards to biennial rebasing, what base data will be used to develop rates for 2021? Will this be a re-base year, especially since 2016 and 2017 data is being used to develop rates for 2020?

Answer 117. Optumas is currently working on 2020 Procurement rates, therefore, there have been no decisions made related to the 2021 rates.

Question 118. Attachment titled “Oregon CY20 Procurement Rate Methodology” Base Data page 5: Please confirm that expenses that have historically been rate "add ons" (e.g. CANS, ACT/SE, etc.) are no longer CCO-specific, and separately break out their contribution to the statewide base data.

Answer 118. All historical add-ons have been incorporated into the statewide base data, except Hepatitis C DAA drugs that will remain subject to a risk corridor. OHA believes the original RFA documents are sufficient and will not be creating an additional exhibit to specify each add-on’s contribution.

Question 119. Attachment titled “Oregon CY20 Procurement Rate Methodology” Base Data page 5: Please provide an aggregated summary of all of the Exhibit Ls as reconciled to the encounter data that was used to develop the statewide base data for 2016 and 2017. Please separately break out subcapitated expenditures, quality pool expenditures, incentive payments, encounters, and any underreporting adjustments to reconcile the amounts included within the rates with the amounts reported as spent by the CCOs (with an explanation for any dollars omitted).

Answer 119. OHA believes the original RFA documents are sufficient and will not be creating the exhibit requested.

Question 120. Attachment titled “Oregon CY20 Procurement Rate Methodology” Covered Population page 7: Please confirm that, while listed in the covered populations, Cover All Kids members are not included within the rates presented in this methodology, and their rate development will occur separately from the rate cells included here.

Answer 120. OHA separately contracts for Cover All Kids with CCOs; however, OHA uses the same capitation rates for that population. The rates cited for Cover All Kids are not applicable to this RFA.

Question 121. Attachment titled "Oregon CY20 Procurement Rate Methodology" page 8: Please provide more detail about how the Service Area Factors were developed, including the normalization for population risk and the relationship to the risk scores provided in Appendix I.F. Please also provide a narrative describing how and when the Service Area Factors will be updated with 2018 data.

Answer 121. Health based risk scores are developed using CDPS+Rx. The risk scores are developed for each Service Area and then normalized to the statewide risk score by rating cohort. This normalized risk score is then used to apply to the data prior to calculating the area factors. More information surrounding how the 2018 data will be used will be shared once the 2018 data is validated.

Question 122. Attachment titled "Oregon CY20 Procurement Rate Methodology" page 8: Please provide a reconciliation to compare actual spending by Service Area against average statewide spending used for the base data development, adjusted by the Service Area and regional risk adjustment factors. It is understood that in order to do this comparison completely, OHA would need to make adjustments to the base data to reflect changes in hospital spending at DRG hospitals for the HRA transition.

Answer 122. OHA believes the original RFA documents are sufficient and will not be creating the exhibit requested.

Question 123. Attachment titled "Oregon CY20 Procurement Rate Methodology" page 8: Please explain how (if at all) the Service Area Factors were normalized to exclude differences in cost between regions due to overutilization or inefficient care delivery.

Answer 123. There were no adjustments related to high value/low value care, nor were there any managed care adjustments. However, the data is adjusted for differences in health-based risk score and OHA reimbursement policies prior to calculating the area factors.

Question 124. Attachment titled "Oregon CY20 Procurement Rate Methodology" page 8: Historically, there has been an A/B Hospital Adjustment applied to CCO-specific rates to account for differences in hospital mix between the CCOs. Has an adjustment of this type been included in the Service Area Factors? If so, please provide additional detail regarding the methodology used. If not, how are these cost differences accounted for in rate development?

Answer 124. Differences in underlying reimbursement across Service Areas for A/B Hospitals are inherent in the Service Area factor development. There is no specific methodology used to quantify differences in A/B utilization and cost. However, to the extent one service area has higher utilization of A/B hospitals, it would materialize in the total PMPM for that service area and therefore would influence the area factor for that specific Service Area.

Question 125. Attachment titled "Oregon CY20 Procurement Rate Methodology" OHPB Policy #1 page 15: CCOs must spend a portion of annual net income or reserves on services designed to address health disparities and SDOH. We acknowledge that the definitions of surplus and the "portion" are not fully defined yet. Please describe any consideration that Optumas has already given to this policy along with the new 200% RBC requirement, in the development of their explicit margin assumption, and confirm that Optumas will revisit their effective margin as a result of whatever policy is ultimately developed.

Answer 125. OHA and Optumas will review the non-medical load assumption once the final policy is developed.

Question 126. Attachment titled "Oregon CY20 Procurement Rate Methodology" 2.06 Non-Medical Loading page 16: Please describe the considerations Optumas made when developing the administrative portion of the non-medical load, and any additional expected adjustment to account for significant increases in reporting requirements, provider analytics, investments in HIE, and other expanded CCO responsibilities required under the contract.

Answer 126. The overall NML of 10.0% is two percentage points higher than the 8.0% that CCOs operated under prior to 2015. In reviewing reported administrative expenses across the CCOs, 10.0% is considered to be reasonable for the CCO program and in fact is consistent with the previous statewide NML in previous methodology which has resulted in reasonable margins for most CCOs. This assumption will be reviewed once the final CCOs are determined.

Question 127. Attachment titled "Oregon CY20 Procurement Rate Methodology" 2.06 Non-Medical Loading page 16: Please confirm that any variable margin will be added to (rather than substituted for) the profit and risk contingency margin included within the Statewide Base Non-Medical Load to develop the CCO Specific margin referenced in the attestations.

Answer 127. Confirmed. Profit and risk contingency will not go lower than 1.0% in CY2020.

Question 128. Attachment titled "Oregon CY20 Procurement Rate Methodology" Hospital Reimbursement Adjustment (HRA) Transition page 16: The rate methodology document states: "The transition is designed to be budget neutral for DRG hospitals and may include rule changes or other administrative processes to ensure the continuation of program policy goals." Please provide a demonstration of budget neutrality, and explain how this can be possible along with DRG payments to DRG hospitals being reduced from 100% of Medicare (or current levels, including CCO payment greater than or equal to 68% plus HRA rate restoration component of 32%) to 80% of Medicare (approximately). Please correct our understanding if these total payment streams are not being reduced.

Answer 128. The methodology of Tier 1 HRA and Tier 2 HRA does not dictate the distribution to hospitals for tax repayment and reimbursement and is not tied to a specific tier for HRA distribution or the 32%. Hospitals currently receive about 25% of total HRA in straight reimbursement, which equates to a 12% of Medicare reimbursement, resulting in an approximate overall adjustment from 68% to 80%. The remaining 75% of HRA that is currently being distributed directly to hospitals will instead be put into a qualified directed payment program starting in 2020. This results in a budget neutral adjustment to DRG hospitals.

Question 129. Attachment titled "Oregon CY20 Procurement Rate Methodology" Hospital Reimbursement Adjustment (HRA) Transition page 16: If the total level of reimbursement to DRG hospitals really is being reduced within the capitation rates plus the (discontinued) rate restoration component of the HRA payment, please clarify whether OHA is relying on their authority under section 438.6(c)(1)(iii)(C) of the Medicaid Managed Care Final Rule to implement a maximum fee schedule that DRG hospitals may be paid tied to 80% of Medicare, or if, instead, OHA is assuming that CCOs will be able to renegotiate their provider contracts prior to the beginning of the program to achieve that level of hospital reimbursement.

Answer 129. CCOs can negotiate with all Providers, including hospitals, for reimbursement. OHA has funded the capitation rates assuming an 80% of base Medicare reimbursement to DRG hospitals for Inpatient and Outpatient services.

Question 130. Attachment titled "Oregon CY20 Procurement Rate Methodology" Hospital Reimbursement Adjustment (HRA) Transition page 16: If OHA is assuming that CCOs will be able to renegotiate their provider contracts prior to the beginning of the program to achieve a level of hospital reimbursement of 80% of Medicare (while current levels may be higher), please provide an analysis that demonstrates how this assumption was made, including any comparison of current CCO payment levels to the desired level.

Answer 130. CCOs can negotiate with all Providers, including hospitals, for reimbursement. OHA has funded the capitation rates assuming an 80% of base Medicare reimbursement to DRG hospitals for Inpatient and Outpatient services.

Question 131. Attachment titled "Oregon CY20 Procurement Rate Methodology" Hospital Reimbursement Adjustment (HRA) Transition page 16: If OHA is not establishing a maximum provider fee schedule, please describe any considerations Optumas made or may make in rate setting to adjust for provider contracts that may not be able to achieve a payment rate of 80% of Medicare for Inpatient or Outpatient Services at DRG Hospitals but which cannot be terminated due to network adequacy requirements.

Answer 131. OHA expects that any CCO that chooses to participate in CCO 2.0 will be able to operate under the reimbursement policies developed by OHA. CCOs should evaluate their ability to achieve the desired levels of efficiency and rate of growth before agreeing to participate. Given this expectation, Optumas assumes the CCOs that participate in CCO 2.0 will achieve the desired efficiency.

Question 132. Attachment titled "Oregon CY20 Procurement Rate Methodology" Health Based Risk Score page 18: Please comment on the current plans for risk adjustment given state law limiting retroactive capitation rate reductions. We are concerned about any proposal to apply a risk corridor or risk adjustment on a half-year basis to full-year rates and would prefer retroactive risk adjustment. Regardless of the methodology proposed to be used, we hope that OHA will work with successful applicants to develop an actuarially sound methodology that appropriately adjusts for seasonality, trend, and other factors.

Answer 132. Thank you for the feedback.

Question 133. Attachment titled "Oregon CY20 Procurement Rate Methodology" Health Based Risk Score page 18: Under Risk Score, item 4, when will the state move to state-specific weights?

