SUMMARY OF CCO CONTRACT REVISIONS

(July 11, 2019 to Sept. 12, 2019)

Date: September 12, 2019

To: RFA Awardees

From: OHA

Introduction

This document summarizes the major revisions made to the CCO Contract template since it was provided to CCO Awardees on July 11, 2019 ("July Contract"). The revisions identified in this summary as well as other less significant revisions are incorporated into what is now the final CCO Contract Template (the "September Contract") which will become effective on October 1, 2019 and is provided simultaneously with this summary. For exact details of revisions made, please see the September Contract in compare form, which shows all the changes made to the July Contract.

1. General Terms

- Added a new provision regarding the applicable Oregon Administrative Rules to clarify that the OARs cites are those currently in effect and those that become effective on January 1, 2020 are those that will become effective as of the same date. The OARs effective as of January 1, 2020 that correspond with those cited in the body of the Contract are cited throughout the Contract in footnotes.

2. Ex. A, Definitions

- The defined terms were previously included in Appendix A. They have now been cut and pasted into Exhibit A of the Contract. All newly defined terms and those which have been modified since July 11 show up redlined.
- "**Protected Information**" is a new term added to Ex. A in order to help CCOs analyze whether particular information could be redacted from a Report that will be subject to public posting in accordance with SB1041.
- "**Report**" – If capitalized then subject to public posting under SB1041. Same Reports are indicated in Exhibit D-Attachment 1 which lists all those documents required to be posted publicly.
- "**Term**" of Contract is explicitly for a period of five calendar years, commencing on January 1, 2020 and expiring on December 31, 2025.
  - There are four Awardees that have been awarded one-year contracts. The word "term" is not defined in these one-year contracts.

3. Exhibit B, Part 1

- **Section 3:** Provides that CCOs will be required to communicate and work with the Tribal Advisory Council organized as a result of SB1041. Also requires CCOs to engage a Tribal Liaison to ensure the CCOs actively engage with the Tribal Advisory Council.

4. **Exhibit B, Part 2 - Covered and Non-Covered Services**
    - **Section 3**: Prior Authorization and Approvals – Added requirement relating to permitting MAT services for SUD treatment for 30 days without requiring prior authorization as required under HB 2257. Also clarified that this requirement applies to each episode of care and may require services to be provided outside of Contractor's Service Area/Provider Network.
    - **Section 5**: NEMT Services
        - Wait times for both drivers and members are 15 minutes.
        - Clarified that all complaints relating to services may go through formal Grievance & Appeal system.
    - **Section 7:** Medication Management
        - Revised for purposes of clarity, especially with respect to pay-for-performance agreements.
        - Revised to require all PBM Subcontracts to be submitted for review and approval by OHA.
    - **Section 8, Para. a:** Intensive Care Coordination Services
        - CCOs are no longer required to have a 1:15 ratio of ICC Care Coordinators to Members receiving ICC services.
        - CCOs are no longer obligated to make ICC services available to Members of Prioritized Populations without the need for an assessment. Instead, CCOs must automatically screen all Members of Prioritized Populations to determine whether they qualify for ICC services. All other Members will be screened for ICC services upon referral.
        - CCO now required to draft ICC policies and procedures which must include a narrative of how they will meet all the needs of those Members receiving ICC Services.
        - OHA is available, upon request by CCOs, for guidance and technical assistance with identifying Members of Prioritized Populations and help with drafting policies and procedures and meeting ICC obligations.

5. **Exhibit B, Part 3 - Patient Rights and Responsibilities, Engagement and Choice**
    - **Section 7, Para. j:** Provider Directory may be posted on CCO website. Letter must be sent to all Members informing them of availability of Provider Directory. Prior to being mailed, the letter must be sent to OHA for review and approval to ensure compliance with Member Material requirements
    - **Section 14:** Revised for purposes of clarity, especially with respect to CCO responsibilities related to transition of care for Members upon the Coverage Effective Date (January 1, 2020).

6. **Exhibit B, Part 4 – Providers and Delivery System**
    - **Sections 1-3:** Revisions made with respect to Indian Health Care Providers and Native American/Alaska Native Members to align with OHA's Waiver from CMS.
    - **Section: 12:** No longer require CCOs to submit Subcontracts to OHA for review and approval. However, OHA shall have the right to request any and all Subcontracts, which must be provided to OHA within two Business Days of request.

