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CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILING CAPTION: Procurement Rule Changes Next Coordinated Care Organization (CCO) Contracting Cycle (CCO 2.0)

EFFECTIVE DATE: 01/01/2019

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RULES:
410-141-3000, 410-141-3010, 410-141-3015

AMEND: 410-141-3000

RULE TITLE: Managed Care Entity Definitions

NOTICE FILED DATE: 10/11/2018

RULE SUMMARY: The Division needs to amend these rules to provide direction and clarification to incumbent Coordinated Care Organizations and potential applicants that may respond to the CCO 2.0 Request for Applications (RFA). Changes are needed to existing rules that are reflective of the original CCO procurement to provide a framework within current OARs to support the CY 20 CCO procurement.

RULE TEXT:
(1) The Oregon Health Authority adopts and incorporates by reference the definitions below for use by the Managed Care Entities in the following administrative rules and applies them to Health System Transformation:
(a) OAR 309-012-0140, 309-016-0605, 309-032-0860, 309-032-1505, 309-033-0210, applicable to mental health services;
(b) OAR 410-120-0000, definitions of the Oregon Health Plan's General Rules; and
(c) OAR 410-141-3000.
(2) "Adjudication" means the act of a court or entity in authority when issuing an order, judgment, or decree, as in a final MCE claims decision or the Authority issuing a final hearings decision. This function is non-delegable under the coordinated care contracts in the context of hearings and appeals.
(3) "Adverse Benefit Determination" means the denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit. The reduction, suspension, or termination of a previously authorized service or the denial of payment for a service. See OAR 410-141-3240 for a member enrolled in an MCE.
(4) "Alternate Format" means any alternate approach to presenting print information to an individual with a disability. The Americans with Disabilities Act (ADA) groups the standard alternate formats: braille, large (18 point) print, audio

narration, oral presentation, and electronic file along with other aids and services for other disabilities, including sign language interpretation and sighted guide; CMS Section 1557 of the ACA outlines requirements for health plans and providers on alternative formats.
(5) “Applicant” means the entity submitting an application to be a CCO or to enter into or amend a contract for coordinated care services.
(6) “Application” means an entity’s written response to a Request for Application (RFA).
(7) “Auxiliary Aids and Services” means services available to members as defined in CMS Section 1557 of the ACA.
(8) “Award Date” means the date on which the Authority acts on the applications by issuing or denying certification and by awarding or not awarding contracts.
(9) “Benefit Period” means a period of time shorter than the five-year contract term, for which specific terms and conditions in a contract between a coordinated care organization and the Oregon Health Authority are in effect.
(10) “Business Day” means any day except Saturday, Sunday, or a legal holiday. The word "day" not qualified as business day means calendar day.
(11) “Capitated Services” means those covered services that a PHP agrees to provide for a capitation payment under contract with the Authority.
(12) “Capitation Payment” means monthly prepayment to a PHP for health services the PHP provides to members.
(13) “CCO Payment” means the monthly payment to a CCO for services the CCO provides to members in accordance with the global budget.
(14) “Certificate of Authority” means the certificate issued by DCBS to a licensed health entity granting authority to transact insurance as a health insurance company or health care service contractor.
(15) “Cold Call Marketing” means an MCE’s unsolicited personal contact, including texting and email, with a potential member for marketing.
(16) “Community Advisory Council” means the CCO-convened council that meets regularly to ensure the CCO is addressing the health care needs of CCO members and the community consistent with ORS 414.625.
(17) “Community Standard” means typical expectations for access to the health care delivery system in the member’s community of residence. Except where the community standard is less than sufficient to ensure quality of care, the Division requires that the health care delivery system available to Division members in MCEs take into consideration the community standard and be adequate to meet the needs of the Division’s enrollment.
(18) “Contract” means an agreement between the State of Oregon acting by and through the Authority and an MCE to provide health services to eligible members.
(19) “Contract Renewal” means an agreement by a CCO to amend the terms or conditions of an existing contract for the next benefit period.
(20) “Coordinated Care Organization (CCO)” means a corporation, governmental agency, public corporation, or other legal entity that is certified as meeting the criteria adopted by the Authority under ORS 414.625 to be accountable for care management and to provide integrated and coordinated health care for each of the organization’s members.
(21) “Coordinated Care Services” mean an MCE’s fully integrated physical health, behavioral health services, and oral health services.
(22) “Corrective Action or Corrective Action Plan” means a Division-initiated request for a contractor or a contractor-initiated request for a subcontractor to develop and implement a time specific plan for the correction of identified areas of noncompliance.
(23) “Dental Care Organization (DCO)” means an MCE that provides and coordinates dental services as capitated services under OHP.
(24) “Dental Case Management Services” means services provided to ensure the member receives dental services including a comprehensive, ongoing assessment of the member’s dental and medical needs related to dental care and the development and implementation of a plan to ensure the member receives those services.
(25) “DCBS Reporting CCO” means a CCO that reports its solvency plan and financial status to DCBS, not a CCO holding a certificate of authority.