Answer 133. OHA will continue to review the option of moving to state-specific weights for CDPS+Rx throughout the CCO 2.0 contract but is not moving to state-specific weights in CY2020.

Question 134. Attachment titled "Oregon CY20 Procurement Rate Methodology" Health Based Risk Score page 18: Please describe the process that will be used to risk adjust enrollees where less than a full county is covered by a particular CCO, or fewer enrollees are present than what would be treated as fully credible. Will any weight be given to the raw risk scores for enrollees covered by the same CCO in a neighboring county, if it falls within a different regional service area?

Answer 134. Each CCO will be assigned a risk score commensurate with its membership. Credibility will be applied using the same actuarial principles that have been used in CCO 1.0.

Question 135. Attachment titled "Oregon CY20 Procurement Rate Methodology" 2.09 Withhold and Payment Rate Percentile Choice 3. page 20: Please illustrate the way Optumas arrived at rate of growth lower than the proposed Governor's Budget, explicitly breaking out any changes to the different ways Quality Pool and HRA are treated in total rates in both years.

Answer 135. The CY2020 procurement rates include a portion of the previous funding associated with the historical HRA funding. Since the rate comparison shown in the narrative is comparing CY2020 to CY2019 (net HRA) the implied rate of growth is higher than 3.4%. Prior to modeling the additional funding previous associated with HRA, the rate of growth was below 3.4%. Therefore, the narrative is correct in stating that the rate of growth was below the governor's budget.

Question 136. Attachment titled "Oregon CY20 Procurement Rate Methodology" Prometheus Analytics page 24: Please confirm that there will be no managed care savings via Prometheus Analytics for 2020 rates. Is there a timeline on when managed care savings will start to be implemented?

Answer 136. OHA has decided not to include a managed care savings adjustment in the initial 2020 procurement rates as released in the RFA.

Question 137. Attachment titled "Oregon CY20 Procurement Rate Methodology" Prometheus Analytics page 24: Will OHA and Optumas work with the CCOs to ensure that an appropriate process is followed to ensure that any dollars removed from rate development are both theoretically and practically removable by CCOs in partnership with providers? For example, reductions are for what is reasonably achievable given real clinical and administrative barriers to care management and replacement costs.

Answer 137. OHA will consider this feedback as it considers this adjustment in the future. Please note, CCO rates are certified as actuarially sound, which require rates to be evaluated based on applicable actuarial principles of what is reasonably attainable in the contract year.

Question 138. Attachment titled "Oregon CY20 Procurement Rate Methodology" Prometheus Analytics page 24: "Optumas has introduced Prometheus Analytics to many Medicaid programs, including Colorado, Iowa, Kansas, Alabama, Ohio, Nebraska, and North Dakota." How will what's been done in those states compare to what's being implemented in Oregon? Are there any lessons learned? Are there meaningful differences in the way care is delivered between Oregon and those programs that will be considered to customize the application to CCO 2.0?

Answer 138. More information related to how Prometheus will be used in CCO 2.0 will be shared once all policies are finalized. Every program is unique, so each program may use Prometheus Analytics in a different manner. With that said, the end goal is to identify inefficiencies within a program which is the common thread across all the states mentioned.

Question 139. Attachment titled "Oregon CY20 Procurement Rate Methodology" Prometheus Analytics page 24: In the event that a small number of CCOs are largely contributing to the statewide Rate of Growth (causing it to be above 3.4%) while the others are performing below the sustainable level, will the significant cost increases from those few CCOs prevent the others from being rewarded with the variable profit margin?

Answer 139. OHA has a set budget and will weigh the final cost of the program against the budget available when determining the variable profit. However, in the scenario presented, the CCOs with lower internal cost growth would still be rewarded by growth in the capitation

rates due to the construction of the statewide base data. The goal and intent is to reward CCOs with increased profit as the capitation rate starts to decrease due to increased efficiency and investments in health-related services. In the event that is not realized on a statewide basis, CCOs that have lower cost growth still have some basis for improved margins relative to the statewide capitation rate increases.

Question 140. Attachment titled "Oregon CY20 Procurement Rate Methodology" Prometheus Analytics page 24: Given that the Prometheus data output will be covering a broad spectrum of episodes of care, are there specific episode types or episode groups (procedural, acute, chronic, etc.) that OHA plans to focus on or prioritize?

Answer 140. Details are in development and additional specifics will be provided at a later time.

Question 141. Attachment titled "Oregon CY20 Procurement Rate Methodology" Prometheus Analytics page 24: Please provide Optumas' initial categorization of dollars into Total Dollars, Episode Dollars, and Potentially Avoidable Complications Dollars by rate cell, episode type and Service Area for each of the two years of base data. Please also confirm that the CCOs should understand that this categorization does not represent the total dollars CCOs should expect to be removed from rate development via an efficiency factor, but rather the upper bound of dollars Optumas might remove after adjusting for dollars not practically removable by CCOs in partnership with providers.

Answer 141. That statement regarding the upper bound to be removed is accurate. PAC means potentially avoidable complications. Optumas conducts additional analyses with clinical input when deciding what portion of the PAC is reasonably avoidable.

Question 142. Attachment titled "OR CCO 2.0 Procurement Rate Methodology Appendix I RDS Data Book": The trend forecast by Optumas from the base to the rating period in the databook is 4.5% in total, made up of 3.5% for non-pharmacy costs and 8.8% for pharmacy costs. If CCOs are expected to be able to control the total rate of growth but are not able to manage the pharmacy cost trends (so that future pharmacy trends will remain in the 8.8% range), this means that CCO provider networks really need to be prepared to live within a budgeted increase of only 2.1% for non-pharmacy expenditures from 2020 to 2021 at the same time that they expand services to members and take on more downside risk due to VBP targets. What testing has OHA or Optumas done to be sure that these dramatic changes are truly feasible in every region and will not compromise provider solvency or member access to care?

Answer 142. Each CCO should evaluate the expected capitation rate to ensure that it can operate efficiently under that level of capitation. These are procurement rates, therefore, Optumas is not testing the projected rates for any one specific CCO. Instead the rates are deemed reasonable from a statewide perspective.

As far as solvency concerns, submitted quarterly financials are reviewed on an ongoing basis. Optumas will continue to review the reported financials throughout 2019 to inform the final 2020 capitation rates.

Question 143. Attachment titled "OR CCO 2.0 Procurement Rate Methodology Appendix I RDS Data Book": Please provide a supplemental exhibit showing, for each of 2016 and 2017, the percent of Medicare represented by actual (before truncation) CCO Inpatient and Outpatient DRG plus tier 1 HRA payments by regional service area, COA, and COS.

Answer 143. OHA believes the original RFA documents are sufficient and will not be providing additional exhibits to supplement the data book.

Question 144. Attachment titled "OR CCO 2.0 Procurement Rate Methodology Appendix I RDS Data Book": Please provide an addendum to the databook to demonstrate the initial base data used from each of 2016 and 2017 before any adjustments. Please show the impact to 2016 and 2017, separately, for all the base data adjustments prior to applying trend (e.g. impact of underreporting/reconciliation adjustments, reimbursement adjustments, redetermination adjustments, etc.). We hope that this will help us understand how the data shown after these adjustments is trended forward for 36 months to the rating period (indicating that the data summarized has a midpoint of 7/1/2017, despite being derived from 2016 and 2017 calendar years, which together have a midpoint of 1/1/2017).

Answer 144. OHA believes the original RFA documents are sufficient and will not be providing additional exhibits to supplement the data book. To clarify, the CY16 base data is trended to CY17 prior to blending the two years. The aggregated base data is then trended 36 months.

Question 145. Attachment titled "OR CCO 2.0 Procurement Rate Methodology Appendix I RDS Data Book": Please describe any changes to the way base data will be stratified and trends will be developed when the majority of provider payments are made under a VBP architecture rather than under fee for service. Is OHA or Optumas concerned that encounter data quality (and thereby risk adjustment and Prometheus or any other similar efficiency analysis) may suffer when providers are paid in a way that relies less on this architecture?

Answer 145. Section B, #4 under Date Reporting: 2022-2024 of "Attachment 8 - Value-base Payment Questionnaire," CCOs must Report complete Encounter Data with contract amounts and additional detail for VBP arrangements.

Question 146. Attachment titled "OR CCO 2.0 Procurement Rate Methodology Appendix I RDS Data Book": Please separately break out the contribution of Quality Pool Expenditures to the Base Data PMPM in the same format shown in this appendix (i.e. by COS and COA, and by Service Area)

Answer 146. The adjustment factor applied to the base data was 3.6% (~$132M) to account for expenditures related to the Quality Pool. Please note, a 10% non-medical load is also applied after this adjustment.

Question 147. Attachment titled "OR CCO 2.0 Procurement Rate Methodology Appendix II Prometheus Analytics": Please provide more information on what is classified as Potentially Avoidable Complications (PACs) (page 25) and how Prometheus determines something is truly avoidable at the time of service.

Answer 147. Examples and Narrative can be found on Altarum website.

Question 148. Attachment titled "OR CCO 2.0 Procurement Rate Methodology Appendix II Prometheus Analytics": It will be critical for providers and CCOs to work with Optumas to develop measures for risk score development.

Answer 148. Thank you for the feedback.

Attachment 13

Question 149. Attachment 13 “Attestations” Page 1 – Instructions, Paragraph 1 Are there page or word limits for the “no” attestation explanations?

Answer 149. Please limit to 5 total pages for "no" responses to Attachment 13

Question 150. Pages 1 through 46: Please describe any analysis Optumas has performed or expects to perform to reflect utilization or cost increases due to the new commitments CCOs will be making via the attestations (e.g. increases in administrative spending for HIE, increases in utilization of behavioral health services, increases in pharmacy costs for drugs prioritized on the state PDL that are more expensive than equivalent drugs covered by CCO PDLs such as Humelog vs. Admelog). Please also describe how these analyses were reflected within the draft or will be reflected within the final capitation rates. For example, the ongoing Myers and Stauffer analysis of the cost implications of requiring alignment to the state PDL explicitly does not include rate development adjustments in its scope.

