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March 22, 2019

RFP 4690

Addendum #6

1. This is Addendum # 6 to Request for Application (RFA) 4690, Coordinated Care Organizations (CCOs) 2.0.

2. OHA amends the RFA as follows:

a. In order to allow for Proposers to restate questions in their Proposals the following overall page limits are re-adjusted:

- Attachment 6 from 5 to 9 pages
- Attachment 7 from 40 to 55 pages
- Attachment 8 from 10 to 15 pages
- Attachment 9 from 36 to 43 pages
- Attachment 10 from 10 to 14 pages
- Attachment 11 from 58 to 66 pages
- Attachment 12 from 20 to 25 pages

b. Attachment 9 "RFA HIT Questionnaire" second bullet is amended as follows, language to be deleted or replaced is ~~struck through~~; new language is **underlined and bold**:

"For example, a response in ~~component 2~~ **Sections B – D** that does not address Behavioral Health Providers will not be considered complete."

c. Attachment 9, Question D.2.g, is amended as follows, language to be deleted or replaced is ~~struck through~~; new language is **underlined and bold**:

g. Please describe any other ways that the Applicant will gather information on, and measure population health status and outcomes (e.g., claims, clinical metrics, etc.).

h. Describe Applicant's HIT capabilities for the purposes of supporting VBP and population management. Again, please provide plans for start of Year 1 as well as plans over the 5-year contract, including activities, milestones, and timelines. Include information about the following items:…."

d. Appendix B. "Sample Contract" will be updated and posted on approximately March 29th. A redline version showing the changes will be posted as well.

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

General Questions

Question 1. What is the primary driver and difference between Attestation, Assurances, and Representations? Are any of them legal binding?

Answer 1. The difference is whether an affirmative answer is required or expected. All are legally binding.

Attachment 6

Question 2. Attachment 6 Section B (1)(c), can you please define “licenses”.

Answer 2. Business licenses held by the organization.

Attachment 7

Question 3. The RFA contains a file called the “Attachment-7-DSN-Provider-Report-Template” Within this template there is a column called “FTE availability (1.0 = full time)”. This column appears on both the Providers and the Facilities tabs. What is the exact data that is required to be filled into these columns?

Answer 3. The DSN report has been updated to include data protocols

Attachment 9

Question 4. 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 4. This is left over from a previous numbering system. Behavioral Health should be addressed in Sections B-D in Appendix 9. The RFA language has been updated according to Section 2 of this document.

Attachment 11

Question 5. We are working on Attachment 11 E.3.m., there is a reference to an implied requirement of ICC Care coordinators having a 15:1 caseload. We can’t find anything in the contract or OAR to back up this requirement. Can you point out where this is found?

Answer 5. The OAR has not been updated to include this requirement.

Question 6. 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 6. Yes

Attachment 12

Question 7. Regarding the document titled "Standards for PBM Contracting Regarding CCO 2.0": It is unclear that this is part of the CCO 2.0 RFA. The Standards repeatedly refer to the Consortium, which we assume is referring to the Northwest Prescription Drug Consortium. Could this be for bidders on the Consortium business (currently administered by Moda), not necessarily requirements for CCOs? We ask because it refers to rebate guarantees (which we cannot do for Medicaid) and market checks (which are already required in CCO 2.0). Also, there is references regarding the "Consortium" auditing CCO's PBM contracts, which seems inappropriate. Does the OHA mean to say "CCO" instead of "Consortium" in the auditing section?

Answer 7. An updated version of the document titled "Standards for PBM Contracting Regarding CCO 2.0" has been posted to the reference documents on the website.

Question 8. Attachment 12.E.3 of the RFA asks applicants for the level of current FFS PDL alignment. In order to complete this analysis, the OHA will need to provide applicants with the fee-for-service Preferred Drug List (PDL) in an Excel file, or other machine-readable file, that includes National Drug Codes (NDCs), FFS PDL placement, and associated UM edits. Will the OHA be providing this file to CCOs? If not, can the OHA please clarify what specific information is being requested and what methodology should be used by CCOs.

Answer 8. There is a web-based application that is available to the public that is searchable by drug name. That link is provided here: http://www.orpdl.org/drugs/

A printable list is available here: https://www.oregon.gov/oha/hsd/ohp/pages/pdl.aspx

A more detailed list has been added to the reference documents available on the website, with the note that it covers a limited timeframe and is subject to change over time.

Question 9. We understand that the time to ask clarifying questions about the CCO 2.0 RFA has lapsed. However, we have identified a concern that we believe is relevant to all CCO 2.0 applicants and the public policy of the State, about which we are seeking clarification.

In Attachment 12 (F) (Required Documentation) on page 3, there is a requirement to file an NAIC Form 11, which is a Biographical Affidavit. The NAIC rules for who is to fill out such a form includes the following language: "The NAIC Biographical Affidavit must be submitted on behalf of all officers, directors and key managerial personnel of the Applicant Company and individuals with a ten percent (10%) or more beneficial ownership in the Applicant Company or the Applicant Company's ultimate controlling person ("Affiant")."

We interpret this to mean every member of an applicant's Board of Directors. Our Board, like many current CCO boards, includes people with lived experience and utilizers of the Medicaid system. In fact, every current CCO is required to have a Community Advisory Council member(s) on their Board, and the majority of all CAC members are required to be Medicaid consumers. Forcing them and other community members to fill out this 12-page, extremely detailed and personal form could stifle CCO Board service throughout the State.

We have two questions:
1. Are we interpreting the NAIC form correctly?

2. What is the purpose of having every Board member fill this out, and is that purpose consistent with the public policy value of encouraging community and consumer participation in CCO governance?