(26) “Department of Consumer and Business Services (DCBS)” means Oregon’s business regulatory and consumer protection department.
(27) “Disenrollment” means the act of removing a member from enrollment with an MCE.
(28) “Exceptional Needs Care Coordination (ENCC)” means for PHPs a specialized case management service provided to members identified as aged, blind, or disabled members who have complex health needs, high health care needs, multiple chronic conditions, behavioral health issues including chemical dependency, or those with severe and persistent behavioral health issues, or those receiving Medicaid-funded long-term care or long-term services and supports. Children and youth shall be provided intensive care coordination and behavioral health services according to presenting needs consistent with OAR 410-141-3170.
(29) “Enrollment” means the assignment of a member to an MCE for management and receipt of health services.
(30) “Entity” means a single legal entity capable of entering into a risk contract that covers coordinated care services with the state and conducting the business of a coordinated care organization.
(31) “Global Budget” means the total amount of payment as established by the Authority to a CCO to deliver and manage health services for its members including providing access to and ensuring the quality of those services.
(32) “Grievance System” means the overall system that includes:
(a) Grievances to an MCE on matters other than actions;
(b) Appeals to an MCE on actions; and
(c) Contested case hearings through the state on actions and other matters for which the member is given the right to a hearing by rule or statute.
(33) “Health Literacy” means the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions regarding services needed to prevent or treat illness.
(34) “Health-Related Services” means non-covered services under Oregon’s Medicaid State Plan intended to improve care delivery and overall member and community health and well-being. Health-related services include flexible services and community benefit initiatives. Flexible services are cost-effective services offered to an individual member to supplement covered benefits. Community benefit initiatives are community-level interventions that include but are not necessarily limited to members and are focused on improving population health and health care quality:
(a) The goals of health-related services are to promote the efficient use of resources and address members’ social determinants of health to improve health outcomes, alleviate health disparities, and improve overall community well-being. Health-related services are provided as a supplement to billable office visits and are often cost-effective services offered as an adjunct to covered benefits. Health-related services lack traditional billing or encounter codes, are not encounterable, and may not be reported for utilization purposes;
(b) To be considered a health-related service, a service must meet the requirements for:
(A) Activities that improve health care quality as defined in 45 CFR 158.150; or
(B) Expenditures related to Health Information Technology and meaningful use requirements to improve health care quality, as defined in 45 CFR 158.151.
(35) “Holistic Care” means incorporating the care of the entire member in all aspects of well-being including physical, psychological, cultural, linguistic, and social and economic needs of the member. Holistic care utilizes a process whereby providers work with members to guide their care and identify needs. This also involves identifying with principles of holism in a system of therapeutics, especially one considered outside the mainstream of scientific medicine as naturopathy or chiropractic and often involving nutritional measures.
(36) “Home CCO” means enrollment in a CCO in a service area based upon a client’s most recent permanent residency, determined at the time of original eligibility or most current point of CCO enrollment prior to hospitalization.
(37) “Indian” means any individual defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12 and:
(a) Is a member of a federally recognized Indian tribe;
(b) Resides in an urban center and meets one or more of the four criteria;
(c) Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated

since 1940 and those recognized now or in the future by the state in which they reside or who is a descendant in the first or second degree of any such member:
(A) Is an Eskimo or Aleut or other Alaska Native;
(B) Is considered by the Secretary of the Interior to be an Indian for any purpose; or
(C) Is determined to be an Indian under regulations issued by the Secretary:
(i) Is considered by the Secretary of the Interior to be an Indian for any purpose; or
(ii) Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.
(38) "Indian Health Care Provider (IHCP)" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).
(39) "Institution for Mental Diseases (IMD)" means, as defined in 42 CFR 435.1010, a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing inpatient psychiatric services such as diagnosis, treatment, or care of individuals with mental diseases, including medical attention, nursing care, and related services. Its primary character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.
(40) "Intensive Case Management (ICM)" means a specialized case management service provided by CCOs to members identified as aged, blind, or disabled members who have complex health needs, high health care needs, multiple chronic conditions, behavioral health issues including chemical dependency or with severe and persistent behavioral health issues, or those receiving Medicaid-funded long-term care or long-term services and supports. Children and youth shall be provided intensive care coordination and behavioral health services according to presenting needs consistent with OAR 410-141-3170.
(41) "Licensed Health Entity" means an MCE that has a Certificate of Authority issued by DCBS as a health insurance company or health care service contractor.
(42) "Limited English Proficient (LEP)" means potential members who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a service, benefit, or encounter.
(43) "Line Items" means condition/treatment pairs or categories of services included at specific lines in the Prioritized List of Health Services.
(44) "Managed Care Entity (MCE)" means, as stated in 42 CFR 457.10, an entity that enters into a contract to provide services in a managed care delivery system including but not limited to managed care organizations, prepaid health plans, and primary care case managers.
(45) "Marketing" means any communication from a PHP or an MCE to a potential member who is not enrolled in the PHP or MCE, and the communication can reasonably be interpreted as intended to compel or entice the potential member to enroll in that PHP or MCE.
(46) "Medicaid-funded Long-term Care or Long-term Services and Supports" means all Medicaid funded services CMS defines as long-term services and supports that include both:
(a) "Long-term Care" means the system through which the Department of Human Services provides a broad range of social and health services to eligible adults who are aged, blind, or have disabilities for extended periods of time. This includes nursing homes and behavioral health care outlined in OAR chapter 410, division 172 Medicaid Payment for Behavioral Health Services, including state psychiatric hospitals;
(b) "Long-term Services and Supports" means the Medicaid services and supports provided under a CMS approved waiver to assist individual's needs and to avoid institutionalization as defined in OAR chapter 411, division 4 and defined as Home and Community-Based Services and Settings and Person-Centered Service Planning (HCBS) and as outlined in OAR chapter 410, division 172 Medicaid Payment for Behavioral Health Services.
(47) "Medical Case Management Services" means services provided to ensure members obtain health services necessary to maintain physical and emotional development and health.