Answer 150. Thank you for your question. This question will be answered in a different addendum that will be posted approximately March 22nd, 2019.

Question 151. Section B. “Provider Participation and Operations Attestations (Attachment 7)” Subsection 1.b.: Regarding this question: "Will Applicant participate in the Learning Collaboratives required by ORS 442.210?" With respect to ORS 442.210: does OHA mean to reference ORS 413.259 (3) (Patient Centered Primary Care Home Program learning collaboratives)? Are we correct in that assumption? If not, please clarify.

Answer 151. Thank you for your question. This question will be answered in a different addendum that will be posted approximately March 22nd, 2019.

Question 152. Section B. “Provider Participation and Operations Attestations (Attachment 7)” Subsection 1.h.: Regarding the sentence: "Will Applicant have all Provider contracts or agreements available to OHA in unredacted form?" Is the CCO required to disclose confidential / proprietary negotiated provider rates as part of this disclosure? Such disclosures may seriously compromise the CCO's ability to effectively administer their programs, particularly in light of RFA Section 6.3 (Ownership/Permission to Use Materials).

Answer 152. Yes, unredacted means including confidential / proprietary negotiated provider rates. It has not been OHA’s experience that such disclosures seriously compromise CCOs’ ability to effectively administer their programs. Section 6.3 provides an opportunity for the Applicant to designate negotiated provider rates as trade secrets.

Question 153. Section E “Social Determinants of Health and Health Equity (SDOH-HE) Attestations (Attachment 10)”: Please provide an indication of the current level of utilization of these services by CCOs under CCO 1.0 (in terms of current spending compared to overall current spending, and compared to expected spending when these services are fully integrated)

Answer 153. Thank you for your question. This question will be answered in a different addendum that will be posted approximately March 22nd, 2019.

Question 154. Section E "Social Determinants of Health and Health Equity (SDOH-HE) Attestations (Attachment 10)": Can these services be billed through the encounter system today, and/or are they expected to be billed through the encounter system in future years under CCO 2.0?

Answer 154. Thank you for your questions regarding Behavioral Health, or Social Determinants of Health and Health Equity. In the areas of Behavioral Health and Social Determinants of Health and Health Equity, the RFA focuses on outcomes as opposed to structures. It is our intent to foster innovation and local collaboration around solutions rather than prescribe acceptable interventions. It is our expectation that these innovations will be Evidence-Based interventions that are linked to lowered cost and improved health status, and that Applicants will clearly identify and describe how outcomes intend to be tracked and achieved through the structures they propose. We look forward to collaborating with Successful Applicants to explore potential approaches in these areas but have no further detail to share at this time regarding preferred approaches to services, billing or plans for data collection.

Question 155. Section E "Social Determinants of Health and Health Equity (SDOH-HE) Attestations (Attachment 10)": If these services are flowing through the encounter system and incorporated within the base data used to inform the procurement rate methodology in Attachment 12, please provide a breakout of their contribution to the base data and any considerations Optumas made for utilization increases due to the THW Utilization and Integration requirements under the contract.

Answer 155. Thank you for your question. This question will be answered in a different addendum that will be posted approximately March 22nd, 2019.

Question 156. Section E "Social Determinants of Health and Health Equity (SDOH-HE) Attestations (Attachment 10)": If these services are not currently flowing through the encounter system and/or are not expected to flow through the encounter system, please describe how they are expected to be identified for inclusion within rate setting, and any adjustments Optumas has made to the base data to include the expected cost for these services, e.g. via a doula add-on to the maternity rate development

Answer 156. Thank you for your question. This question will be answered in a different addendum that will be posted approximately March 22nd, 2019.

Question 157. Section E "Social Determinants of Health and Health Equity (SDOH-HE) Attestations (Attachment 10)": If Optumas did not and is not planning to adjust rates to reflect increased utilization of these services, please describe why not.

Answer 157. Thank you for your question. This question will be answered in a different addendum that will be posted approximately March 22nd, 2019.

Question 158. Section F. “Behavioral Health Attestations (Attachment 11)” Subsection 1.d.: Regarding this item: "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." We assume that the above means that the Applicant may not pay BH providers on a Per Member Per Month basis - unless that BH provider is part of a wider ranging organization (e.g. PCPCH) where the PMPM covers physical and BH services. Are we correct in our assumption? If we are not correct, please clarify.

Answer 158. Yes, that is correct.

Question 159. Section F. “Behavioral Health Attestations (Attachment 11)” Subsection 1.f.: This attestation asks about individual CCO's capacity to integrate the Behavioral Health benefit with oral and physical health care benefits. However, as described in the RFA and rate methodology, all of the financial resources the CCOs have should come from capitation rates. Please describe the expected level of additional investment, if any, OHA and Optumas regard as needed to support this initiative (relative to statewide average historical administrative spending, which was used to inform the non-medical loading) and any addition to non-medical funding Optumas included or will include within the non-medical loading to reflect these expected additional expenditures.

Please also consider re-wording the question to clarify this relationship between rate development and CCO capacity to do this work, particularly given that the non-medical loading included within the draft rate methodology does not explicitly address these additional requirements and does qualify the amounts shown with: "OHA reserves the right to update the non-medical load based upon the result of the CCO 2.0 procurement."

Answer 159. OHA is not intending to build additional dollars in the non-administrative load to support specific investments in integration. This question is instead asking whether the Applicant has the expertise, relationships, or other tools needed to support integration. OHA recognizes that some components of integration will require some additional investment, such as reprogramming claims payment systems to authorize reimbursement for certain services/settings, but OHA believes this is covered within the existing non-medical load.

Question 160. Section G. “Cost and Financial Attestations (Attachment 12)” Subsection 6.a.: Please clarify how OHA expects respondents to attest to this item, given the clarifying statement in the summary of Stakeholder responses: “Require CCOs to align PDLs with state PDL: Clarified the goals and process of alignment. OHA will not impose requirements to align PDLs without first working with the CCOs to evaluate benefits and cost implications.” Does OHA regard this attestation as a commitment to work in good faith with OHA on aligning the PDL subject to benefit and cost evaluation or as a commitment to actually align their PDL with the state PDL?

Answer 160. OHA regards this attestation as a commitment to work with OHA on aligning the PDL.

Question 161. Section G. “Cost and Financial Attestations (Attachment 12)”: The attestations in this section refer generally to performance and efficiency evaluation, and to efficiency analysis, while the Draft Procurement Rate Methodology includes a section on Prometheus Analytics. Please answer the following questions to allow us to answer these attestations correctly:

* None of the files referenced at this link can be opened due to Prometheus reviewing its access policies: http://www.prometheusanalytics.net/deeper-dive/definitions-readable. Please provide the referenced files for CCO use in evaluating the Episode of Care definitions, and please also provide the definitions for Potentially Avoidable Complications

* Do the attestations in this section not explicitly refer to Prometheus because some alternative means may be used to evaluate CCO efficiency in future years under the contract?

* Does OHA have any concerns that Prometheus may not function as initially intended when the majority of payments have been moved to APMs rather than the fee for service architecture on which the analysis currently (seems to) run?

* Is OHA concerned about the ability of Altarum Institute to continue to update Prometheus's specifications to support APMs, and CCO ability to acquire and run this software to be able to act on any inefficiencies within CCO provider network, particularly given the large number of small CCOs in Oregon?

Answer 161. Thank you for your question. This question will be answered in a different addendum that will be posted approximately March 22nd, 2019.

Question 162. Section G. “Cost and Financial Attestations (Attachment 12)” Subsection 8.a: Historical growth rates have varied significantly between populations (rate cell), health care category of service, and geography. Please confirm whether CCOs are each individually expected to commit to meeting the 3.4% rate of growth target regardless of their mix of services and members.

Answer 162. Yes, CCOs are each individually expected to commit to meeting the 3.4% rate of growth target.

Question 163. Section G. “Cost and Financial Attestations (Attachment 12)” Subsection 8.a: Historical growth rates have historically been driven in large part by extremely high pharmacy trends. If CCOs are required to align their PDLs to the state's PDL, please describe any consideration given to account for this component of rate of growth when evaluating each CCO's rate of growth.

Answer 163. OHA will evaluate each CCO’s rate of growth across all services, including pharmacy. OHA will consider the impact on costs when developing requirements to align the PDL.

Question 164. Section G. “Cost and Financial Attestations (Attachment 12)” Subsection 8.a: Historical growth rates for some plans that have already expanded access to behavioral health services have historically been driven in part by these investments in access to these services. If all CCOs are required to further expand access to behavioral health services, please describe any consideration given to account for this contribution to overall rate of growth when evaluating each CCO's rate of growth.

Answer 164. OHA will evaluate each CCO’s rate of growth across all services, including Behavioral Health. There will be no adjustments to overall growth rate targets.

Question 165. Section G. "Cost and Financial Attestations (Attachment 12)" Subsection 8.a: Please provide the methodology for calculating the CCO-specific rate of growth that will be compared to the 3.4% target. What expenses will be included/excluded (e.g. SDOH expenditures)? How will costs be normalized for differences in populations within or between rate cells, and/or for differences in mix of services utilized by different populations?

Answer 165. Thank you for your question. This question will be answered in a different addendum that will be posted approximately March 22nd, 2019.

Question 166. Section G. "Cost and Financial Attestations (Attachment 12)" Subsection 8.a: Will the CCO-specific rates of growth be adjusted for health costs beyond CCO control, such as redetermination, increases due to new benefits/policy changes, etc.?

Answer 166. No.