Answer 9. OHA reviewed the requirement and determined that community directors are exempt from the Biographical Affidavit.

The Biographical Affidavit requirement applies to the following:

1) CEO, CFO, and COO or equivalent senior officers
2) Provider directors and other non-community directors
3) Key managerial personnel (including heads of risk management, compliance, internal audit or other individuals who will control the operations of the Applicant or have binding authority over the Applicant)

Biographical Affidavits from holding companies are not required at this time but may be required in the future.

Attachment 13

Question 10. What happens if an organization says no to an item on Attachment 13- Attestations, does it prohibit the organization from obtaining a successful award?

Answer 10. A negative answer to certain questions may be disqualifying. On others, the reason given for a negative answer will be taken into account.

Question 11. Attachment 13, section C discusses having VBPs in certain delivery areas, specifically hospital care, maternity care, children's health care, oral health care, and behavior health. However, section F (1)(d) suggest that CCOs will not "enter into any Value-Based Payment arrangements under which Behavioral Health spending is tracked separately from physical health services." Aren't these contradictory in both statement and policy? And if not, please explain how a CCO is supposed to do a VBP for behavioral health services but not track spending separately.

Answer 11. There are no requirements to separately report spending on care delivery VBPs. Care delivery VBP models will be described in annual CCO VBP interviews.

Question 12. Attachment 13 Section F (3)(b): Please define what is meant by "and be financially responsible for services for Members admitted to Oregon State Hospital after the second year of the contract." What does that cost look like? What services will CCO be required to pay (lodging, physical provider fees, behavioral health provider fees, etc.). Will OSH enter into agreements with CCO? VBP with OSH?

Answer 12. A workgroup, including OHA, OSH and CCOs, is developing a risk sharing model, which will be implemented after year 2021. This will be a separate contract between OHA and CCOs.

Question 13. "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 13. OHA/Optumas will review all applicable policy changes and their financial impact as part of the final CY20 rate development. OHA expects that any CCO that chooses to participate in CCO 2.0 will be able to operate under the requirements/expectations associated with CCO 2.0 program. CCOs should evaluate their ability to achieve the desired levels of efficiency and rate of growth before agreeing to participate.

Question 14. 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 14. This information is not available.

Question 15. 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 15. Health Related Services related to SDoH-HE are not included in base data as these services are not state plan services and therefore cannot be included in medical base data associated with capitation rate development, per CMS guidance.

Question 16. 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 16. Funding for these types of services is expected to stem from several sources:

1) Savings generated on the acute care (healthcare) side due to investment in SDoH strategies
2) Quality Pool Funding designed to support CCO SDoH infrastructure and continued support
3) Variable Margin, designed to reward CCOs for successful investments in SDoH interventions and other cost initiatives

Question 17. 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 17. The concept of CCOs investing in SDoH is predicated on the assumption that these types of investments will assist CCOs in achieving the sustainable rate growth targets or lower healthcare cost. OHA has designed the CCO 2.0 program to promote these types of investments by creating the following sources of funding:

1) Savings generated on the acute care (healthcare) side due to investment in SDoH strategies
2) Quality Pool Funding designed to support CCO SDoH infrastructure and continued support
3) Variable Margin, designed to reward CCOs for successful investments in SDoH interventions and other cost initiatives

Other than the funding sources listed above, Optumas will not be adding additional funding for these types of services.

Question 18. 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. 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 18. Q2 - Yes
Q3 - No, OHA expects the same standards associated with data quality under APMs as it does without APMs.
Q4 - Prometheus Analytics is supported and will continue to be supported by Altarum

with ongoing updates to supporting Metadata and Software. Optumas pays fees to Altarum to access the Prometheus Analytic Software and therefore any entity wanting direct access to the software will also be required to pay the appropriate fees to Altarum. Otherwise, summarized results of the Prometheus Analytics will be shared with all stakeholders at no additional cost.

Question 19. 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 19. CCO specific rate of growth is calculated by comparing aggregate per capita expenses across calendar years, normalizing for population mix changes.

Attachment 14

Question 20. What happens if an organization says no to an item on Attachment 14- Assurances, does it prohibit the organization from obtaining a successful award?

Answer 20. A negative answer to certain questions may be disqualifying. On others, the reason given for a negative answer will be taken into account.

Attachment 15

Question 21. What happens if an organization says no to an item on Attachment 15- Representative, does it prohibit the organization from obtaining a successful award?

Answer 21. Neither a yes or no answer is normal in answers to this Attachment. The Applicant's reasons will be taken into account.

Appendix B

Question 22. 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 22. 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 and opportunities for contract negotiation in the future

Appendix C

Question 23. 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 23. As part of the rate range development for CCO 2.0, OHA has moved from an incentive payment to a withhold. This requires that the incentive dollars spent be included in the base data so that the final rate range for CCO 2.0 reflects all CCO expenditures inclusive of expenditures funded by incentive payment dollars.

The point within the rate range chosen by OHA considers the fact that there is a reasonable amount of earn-back associated with the withhold. In general, CCOs have historically earned back ~80% so the payment rate has been chosen such that if the 80% earn-back continues, the resulting premium will still be within the actuarial sound rate range.

Please note the following:

1) The rates are not certified at the CCO level, so the assumption of reasonable earn-back should not be considered from the specific CCO level.
2) The CCO 2.0 program is a new program with new policies. As such, previous funding that was not spent on medical expenditures but instead accumulated for margin or administrative expense for the previous CCO's business models were not considered to be appropriate for CCO 2.0.

OHA expects each CCO to evaluate the CCO 2.0 procurement rates and policies and decide whether their specific CCO business model aligns with the expectations of the CCO 2.0 program. CCO 2.0 will not be funded based upon previous CCO business model's needs.

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