(48) “Member” has the meaning given that term in OAR 410-120-0000.
(49) “Mental Health Organization (MHO)” means an MCE that provides capitated behavioral services for clients.
(50) “National Association of Insurance Commissioners (NAIC)” means the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories.
(51) “Net Premium” means the premium, net of reinsurance premiums paid, HRA and GME payments, and MCO tax expenses.
(52) “Non-Participating Provider” means a provider that does not have a contractual relationship with an MCE and is not on their panel of providers.
(53) “Oregon Health Authority or Authority Reporting MCE” means an MCE that reports its solvency plan and financial status to the Authority under these rules.
(54) “Participating Provider” means a provider that has a contractual relationship with an MCE and is on their panel of providers.
(55) “Potential Member” means an individual who meets the eligibility requirements to enroll in the Oregon Health Plan but has not yet enrolled with a specific PHP or CCO.
(56) “Prevalent Non-English Language” means all non-English languages that are identified as the preferred written language by the lesser of either:
(a) Five percent of the MCE’s total OHP enrollment; or
(b) One thousand of the MCE’s members.
(57) “Readily Accessible” means electronic information and services that comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C’s Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.
(58) “Request for Applications (RFA)” means the document used for soliciting applications for a CCO, award of or amendment of a CCO services contract, or other objectives as the Authority may determine appropriate for procuring coordinated care services.
(59) “Service Area” means the geographic area within which the PHP or MCE agreed under contract with the Authority to provide health services.
(60) “Treatment Plan” means a documented plan that describes the patient's condition and procedures that will be needed, detailing the treatment to be provided and expected outcome and expected duration of the treatment prescribed by the healthcare professional. This therapeutic strategy shall be designed in collaboration with the member, the member’s family, or the member’s representative.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

AMEND: 410-141-3010

RULE TITLE: CCO Application and Contracting Procedures

NOTICE FILED DATE: 10/11/2018

RULE SUMMARY: The Division needs to amend these rules to provide direction and clarification to incumbent Coordinated Care Organizations and potential applicants that may respond to the CCO 2.0 Request for Applications (RFA). Changes are needed to existing rules that are reflective of the original CCO procurement to provide a framework within current OARs to support the CY 20 CCO procurement.

RULE TEXT:

(1) The Authority shall establish an application process for entities seeking contracts as CCOs.

(2) The Authority shall use the following RFA processes for CCO procurement and contracting:

(a) The Authority shall provide public notice of every RFA on its website. The RFA shall indicate how prospective applicants are made aware of addenda by posting notice of the RFA on the electronic system for notification to the public of Authority procurement opportunities or, upon request, by mailing notice of the availability of the RFA to persons that have expressed interest in the RFA;

(b) The RFA process shall begin with a public notice that shall be communicated using the Oregon Procurement Information Network (ORPIN) website. A public notice of an RFA shall identify the services the Authority is seeking, the designated service areas where services are requested, a sample contract, and how potential applicants can keep informed of RFA updates;

(c) The RFA may specify that applicants must submit a letter of intent to the Authority within the specified time period. The letter of intent does not commit any applicant to apply. If a letter of intent is required, the Authority may not consider applications from applicants who fail to submit a timely letter of intent except as provided in the RFA;

(d) The RFA may request applicants to appear at a public meeting to provide information about the application;

(e) The RFA shall request information from applicants to allow the Authority to engage in appropriate state supervision necessary to promote state action immunity under state and federal antitrust laws;

(f) The Authority shall consider only applications that are responsive, completed as described in the RFA, and submitted in the time and manner described in the RFA. The RFA may require electronic submission of the application in accordance with OAR 137-047-0330, Electronic Procurements. If an electronic procurement process is used, applications shall be accepted only from applicants who accept the terms and conditions of the electronic method being used for application submission.

(3) Readiness Reviews:

(a) The Authority shall have discretion whether to have a readiness review process unless otherwise required by law and require successful completion of the readiness review as a condition to contracting;

(b) If the Authority chooses to have a readiness review process and require successful completion as a condition to contracting, the process shall be described in the underlying procurement document or otherwise communicated to respondents during the procurement process;

(c) Readiness review shall include those areas required by law and may also include other topics identified by the Authority;

(d) The Authority reserves the right to request to provide updated information gleaned during the readiness review process throughout the term of the resulting contract as needed for compliance monitoring and performance reviews.