Question 167. Section G. "Cost and Financial Attestations (Attachment 12)" Subsection 8.d: Please describe what a corrective action plan might entail if a CCO does not achieve the expenditure growth target.

Answer 167. OHA is still developing its approach to addressing growth in excess of the target, including specific requirements related to a corrective action plan.

Attachment 14

Question 168. Attachment 14 “Assurances” Page 1 – Instructions, Paragraph 1 Are there page or word limits for the “no” assurance explanations?

Answer 168. Please limit to 5 total pages for "no" responses to Attachment 14

Question 169. Attachment 14 “Assurances” Page 5 – Item 15 “Assurances of Compliance with Medicaid Regulations” Are there page limits for the narrative descriptions of each Assurance of Compliance with Medicaid Regulations? May supporting materials be provided as attachments that do not count toward any page limit?

Answer 169. Please limit to 5 total pages for "no" responses to Attachment.

Attachment 15

Question 170. Attachment 15 “Representations” Page 1 – Paragraph 1 Are there page or word limits for the representation explanations?

Answer 170. Please limit to 5 total pages for "no" responses to Attachment 15.

Attachment 16

Question 171. Attachment 16 “Member Transition Plan” Page 3: We are unable to access "2019 Contract Extension, Contract Termination and Closeout Requirements" under Section 3. Reference Documents. Can OHA please provide this document?

Answer 171. Yes, OHA will post the 2019 CCO Contract as a reference document.

Appendix A

Question 172. Section H "Terms Defined by this RFA" definition for "Member Months": OHA has added "quarterly" into the definition of Member Months. Can OHA please clarify/explain as we are not familiar with a member month being calculated on a quarterly basis.

Answer 172. OHA will take the average number of members during the quarter, which represents the average point-in-time enrollment in the plan. That number will be multiplied by the number of months to calculate member months.

Question 173. With regard to (123), the CCO Contract refers to CCOs establishing partnerships with SDOH-HE organizations but those are not defined. What is the criteria for considering an organization as SDOH-HE? Could OHA please clarify that in the contract either by explanation or definition?

Answer 173. SDOH-HE organizations are entities that can deliver services to address SDOH-HE needs.

Appendix B

Question 174. There are many places in the contract where defined terms are not capitalized; typically for terms such as Contractor, Corrective Action Plan, Member, Provider, Subcontractor. Request that OHA review and update for consistency as specific meaning is attributed to capitalized vs. non-capitalized terms which can affect contract interpretation.

Answer 174. OHA is revising the Sample Contract to clarify use of defined terms. Please review the revised Sample Contact when posted.

Question 175. Appendix B "Sample Contract" Exhibit B Part 1 "Governance and Organizational Relationships": What constitutes a "key committee" for purposes of reporting to OHA, i.e. reporting of membership, roles, etc.?

Answer 175. Thank you for your question. We will not be providing any further detail regarding the sample contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 176. Appendix B "Sample Contract" Exhibit B, Part 2 "Covered and Non-Covered Services" Section 3 "Authorization or Denial of Covered Services" Subsection d.: Can Members only refer to THW's in the CCOs network? If not, how does OHA intend for CCOs to ensure proper qualifications non-contracted THWs?

Answer 176. Thank you for your question. This question will be answered in a different addendum that will be posted approximately March 22nd, 2019.

Question 177. Appendix B "Sample Contract" Exhibit B, Part 2 "Covered and Non-Covered Services" Section 4 "Covered Service Components" Subsection b. Non-Emergent Medical Transportation (NEMT)": Section (2)(b) states that CCO shall confirm "that the service for which NEMT service is requested is an OHP covered services or for flex services as determined by the CCO." Does OHA intend for CCOs to cover transportation to a flexible services be covered by NEMT, i.e. if CCO approves a gym membership for a Member must the CCO provide NEMT covered transportation to the gym? If not, could OHA please explain the intent of the language and consider revising appropriately?

Answer 177. Yes, OHA intends for CCOs to cover transportation to flexible services.

Question 178. Appendix B "Sample Contract" Exhibit B, Part 2 "Covered and Non-Covered Services" Section 4 "Covered Service Components" Subsection b. Non-Emergent Medical Transportation (NEMT)" Item (4)(b): please provide more clarity on what a "contingency plan" means. If it means that we have a requirement to send a new vehicle, that would require that we contract for vehicles on standby to cover trips in addition to our normal fleet. Also, in the Metro area, 20 minutes is not excessive (normal traffic can result in regular delays of 20 minutes). Also, from a practical standpoint, oftentimes a ride that is 20 minutes late will arrive sooner than a newly-dispatched ride. We can see this being a good requirement for smaller markets, but it would be very expensive to make this work in its current form in the tri-county service area without considerable additional cost for a contingency fleet. Would OHA consider adjusting the timing of "excessively late" to take into account CCOs that serve large service areas? This would also be workable if 1 hour was considered excessive instead of 20 minutes.

Answer 178. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process.

There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 179. Appendix B "Sample Contract" Exhibit B, Part 2 "Covered and Non-Covered Services" Section 4 "Covered Service Components" Subsection b. Non-Emergent Medical Transportation (NEMT)" Item (4)(b): Section (6), there is a lack of clarity here regarding the definitions. Our proposal would be to use the following definitions:

Schedule: The authorization and recording of a trip for future assignment and dispatch by the Contractor.

Assign: The delegation of a ride to a particular transportation provider. Assigned rides are not in place until accepted by the transportation provider.

Dispatch: The act of sending the appropriate vehicle and driver to perform a ride.

If the definition of "schedule" is more expansive than the above (e.g., includes the assignment to a particular provider), then this is not practicable, particularly if liquidated damages are involved. If this requirement simply means that a trip should be scheduled within 24 hours of request, then it should be doable. Also, we would recommend OHA require a 24-hour dispatch requirement.

Answer 179. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 180. Appendix B "Sample Contract" Exhibit B, Part 2 "Covered and Non-Covered Services" Section 4 "Covered Service Components" Subsection b. Non-Emergent Medical Transportation (NEMT)" Item (8): We are very concerned about this provision. The onerousness of this provision depends on the definition of when "arrangement are in place." In order to use our network as efficiently as possible, we start assigning rides for a particular day several days in advance in order to fill up our capacity ahead of time. This sometime requires several assignments for a particular ride before it is accepted by the provider. Assuming this is limited to when a provider accepts the assignment, it might be possible to text or email members of changes, keep in mind that members will likely be inundated with messages. More importantly, if we would be required to call, fax, or send other types of communications to members based on their preference, this would result in a significant resources in terms of additional outbound calls and labor. Furthermore, the contract currently requires too much information to be sent to members. We agree that the scheduled time, name of transportation provider, address of pick-up, and address of drop-off make sense. The number of the transportation provider is not advisable because our call center and dispatch are better equipped to address ride issues than individual transportations companies are. Furthermore, these calls could result in drivers using their phones while driving, which even with hands-free devices is not advisable. Also, the name of medical provider should not be included because we are often not provided that information. We ask for an opportunity to discuss this provision with OHA and negotiate a member notification provision that is more workable while providing members with necessary information.

Answer 180. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 181. Appendix B "Sample Contract" Exhibit B, Part 2 "Covered and Non-Covered Services" Section 4 "Covered Service Components" Subsection b. Non-Emergent Medical Transportation (NEMT)" Item (9): Would OHA consider including in this provision a clause that suspends performance requirements pending the duration of adverse weather?

Answer 181. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 182. Appendix B "Sample Contract" Exhibit B, Part 2 "Covered and Non-Covered Services" Section 4 "Covered Service Components" Subsection b. Non-Emergent Medical Transportation (NEMT)" Item (11)(a): Would OHA consider giving Members more than 5 minutes after a scheduled pick-up time. We would recommend 10 to 15 minutes, with very strict enforcement of that time?

Answer 182. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 183. Appendix B "Sample Contract" Exhibit B, Part 2 "Covered and Non-Covered Services" Section 4 "Covered Service Components" Subsection b. Non-Emergent Medical Transportation (NEMT)" Item (11)(c): Members should be allowed to request drop-off before a facility opens their doors. Some members want to be first in line or have the first appointment and want to be there ahead of time. This also conflicts with the requirement that members must be 15 minutes early to appointments. Could OHA please consider revising?

Answer 183. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 184. Appendix B "Sample Contract" Exhibit B, Part 2 "Covered and Non-Covered Services" Section 4 "Covered Service Components" Subsection b. Non-Emergent Medical Transportation (NEMT)" Item (11)(d): Request that OHA add that it is the appointment time that the member provided to the CCO. Members are not obligated to obtain documentation or proof of appointments, so we have to rely on the member's word. A ride should not be considered late if the member gave the CCO the wrong information.

Answer 184. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 185. Appendix B "Sample Contract" Exhibit B, Part 2 "Covered and Non-Covered Services" Section 4 "Covered Service Components" Subsection b. Non-Emergent Medical Transportation (NEMT)" Item (12): We are very wary of "service reason" if it will become a "protocol list" that agents are required to enter for a finite list. Doing so runs the risk of call center agents finding categories that are covered instead of capturing the true nature of the ride. If there is no requirement that we maintain a list of service reasons, then we are fine with this requirement. Please clarify.

Answer 185. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 186. Appendix B "Sample Contract" Exhibit B, Part 2 "Covered and Non-Covered Services" Section 4 "Covered Service Components" Subsection b. Non-Emergent Medical Transportation (NEMT)" Item (13)(b): We request that the NEMT call center should operate 24/7. Would OHA consider adding that requirement?

Answer 186. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 187. Appendix B "Sample Contract" Exhibit B, Part 2 "Covered and Non-Covered Services" Section 4 "Covered Service Components" Subsection b. Non-Emergent Medical Transportation (NEMT)" Item (13)(d): The performance standards should be measured across all queues, not measured on each queue. Will OHA consider making that clarification in the contract?