7. **Exhibit B, Part 8 – Accountability and Transparency of Operations**
    - **Section 20:** Added details about CCO responsibility to provide notice of any breach of IT security or breach of any confidentiality of clinical records or other confidential personally identifiable information that was or is in paper form.
    - **Section 20.** Revised paragraph a regarding disclosure of change in control of CCO.

8. **Exhibit B, Part 9 – Program Integrity**
    - No substantive revisions

9. **Exhibit B, Part 10**
    - **Section 8:** Clarified that OHA will not be performing any External Quality Review Audits. Those will all be performed by third parties.

10. **Exhibit C – Consideration**
    - **Section 1:** Since the BUILD Fund will not be implemented, deleted provisions relating to that program.
    - **Section 3:** Revised to comply with SB1041 so that OHA will not put Contractor's risk-based capital at risk when recouping Overpayments.

11. **Exhibit D – Standard Terms and Conditions**
    - **Section 14:** Revised to comply with SB1041 & set forth procedures for Contractor providing redacted Reports (that will be publicly posted) to OHA for review and approval
    - **Section 15:**
        - Added provision relating to access requirements when OHA or designees perform audits
        - Revised to comply with SB1041 regarding OHA information sharing with DCBS
    - **Section 26:** Added section providing CCOs with the right to request an extension of time to respond to OHA requests for documents.

12. **Exhibit E –**
    - No substantive revisions

13. **Exhibit F –**
    - No substantive revisions

14. **Exhibit G –**
    - No substantive revisions

15. **Exhibit H –**
    - Revised for purposes of clarity and also revised areas for which VBPs need to be developed or expanded and updated deadlines.

16. **Exhibit I – Grievance and Appeal System**
    - Revised for purposes of repetitiveness and clarity.
    - **Section 1, Para. e:** Added provision regarding ensuring Grievance and Appeal System must be made accessible in accordance with Ex. B, Part 3 of the Contract. Specifically, Contractor must provide all Members with the help necessary to fill out forms, and provide other reasonable assistance to ensure Member's are able to navigate Grievance and Appeal System

17. **Exhibit J**
    - No substantive revisions

18. **Exhibit K – Social Determinants of Health and Equity**
    - **Section 2:** Revised to allow Consumer Representatives to sit on CAC for 6 months, (plus, another 30 days if requested), after Consumer Representative ceases to receive services under Medicaid.
    - **Section 4:** Clarified duties of the CAC
    - **Section 5:** Revised requirements of CAC Demographic report (i.e. report on comparison of demographics w/ Service Area vs. validating CAC demographics align with Service Area demographics).
    - **Section 8:** Since Build Fund program will not be implemented, all provisions related thereto have been deleted. Revised some language regarding the SHARE Initiative for clarity and new requirements in light of BUILD Fund not being implemented
    - **Section 10:**
        - Revised section relating to Methods and Processes required to be included in Health Equity Plan
        - Revised requirements for Cultural Responsiveness and Implicit Bias Training for CCO's Provider Network and Provider Network staff – only required to ensure that they attend trainings and report on such training instead of requiring CCOs to provide the training directly to its Provider Network.
    - **Section 11:** Removed requirement to employ a Traditional Health Worker at 1.0 FTE. Added provision requiring CCOs to provide THW job description to OHA for review and approval

19. **Exhibit L - Solvency Plan, Financial Reporting and Sustainable Rate of Growth**
    - Revised entirety of Exhibit to comply with SB1041.

20. **Exhibit M – Behavioral Health**
    - **Section 1:**
        - Deleted prohibition on subcontracting with only one Behavioral Health Provider
        - Added requirement under HB 2257 to post best practices relating to BH services and resources on CCO website
    - **Section 5:** Directs Contractor to review Sec. 3 of Ex. B, Part 2 relating to MAT treatment for SUD services in order to comply with HB 2257.
    - **Section 12:** Requires CCOs to create a comprehensive Behavioral Health Plan in accordance with ORS 430.630 and to submit to OHA for review and approval
    - **Section 19:**
        - Clarified when certain evaluations and treatments must be provided to children and adolescents.

- Now requires CCOs to develop and maintain written policies relating to the prescription of psychotropic drugs for children, especially if in DHS custody.
- Wraparound coordinators shall not be assigned more than 15 families. Other new provisions relating to Wraparound processes including CCO policies and procedures and Fidelity reviews

➢ **Section 20**: Revised to clarify requirements with respect to annual Behavioral Health metrics reporting.