Answer 187. Thank you for your question. We will not be providing any further details regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 188. Appendix B "Sample Contract" Exhibit B, Part 2 "Covered and Non-Covered Services" Section 4 "Covered Service Components" Subsection b. Non-Emergent Medical Transportation (NEMT)" Item (13)(e): We recommend that the first sentence read "leave a message or callback request." This small change would allow a CCO to automate the message process (i.e. include system that will automatically keep a member in queue and call back members if requested) instead of adding the additional cost of listening to messages and then returning calls to members in a timely manner. The former is much more efficient and quick. Additionally, the 3-hour timeframe to respond should be limited to the member lines. Would OHA consider those changes?

Answer 188. Thank you for your question. We will not be providing any further details regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 189. Appendix B "Sample Contract" Exhibit B, Part 2 "Covered and Non-Covered Services" Section 4 "Covered Service Components" Subsection b. Non-Emergent Medical Transportation (NEMT)" Item (13)(h): We do not believe scripts are in the best interests of our members for most conversations. The rigidity of scripts would likely prevent us from adequately serving the needs of members by limiting follow up questions. While we would be happy to send our rough scripts for OHA approval, we would expect a level of flexibility, especially on needs assessment calls. We could consider scripts for more routine calls such as scheduling trips, but even then, we need to reassess needs. Would OHA consider making this requirement more flexible?

Answer 189. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 190. Appendix B "Sample Contract" Exhibit B, Part 2 "Covered and Non-Covered Services" Section 4 "Covered Service Components" Subsection b. Non-Emergent Medical Transportation (NEMT)" Item (17): Seems to ask us to "determine" if a member was injured "as a result of the driver's failure to provide" a ride. While we currently follow up with members that miss rides, this provision would essentially ask us to make a judgment call about whether a member's injury was caused by a ride, when any number of factors could have contributed. This also highlights the difficulty of determining if a provider was really a "no-show." When a member files a grievance for a no-show, the circumstances vary wildly. Oftentimes, the driver was not really a no-show (the driver was late, the member canceled, miscommunication about pick-up location). True no-shows could be addressed as the provision requires, provided we are not required to essentially admit liability for harm to members. Would OHA consider revisions to this section, accordingly?

Answer 190. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 191. Appendix B "Sample Contract" Exhibit B, Part 2 "Covered and Non-Covered Services" Section 4 "Covered Service Components" Subsection b. Non-Emergent Medical Transportation (NEMT)": Recommended Provision, Technology Redundancy SLA. We would like OHA to consider requiring Contractors to have a Redundancy Requirement for its technology platforms. We cannot imagine the impact on our members had we not had sufficient redundancies in place since we have been operating. This requirement would have a significant positive effect on members and their ability to access NEMT. If OHA is open to considering that requirement we would be happy to share our experiences and the benefits to Members if redundancies are required.

Answer 191. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 192. Appendix B "Sample Contract" Exhibit B, Part 2 "Covered and Non-Covered Services" Section 4 "Covered Service Components" Subsection k. "Oral Health Services": This section lists the timeframes for emergent and urgent dental care delivery, consistent with OAR 410-141-3220(8), which is to be seen or treated within 1-2 weeks for urgent dental care. However, (2)(b) states that urgent dental must be seen or treated within 72 hours. We would request that the contract match the rule, as in (2).

Answer 192. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 193. Appendix B "Sample Contract" Exhibit B, Part 3 "Patient Rights and Responsibilities, Engagement and Choice" Section 1 "Member and Member Representative Engagement and Activation" Item (c): Why has OHA removed the designation of "Certified" from Traditional Health Worker? Is OHA moving away from requiring THWs to be certified?

Answer 193. The definition of Traditional Health Worker aligns with the definition in the Oregon Administrative Rules.

Question 194. Appendix B "Sample Contract" Exhibit B, Part 3 "Patient Rights and Responsibilities, Engagement and Choice" Section 2 "Member Rights under Medicaid": With regard to (d), OHA refers to member rights for "males and females" in discussing access to appropriate facilities. Would OHA consider revising the language to say "male or female identified" as a way of opening the door for transgender identified people to get culturally responsive care/access to facilities?

Answer 194. OHA is revising the Sample Contract to eliminate unnecessary gendered language. Please review the revised Sample Contact when posted.

Question 195. Appendix B "Sample Contract" Exhibit B, Part 4 "Providers and Delivery System" Section 1 "Integration and Coordination": What is meant by "within 10 days if the member is referred?

Answer 195. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 196. Appendix B "Sample Contract" Exhibit B, Part 4 "Providers and Delivery System" Section 1 "Integration and Coordination" Item (d): will OHA or OSPHL provide notice to CCOs if the list of communicable disease testing lab services required for reimbursement changes? If so, how much notice will be given and how will it be communicated to CCOs?

Answer 196. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 197. Appendix B "Sample Contract" Exhibit B, Part 4 "Providers and Delivery System" Section 2 "Access to Care" Modified language in (b) appears to be duplicative of Exhibit B, Part 2, Section 4 (k), Oral Health Services.

Answer 197. OHA intended to ensure that requirements were located in all applicable sections. OHA does not believe there is anything contradictory about these requirements.

Question 198. Appendix B "Sample Contract" Exhibit B, Part 4 "Providers and Delivery System" Section 2 "Access to Care": With regard to (2)(b), this language still does not match the OAR 410-141-3220 (8) which states routine dental care be delivered in an average of 8 weeks and no more than 12 weeks, or the community standard. Can OHA please clarify which standard is intended?

Answer 198. OHA intends to make the standards more stringent than those required by the rule in order to ensure timely access.

Question 199. Appendix B "Sample Contract" Exhibit B, Part 4 "Providers and Delivery System" Section 3 "Delivery System and Provider Capacity": With regard to (a)(3), OHA has previously required CCOs to report on the DSN all providers providing services to Members whether that provider has an agreement with the CCO or whether the provider is providing services as part of a facility provider agreement with the CCO. This new language seems to not reporting of providers that do not have a direct contract with the CCO, i.e. those working under a facility agreement. Is that the intent?

Answer 199. Providers must have a written agreement to provide services to Applicant's members whether through direct contract with the CCO or through a subcontracted entity.

Question 200. Appendix B "Sample Contract" Exhibit B, Part 4 "Providers and Delivery System" Section 4 "Provider Workforce Development": Will OHA provide CCOs with report form to satisfy (a)?

Answer 200. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 201. Appendix B "Sample Contract" Exhibit B, Part 4 "Providers and Delivery System" Section 4 "Provider Workforce Development": Will OHA provide any guidance on what it deems an acceptable training on implicit bias? Will CCOs be required to seek OHA review/approval if they choose to provide implicit bias training for their staff and/or provider network?

Answer 201. OHA will provide a guidance document on implicit bias training. The guidance document will include any approval requirements.

Question 202. Appendix B "Sample Contract" Exhibit B, Part 4 "Providers and Delivery System" Section 4 "Provider Workforce Development": Item (g) states that "Non-Participating Providers must coordinate with Contractor with respect to payment." Often, non-participating providers (especially out of area providers) don't wish to comply with CCO requirements and/or accept CCO reimbursement because they do not have a contract with the CCO. How does OHA expect CCOs to hold non-participating providers accountable when they do not have a contract with those providers?

Answer 202. OHA expects that the CCO would enter into a single case agreement with the Non-Participating Providers to govern the terms of their delivery of care and their coordination

with the CCO. This requirement applies to services that the CCO is unable to provide appropriately within its network; this requirement would not apply to Emergency Services, for example, where the CCO would not be able to enter into a single case agreement with the Non-Participating Providers prior to the delivery of services.

Question 203. Appendix B "Sample Contract" Exhibit B, Part 4 "Providers and Delivery System" Section 5 "Provider Selection" Item (a): Providing the DSN Report on a quarterly basis is a significant administrative burden, especially given the narrative sections of that report. Does OHA really want the entire DSN quarterly or does it simply want the portion of the DSN that is the list of providers contracted with the CCO? If so, would OHA consider just receiving an update of any changes made in lieu of a full report each quarter? Perhaps CCOs could provide an annual DSN and then just provide updates quarterly?

Answer 203. OHA is exploring more efficient data transmission options for collecting accurate provider network data from CCOs. More information will be posted in a future addendum.

Question 204. Appendix B "Sample Contract" Exhibit B, Part 4 "Providers and Delivery System" Section 5 "Provider Selection" With regard to (c) which states "including the use of independent third party arbitrator", the OAR contemplates a mediation process prior to arbitration. Does OHA still intend for mediation to be part of the process of dispute resolution? Also, the language regarding use of an arbitrator seems to be required by the contract but the rule does not explicitly require it. Does OHA intend for arbitration to be required in all provider contracting disputes? If so, that could be a substantial financial burden on providers and CCOs.

Answer 204. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 205. Appendix B "Sample Contract" Exhibit B, Part 4 "Providers and Delivery System" Section 5 "Provider Selection" With regard to the new last paragraph, will OHA be conducting the fingerprint-based background checks on any providers who meet the "high-risk" requirements of the applicable CFR or does OHA expect CCOs to conduct those background checks? If the latter, can OHA please provide guidance on what needs to be included in those checks and where they need to be obtained (i.e. what agency or company can produce a report that meets OHA expectations).

Answer 205. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 206. Appendix B "Sample Contract" Exhibit B, Part 4 "Providers and Delivery System" Section 6 "Credentialing": With regard to (b), is it the CCOs responsibility to conduct and pay for the finger-print based background check or is that the obligation of the provider? Will OHA provide guidance to CCOs on what it deems an acceptable finger-print based background check and/or which agency organization is deemed acceptable to perform such checks? Similarly, will OHA provide guidance on what must be included in the site visit?

Answer 206. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 207. Appendix B "Sample Contract" Exhibit B, Part 4 "Providers and Delivery System" Section 8 "Care Coordination": With regard to (g), shouldn't "covered services" be capitalized as it is a defined term?

Answer 207. OHA is revising the Sample Contract to clarify use of defined terms. Please review the revised Sample Contact when posted.

Question 208. Appendix B "Sample Contract" Exhibit B, Part 4 "Providers and Delivery System" Section 8 "Care Coordination": With regard to (h), shouldn't "warm handoff" be capitalized as it is a defined term?

Answer 208. OHA is revising the Sample Contract to clarify use of defined terms. Please review the revised Sample Contact when posted.

Question 209. Appendix B "Sample Contract" Exhibit B, Part 4 "Providers and Delivery System" Section 8 "Care Coordination": With regard to (h), shouldn't "covered services" be capitalized as it is a defined term?

Answer 209. OHA is revising the Sample Contract to clarify use of defined terms. Please review the revised Sample Contact when posted.

Question 210. Appendix B "Sample Contract" Exhibit B, Part 4 "Providers and Delivery System" Section 8 "Care Coordination": With regard to (i), shouldn't "corrective action plan" be capitalized as it is a defined term?

Answer 210. OHA is revising the Sample Contract to clarify use of defined terms. Please review the revised Sample Contact when posted.

Question 211. Appendix B "Sample Contract" Exhibit B, Part 4 "Providers and Delivery System" Section 10 "Quality, Transformation, Performance Outcomes and Accountability" Section 2 "Transformation and Quality Strategy Requirements" Items e. and f.: Is the annual QAPI program evaluation separate, and in addition to, the Transformation and Quality strategies (TQS) submission?

Answer 211. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 212. Appendix B "Sample Contract" Exhibit B, Part 12 "Health Promotion and Prevention": This section requires health promotion and prevention programs to be provided simultaneously in an "evidenced-based" and "culturally responsive" manner. Many evidence-based programs are based on research/work with white populations. Many culturally specific programs are more often called, "promising or best practice based." Can OHS use that language? There are not a lot of "evidence-based" programs that are culturally appropriate or specific.

Answer 212. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 213. Appendix B "Sample Contract" Exhibit B, Part 4 "Providers and Delivery System" Section 13 "Subcontract Requirements": Will OHA provide a form or guidance to CCOs regarding what items must be included in the required subcontractor readiness review?

Answer 213. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 214. Appendix B "Sample Contract" Exhibit B, Part 4 "Providers and Delivery System" Section 13 "Subcontract Requirements": Does the requirement to perform a readiness review and provide a copy of that review evaluation to OHA extend to subcontractors of an entity to which the CCO delegates all or a portion of the work described in the CCO Contract?

Answer 214. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 215. Appendix B "Sample Contract" Exhibit B, Part 4 "Providers and Delivery System" Section 13 "Subcontract Requirements": With regard to (a)(3), with OHA provide guidance on what is deemed an acceptable background check. Additionally, must the CCO conduct the background check? If the Subcontractor obtained a criminal background check for other reasons, is that deemed acceptable by OHA such that CCO would not need to conduct or require Subcontractor to complete an additional background check?

Answer 215. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 216. Appendix B "Sample Contract" Exhibit B, Part 4 "Providers and Delivery System" Section 13 "Subcontract Requirements": With regard to (a)(9), if a CCO discovers a deficiency may it set the timelines for subcontractor to respond and remedy or must it ask OHA to set those timelines. The language seems to indicate that no matter which entity discovers the deficiency, OHA will set the timelines. If that is the intent is seems a bit onerous and does not provide the CCO with autonomy to hold the Subcontractor accountable in the ways the CCO deems appropriate.

Answer 216. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 217. Appendix B "Sample Contract" Exhibit B, Part 4 "Providers and Delivery System" Section 13 "Subcontract Requirements": With regard to (b)(1)(d), this section requires subcontractor (provider?) to submit valid claims, but if provider does not produce claims, only encounter data, is this section necessary? Especially in light of new VBP arrangements.

Answer 217. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 218. Appendix B "Sample Contract" Exhibit B, Part 4 "Providers and Delivery System" Section 13 "Subcontract Requirements": With regard to (b)(2), if a Subcontractor does not include Participating Providers, how/when would a CCO ever be able to provide notice of termination of a subcontract to Members who received primary care services from the Subcontractor?

Answer 218. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 219. Appendix B "Sample Contract" Exhibit B, Part 13 "Subcontract Requirements": With regard to (b)(2) (and entire section), if Participating Providers are not Subcontractors per the CCO Contract, why are there requirements listed in this section that apply to Participating Providers?

Answer 219. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 220. Appendix B "Sample Contract" Part 4 "Providers and Delivery System" Section 13 "Subcontract Requirements": With regard to (b)(4), there may be some legal reasons (i.e. confidentiality protections) why the specific reasons for a for-cause termination of a Subcontractor or Participating Provider cannot be shared. How does OHA intend to take those concerns into account with regard to the contract termination reporting it is requiring of CCOs? Will CCOs be able to mark such disclosures as protected from disclosure in a public records request?

Answer 220. CCOs must disclose the basis of termination to OHA, and OHA expects that any confidentiality provisions in any contracts with a Subcontractor or Participating Provider expressly allow for disclosure to OHA. CCOs may inform OHA that a certain piece of information shared is confidential, and OHA will protect such information from disclosures in a public records request to the extent permissible by law.

Question 221. Appendix B "Sample Contract" Exhibit B, Part 4 "Providers and Delivery System" Section 15 "Adjustments in Service Area or Enrollment": With regard to (c), can OHA please clarify the intent of the language? As written it is confusing. It seems to suggest that a CCO cannot transfer members from a Provider if that Provider was terminated for quality of care, competence or fraud reasons. It seems that those circumstances would be exactly why OHA would want to approve a transfer? Perhaps the language just needs to be adjusted to confirm meaning?

Answer 221. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 222. Appendix B "Sample Contract" Exhibit B, Part 4 "Providers and Delivery System" Section 15 "Adjustments in Service Area or Enrollment": With regard to (e), the term Managed Care Plan does not appear to be defined by the CCO Contract. Should include a definition or revise to state Managed Care Entity which I assume is the intent of this section.

Answer 222. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 223. Appendix B "Sample Contract" Exhibit B, Part 8 "Operations" Section 4 "Payment Procedures" With regard to (g), shouldn't "covered services" be capitalized as it is a defined term?

Answer 223. OHA is revising the Sample Contract to clarify use of defined terms. Please review the revised Sample Contact when posted.

Question 224. Appendix B "Sample Contract" Exhibit B, Part 8 "Operations" Section 4 "Payment Procedures": With regard to (h), shouldn't "warm handoff" be capitalized as it is a defined term?

Answer 224. OHA is revising the Sample Contract to clarify use of defined terms. Please review the revised Sample Contact when posted.

Question 225. Appendix B "Sample Contract" Exhibit B, Part 8 "Operations" Section 10 "Encounter Claims Data": With regard to (h), shouldn't "covered services" be capitalized as it is a defined term?

Answer 225. OHA is revising the Sample Contract to clarify use of defined terms. Please review the revised Sample Contact when posted.

Question 226. Appendix B "Sample Contract" Exhibit B, Part 8 "Operations" Section 10 "Encounter Claims Data": With regard to (i), shouldn't "corrective action plan" be capitalized as it is a defined term?

Answer 226. OHA is revising the Sample Contract to clarify use of defined terms. Please review the revised Sample Contact when posted.

Question 227. Appendix B "Sample Contract" Exhibit B, Part 9 "Program Integrity" Section 4 "Corrective Action Plan": Is there a form/format of a Corrective Action Plan that OHA will provide to CCOs?

Answer 227. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 228. Appendix B "Sample Contract" Exhibit B, Part 10 "Quality, Transformation, Performance Outcomes and Accountability" Section "Quality Performance Improvement Projects": With regard to (b)(4), the statewide PIP is prescribing of opioids, not integration. Can OHA please clarify or revise accordingly?

Answer 228. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 229. Appendix B "Sample Contract: Exhibit C "Consideration" Section 6 "CCO Risk Corridor": With regard to (a)(4), is it a final decision of OHA that the initial procurement risk corridor be used?

Answer 229. Yes.

Question 230. Appendix B "Sample Contract" Exhibit D "Standard Terms and Conditions" Section 9 "Default; Remedies; and Termination": This section needs to be updated with correct references to Sections, i.e. refers to section 10 when it should be section 9 because of renumbering of contract sections.

Answer 230. OHA is revising the Sample Contract to clarify cross-references. Please review the revised Sample Contact when posted.

Question 231. Appendix B "Sample Contract" Exhibit D "Standard Terms and Conditions" Section 19 "Amendments": This section needs to be updated with correct references to Sections, i.e. refers to section 10 when it should be section 9 because of renumbering of contract sections.

Answer 231. OHA is revising the Sample Contract to clarify cross-references. Please review the revised Sample Contact when posted.

Question 232. Appendix B “Sample Contract” Exhibit G “Reporting of Delivery System Network Providers, Cooperative Agreements, and Hospital Adequacy” Section 1 “Delivery System Network (DSN) Reports”: Are there distinct Capacity and Narrative Reports? Are both required to be submitted quarterly?

Answer 232. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 233. Appendix B “Sample Contract” Exhibit G “Reporting of Delivery System Network Providers, Cooperative Agreements, and Hospital Adequacy” Section 1 “Delivery System Network (DSN) Reports”: What does OHA mean when it says the CCO must "promptly and fully remedy any provider network deficiencies" identified through multiple types of monitoring? How is "prompt" and "fully" measured?

Answer 233. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 234. Appendix B “Sample Contract” Exhibit G “Reporting of Delivery System Network Providers, Cooperative Agreements, and Hospital Adequacy” Section 1 “Delivery System Network (DSN) Reports”: With regard to (2)(e), a CCOs source of member demographic data is populated via OHA's daily 834 report which frequently omits or provides faulty linguistic/racial/ethnic information. Does OHA propose to improve the way in which it obtains quality member demographic information so the CCO may adequately identify and address the needs of "linguistically and culturally diverse populations within its community?"

Answer 234. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 235. Appendix B “Sample Contract” Exhibit G “Reporting of Delivery System Network Providers, Cooperative Agreements, and Hospital Adequacy” Section 3 “Provider Capacity”: Section (b), Unlike prior CCO Contracts, this version does not specify what "required data elements" must be captured in the DSN Provider Report. It would be helpful if OHA could specify the required elements.

Answer 235. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 236. Appendix B “Sample Contract” Exhibit G “Reporting of Delivery System Network Providers, Cooperative Agreements, and Hospital Adequacy” Section 3 “Provider Capacity”: Section (c), Is the "Provider Taxonomy Code" the same as what is provided on the DMAP Provider File and NPPES NPI Registry, e.g. 104100000X? Or does OHA mean to require the Provider Type Code and Description, e.g. "69 - Social Worker?"

Answer 236. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 237. Appendix B “Sample Contract” Exhibit G “Reporting of Delivery System Network Providers, Cooperative Agreements, and Hospital Adequacy” Section 3 “Provider Capacity”: The requirement (c), to include the PCPCH certification Tier and # of members assigned to that PCPCH Network Provider appear to be imported from former DSN Narrative Guidance documents. Should this be updated?

Answer 237. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 238. Appendix B “Sample Contract” Exhibit G “Reporting of Delivery System Network Providers, Cooperative Agreements, and Hospital Adequacy” Section 3 “Provider Capacity”: With regard to 3(d), what report is OHA referring to when it asks the CCO to identify "any other information listed on the report?"

Answer 238. This refers to the DSN report.

Question 239. Appendix B “Sample Contract” Exhibit G “Reporting of Delivery System Network Providers, Cooperative Agreements, and Hospital Adequacy” Section 3 “Provider Capacity”: With regard to 3(f), that section appears to duplicate section 2(c) except for the addition of sanctions if "any listed Providers do not have written agreements to provide services." Could OHA provide TA to the CCO to correct its data in accordance with the "validating data" against which it was compared, in lieu of imposing penalties or sanctions?

Answer 239. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 240. Appendix B “Sample Contract” Exhibit G “Reporting of Delivery System Network Providers, Cooperative Agreements, and Hospital Adequacy” Section 4 “Cooperative Agreements with Publicly Funded Programs Report: In conflict with prior requirement to submit a "DSN Provider Report" to OHA on a quarterly basis, this section maintains the requirement to submit an annual report on July 1st of each year.

Answer 240. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 241. Appendix B "Sample Contract" Exhibit G "Reporting of Delivery System Network Providers, Cooperative Agreements, and Hospital Adequacy" Section 5 "Cooperative Agreements with Community Social and Support Service and Long Term Care Report:": In conflict with prior requirement to submit a "DSN Provider Report" to OHA on a quarterly basis, this section maintains the requirement to submit an annual report on July 1st of each year.

Answer 241. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 242. Appendix B "Sample Contract" Exhibit G "Reporting of Delivery System Network Providers, Cooperative Agreements, and Hospital Adequacy" Section 5 "Cooperative Agreements with Community Social and Support Service and Long Term Care Report:": References to Exhibit B appear to be erroneous.

Answer 242. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 243. Appendix B "Sample Contract" Exhibit I "Grievance and Appeal System" Section 3 "Notice of Adverse Benefit Determination" With regard to (b)(3), Primary Care Dentist (PCD) is not a defined term. Please clarify.

Answer 243. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 244. Appendix B "Sample Contract" Exhibit I "Grievance and Appeal System" Section 3 "Notice of Adverse Benefit Determination" With regard to (b)(9), does the language below 9 belong with that subsection? i.e. "clear and through (sic) explanation for the specific reasons…

Answer 244. The language below 9 should be its own subsection and the final word "reason" should be struck.

Question 245. Appendix B "Sample Contract" Exhibit I "Grievance and Appeal System" Section 3 "Notice of Adverse Benefit Determination" With regard to (b)(12) and (13), given the change to the rule and process, should the right to request a hearing still be included, even though a Member can't ask for a hearing until after they exhaust an appeal?

Answer 245. Yes, the reference to the hearing should remain. The letter can include details about when the enrollee has the right to request that hearing.

Question 246. Appendix B "Sample Contract" Exhibit J "Health Information Technology" Section 2 "Health Information Technology (HIT) Roadmap": With regard to (c)(2), does the CCO pick 20 samples to provide or will OHA pick 20 from the log and then request the documentation to be provided within 14 days?

Answer 246. Thank you for your question. We will not be providing any further detail regarding the Sample Contract at this time as the information is not critical to the application process. There will be contract revisions, technical assistance, and opportunities for contract comments in the future.

Question 247. Appendix B "Sample Contract" Exhibit J "Health Information Technology" Section 2 "Health Information Technology (HIT) Roadmap": With regard to (i) and (j), are these sections duplicates? Please clarify.

Answer 247. No, they are not duplicates. Subsection (i) addresses the specific use of hospital event notifications, while subjection (j) discusses the uses of HIT more generally.

Question 248. Appendix B "Sample Contract" Exhibit L "Solvency Plan and Financial Reporting and Cost": This Exhibit contains many inconsistencies, duplicative reporting, two solvency calculations that are inconsistent, and an Exhibit L template that is not adequately referenced in contract. Could OHA please review and provide better clarity/consistency in this Exhibit?

Answer 248. OHA intends to shift from the current financial reporting structure to one aligned with NAIC standards for risk-based capital. For the period during which this transition occurs, there will need to be two distinct solvency calculations and the reporting to support each of those.

Question 249. Appendix B "Sample Contract" Exhibit N "Social Determinants of Health and Health Equity" Section 1 "Community Advisory Council (CAC)": Section (b) requires semi-annual public meetings but ORS 414.627 requires quarterly public meetings. Can OHA please clarify the correct public meeting requirements for CCOs?

Answer 249. The Sample Contract will be updated to reflect that these public meetings should occur quarterly, in accordance with ORS 414.627.

Question 250. Appendix B "Sample Contract" Exhibit N "Social Determinants of Health and Health Equity" Section 1 "Community Advisory Council (CAC)": Section (c)(1) requires CCOs to report demographic data on CAC members. Does demographic data just mean race/ethnicity, age, etc. or does it include things like history of substance use, disability, queer, etc. Those items seem to be private items that a CAC member may not be willing to share publically. Would OHA consider adding that CCOs report that information only to the extent that the CAC member consents?

Answer 250. Demographic data means things like race/ethnicity, age, town/county of residence, gender, and other similar, non-sensitive characteristics. OHA does not anticipate detailed information that may touch on sensitive topics.

Question 251. Appendix B "Sample Contract" Exhibit N "Social Determinants of Health and Health Equity" Section 1 "Community Advisory Council (CAC)": Section (c)(8) requires CCOs to provide an organizational chart that shows "the connection between the CAC, CCO Board of Directors and any other CCO committees." Can OHA clarify what it means by "any other CCO committee" as that term, as written, is quite broad. Any clarification as to what type of committees OHA intends to be included would be helpful in meeting contract expectations.

Answer 251. This means other committees within the CCO governance structure, such as a finance committee or quality committee.

Question 252. Appendix B "Sample Contract" Exhibit N "Social Determinants of Health and Health Equity" Section 3 "Social Determinants of Health and Health Equity": Section (e), CCO SDOH-HE proposal and written agreements with SDOH-HE partners are due on the same date. Shouldn't the first action precede the second?

Answer 252. Not necessarily. OHA wants to ensure that the dollars flow as quickly as possible, which is why the proposal and the contracts are due on the same date. The contracts with the SDOH-HE partners could include provisions specifying that if OHA requires changes to the CCO's proposal, that the CCO may amend the contract with the SDOH-HE partners to reflect the changes required by OHA.

Question 253. Appendix B "Sample Contract" Exhibit N "Social Determinants of Health and Health Equity" Section 3 "Social Determinants of Health and Health Equity": With regard to (b), OHA references "four SDOH-HE domains." What are those four domains and where are they described in RFA supporting documents? With regard to (c), the deadline for submitting a plan for SDOH-HE projects by April 30, 2020 that is based on CHP priorities. Can OHA clarify that CCO can use existing CHP identified priorities? Or, does OHA intend for CCOs to complete a new CHP, including priority areas, prior to April 2020?

Answer 253. Answer with regard to (b): The four SDOH-HE domains are listed in RFA reference document SDOH and Health Equity Glossary. They are: Neighborhood and Built Environment, Economic Stability, Education, and Social and Community Health. The glossary also provides a link to the Oregon Medicaid Advisory Committee (MAC) graphic of Social Determinants of Health and Equity (see pg. 6 at link), which provides a list of SDOH examples within the four key domains.

Answer with regard to (c): For its SDOH-HE priorities that must be aligned with the CCO's CHP, CCOs may use existing CHP identified priorities from the CCO's existing CHP (so long as the CCO's service area has not changed) or from the CCO's review of existing CHP priorities in the CCO's new/changed service area. OHA does not intend for CCOs to complete a new CHP prior to April 2020. Existing CCOs with a current CHP in place that matches the CCO's 2020 service area will be required to submit information in their 2020 CHP progress reports related to how they plan to comply with new requirements (e.g. alignment with State Health Improvement Plan Priorities). If the CCO is new in 2020 or has an existing CHA or CHP that is not representative of the CCO's current service area, the CCO must submit a new CHA or CHP in June 2021 that complies with all requirements.

Additionally, the questioner lists an inaccurate deadline in the question: April 30, 2020. To clarify, the deadlines related to SDOH-HE priorities as described in the Sample Contract are:

March 15, 2020: CCOs are required to submit an implementation plan, including proposed SDOH-HE spending priorities for 2021. If the CCO has an existing and current CHA/CHP for the Service Area, priorities are to be aligned with the existing plan and, specifically, based on an analysis of CHP priorities that meet the SDOH-HE definition (to be defined in rule). If the CCO has no existing and current CHA/CHP for its Service Area, priorities are to be selected from an analysis of existing CHPs in the CCO's Service Area. In either case, the CCO must go through a process to identify and vet with community stakeholders its SDOH-HE priorities by the March 15, 2020 deadline (see RFA Community Engagement Plan Required Components required document, Table 5).

By April 30, 2021, CCOs must submit a proposal for SDOH-HE spending to OHA, including selected priorities aligned with the CHP. These priorities will be the same as those submitted with the CCO's 2020 implementation plan, unless the CCO submits justification for changes.

Question 254. Appendix B "Sample Contract" Exhibit N "Social Determinants of Health and Health Equity" Section 3 "Social Determinants of Health and Health Equity": With regard to (b), OHA references "four SDOH-HE domains." What are those four domains and where are they described in RFA supporting documents?

Answer 254. The "four SDOH-HE domains" are included in the definition of SDOH-HE found in Appendix A. That definition states SDOH means the social, economic, political, and environmental conditions in which people are born, grow, work, live, and age

Question 255. Appendix B "Sample Contract" Exhibit N "Social Determinants of Health and Health Equity" Section 4 "Health-Related Services": With regard to 4(b), how does OHA distinguish between "acceptable" and "effective" alternatives to covered services?

Answer 255. OHA requires that members agree to receive Health-Related Services as an alternative to Covered Services. OHA assumes that the CCO would only offer the Health-Related Service if it believes that such service would be effective.

Question 256. Appendix B "Sample Contract" Exhibit N "Social Determinants of Health and Health Equity" Section 4 "Health-Related Services": With regard to 4 (d)(4), since flexible services typically do not the same or a direct impact on SDOH whereas community-benefit initiatives can address SDOH, could OHA confirm that it will only require evaluation of CBI's impact on SDOH? In addition, since evaluating the outcome of a CBI can take more time than the 5 year CCO Contract cycle, what mid-term outcomes would OHA accept as part of the CCO's evaluation of its CBI investments on SDOH?

Answer 256. With regard to whether OHA will only require evaluation of Community Benefit Initiatives' (CBI) impact on SDOH, OHA does not confirm this. Both flexible services and CBIs should be considered in the process and analysis Applicants/Contractors will use to evaluate investments in Health-Related Services (HRS) and initiatives to address SDOH-HE.

With regard to the outcomes OHA may accept as part of the CCO's evaluation of its investments in HRS, OHA cannot provide specific outcomes it may accept at this time. Applicants may refer to existing HRS guidance documents and RFA reference documents, including Exhibit L reporting guidelines, and HRS guidance available here: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Health-Related-Services.aspx

Question 257. Appendix B “Sample Contract” Exhibit N “Social Determinants of Health and Health Equity” Section 5 “Health Plan”: With regard to (a), how does the Health Equity Plan relate to the CHP? Should the CCO submit two separate Plans?

Answer 257. The Health Equity Plan is distinct from the CHP; the CCO will need to include both. The Health Equity Plan, as its name suggests, focuses on promoting health equity, while the CHP has a broader focus of addressing a full range of health needs in the Community.

Question 258. Appendix B “Sample Contract” Exhibit N “Social Determinants of Health and Health Equity” Section 5 “Health Plan”: With regard to (b), the Narrative Section of the Health Equity Plan must include a description of the demographics of the CCO's workforce. Does "workforce" include the provider network, or only the CCO administrative/programmatic staff?

Answer 258. Workforce includes the Provider Network.

Question 259. Appendix B “Sample Contract” Exhibit N “Social Determinants of Health and Health Equity” Section 5 “Health Plan”: With regard to (b) and (c), the Narrative and "Strategies, Goals, Objectives, Activities and Metrics" Sections of the Health Equity Plan must include a description and "collection, analysis, and maintenance of accurate and reliable demographic (REAL-D)" member data [this point is duplicated in Sec. c(2) and c(11)]. However, a CCOs source of member demographic data is populated via OHA's daily 834 report which frequently omits or provides faulty linguistic/racial/ethnic information. Does OHA propose to improve the way in which it obtains quality member demographic information so the CCO may effectively focus its Health Equity Plan on the members who require specific services/supports?

Answer 259. Thank you for your questions regarding Behavioral Health, and Social Determinants of Health and Health Equity. In the areas of Behavioral Health and Social Determinants of Health and Health Equity, the RFA focuses on outcomes as opposed to structures. It is our intent to foster innovation and local collaboration around solutions rather than prescribe acceptable interventions. It our expectation that these innovations will be Evidence-Based interventions that are linked to lowered cost and improved health status, and that Applicants will clearly identify and describe how outcomes intend to be tracked and achieved through the structures they propose. We look forward to collaborating with Successful Applicants to explore potential approaches in these areas but have no further detail to share at this time regarding preferred approaches to services, billing or plans for data collection.

Question 260. Appendix B “Sample Contract” Exhibit N “Social Determinants of Health and Health Equity” Section 5 “Health Plan”: With regard to (d), how would CCO's "single point of HEP accountability" speak for delegated entities, re: their compliance with those requirements?

Answer 260. Even when the CCO delegates certain responsibilities to other parties, the CCO remains liable for ensuring compliance. Accordingly, any contract delegating functions that address the types of issues that the CCO’s single point of HEP accountability might be required to address should include provisions ensuring that a representative from the delegated entity is in regular contact with the single point of accountability so that the CCO’s single point of accountability has the information needed to report on compliance.

Question 261. Appendix B "Sample Contract" Exhibit N "Social Determinants of Health and Health Equity" Section 6 "Traditional Healthcare Workers": Section (c), How will OHA measure of "clear and consistent" communications regarding THW services and benefits?

Answer 261. Thank you for your questions regarding Behavioral Health, and Social Determinants of Health and Health Equity. In the areas of Behavioral Health and Social Determinants of Health and Health Equity, the RFA focuses on outcomes as opposed to structures. It is our intent to foster innovation and local collaboration around solutions rather than prescribe acceptable interventions. It our expectation that these innovations will be Evidence-Based interventions that are linked to lowered cost and improved health status, and that Applicants will clearly identify and describe how outcomes intend to be tracked and achieved through the structures they propose. We look forward to collaborating with Successful Applicants to explore potential approaches in these areas but have no further detail to share at this time regarding preferred approaches to services, billing or plans for data collection.

Question 262. Appendix B "Sample Contract" Exhibit N "Social Determinants of Health and Health Equity" Section 6 "Traditional Healthcare Workers": Section (d), Should THW data that is to be submitted to OHA on 4/1 be aligned with HEP data that is to be submitted to OHA on 3/15 of each year?

Answer 262. Thank you for your questions regarding Behavioral Health, and Social Determinants of Health and Health Equity. In the areas of Behavioral Health and Social Determinants of Health and Health Equity, the RFA focuses on outcomes as opposed to structures. It is our intent to foster innovation and local collaboration around solutions rather than prescribe acceptable interventions. It our expectation that these innovations will be Evidence-Based interventions that are linked to lowered cost and improved health status, and that Applicants will clearly identify and describe how outcomes intend to be tracked and achieved through the structures they propose. We look forward to collaborating with Successful Applicants to explore potential approaches in these areas but have no further detail to share at this time regarding preferred approaches to services, billing or plans for data collection.

Question 263. Appendix B "Sample Contract" Exhibit N "Social Determinants of Health and Health Equity" Section 6 "Traditional Healthcare Workers": With regard to (f), to whom is THW interaction data to be submitted? With what frequency? What is the intended goal?

Answer 263. Thank you for your questions regarding Behavioral Health, and Social Determinants of Health and Health Equity. In the areas of Behavioral Health and Social Determinants of Health and Health Equity, the RFA focuses on outcomes as opposed to structures. It is our intent to foster innovation and local collaboration around solutions rather than prescribe acceptable interventions. It our expectation that these innovations will be Evidence-Based interventions that are linked to lowered cost and improved health status, and that Applicants will clearly identify and describe how outcomes intend to be tracked and achieved through the structures they propose. We look forward to collaborating with Successful Applicants to explore potential approaches in these areas but have no further detail to share at this time regarding preferred approaches to services, billing or plans for data collection.

Appendix C

Question 264. Policy #OHPB 13: Please define the calculation of "Quality Pool funds retained by the CCO" for purposes of the required disclosure of the distribution of Quality Pool Dollars in this section. In particular, given that the Quality Pool Funds constitute a return of the withhold from actuarially sound rates, the amount CCOs earn back from this amount may not add up exactly to the amount built into the base above and beyond any payment for "base payment to Providers the Providers would have received absent a quality incentive." For example, assuming CCOs distributed 53% of the 4.5% of revenue they earned in 2016 and 2017, the capitation revenue should include the expected value of base payments to providers PLUS 53% * 4.5% of revenue or less than 2.3% of revenue in total, whereas 5% of capitation rates will be removed from revenue to be earned back by CCOs. Therefore, CCOs will need to retain at least 2.7% of revenue (more than half of quality pool funds earned back assuming 100% of metrics are met) just to have a revenue stream that is expected to cover their costs to deliver the base services under the contract.

Answer 264. Thank you for your question. This question will be answered in a different addendum that will be posted approximately March 22nd, 2019.

4. All other terms, provisions, and conditions of this RFA remain unchanged.