(4) The Authority shall determine that organizations meet the criteria for being CCOs as follows:

(a) The Authority shall evaluate applications for being a CCO based on criteria in OAR 410-141-3015, information contained in the RFA, the application, and any additional information that the Authority obtains. Application evaluations shall be based on RFA criteria;

(b) The Authority shall notify each applicant that applies for CCO status if it meets the criteria for being a CCO;

(c) The Authority shall issue CCO contracts only to applicants that meet the criteria in OAR 410-141-3015, meet the RFA requirements, and provide the assurances specified in the RFA. The Authority shall determine if the applicant

qualifies for being a CCO based on the application and any additional information and investigation that the Authority may require;
(d) The Authority determines an applicant is eligible for a CCO contract when the applicant meets the requirements of the RFA including written assurances satisfactory to the Authority that the applicant:
(A) Provides the coordinated care services in the manner described in the RFA and the Authority's rules;
(B) Is responsible and meets standards established by the Authority and DCBS for financial reporting and solvency;
(C) Is organized and operated and shall continue to be organized and operated in the manner required by the contract and described in the application; and
(D) Shall comply with any assurances it gives the Authority.
(e) The Authority may determine that an applicant is potentially eligible for a CCO contract in accordance with paragraph (f) below. The Authority is not obligated to determine whether an applicant is potentially eligible for a CCO contract if, in its discretion, the Authority determines that sufficient applicants eligible for a CCO contract are available to attain the Authority's objectives under the RFA;
(f) The Authority may determine that an applicant is potentially eligible for a CCO contract if:
(A) The Authority finds that the applicant is reasonably capable of meeting the operational and solvency requirements of the RFA within a specified period; and
(B) The applicant enters into discussions with the Authority about areas of qualification that must be met before the applicant is operationally and financially eligible for a CCO contract. The Authority shall determine the date and required documentation and written assurances required from the applicant;
(C) If the Authority determines that an applicant potentially eligible for a CCO contract does not meet the criteria for a CCO contract within the time announced in the RFA for contract award, the Authority may:
(i) Offer a CCO contract at a future date when the applicant demonstrates to the Authority's satisfaction that the applicant is eligible for a CCO contract within the scope of the RFA; or
(ii) Inform the applicant that it is not eligible for a CCO contract.
(g) The Authority shall enter into a new contract or contract renewal with a CCO only if the CCO meets the criteria for being a CCO and the Authority determines that the contract would be within the scope of the RFA and consistent with the purposes and effective administration of the Oregon Integrated and Coordinated Health Care Delivery System that includes but is not limited to:
(A) The capacity of any existing CCO in the region compared to the capacity of an additional CCO for the number of potential enrollees in the addenda; and
(B) The number of CCOs in the region.
(5) The application is the applicant's offer to enter into a contract and is a firm offer for the period specified in the RFA. The Authority's award of the contract constitutes acceptance of the offer and binds the applicant to the contract:
(a) Except to the extent the applicant is authorized to propose certain terms and conditions pursuant to the RFA, an applicant may not make its offer contingent on the Authority's acceptance of any terms or conditions other than those contained in the RFA;
(b) The Authority may enter into negotiation with applicants concerning potential capacity and enrollment in relation to other available or potentially available capacity, the number of potential enrollees within the service area, and other factors identified in the RFA;
(c) The Authority may award multiple contracts or make a single award or limited number of awards to meet the Authority's needs, including but not limited to adequate capacity for the potential enrollees in the service area, maximizing the availability of coordinated care services, and achieving the objectives in the RFA; and
(d) Subject to any limitations in the RFA, the Authority may execute a contract renewal for CCO services by amending an existing contract or issuing a replacement contract without issuing a new RFA.
(6) Disclosure of application contents and release of information:
(a) Except for the letter of intent to apply, information may not be disclosed to any applicant or the public until the award date, unless otherwise specified in the RFA and allowed by law. No information may be given to any applicant or

the public relative to its standing with other applicants before the award date except under the following circumstances:
(A) The information in the application may be shared with the Authority, DCBS, Oregon Health Insurance Marketplace, PEBB, OEBB, PERS, CMS, and those individuals involved in the application review and evaluation process; and
(B) Information may be provided by the applicant to the public as part of a public review process.
(b) Application information may be disclosed on the award date, except for information that has been clearly identified and labeled confidential in the manner specified in the RFA if the Authority determines it meets the disclosure exemption requirements.
(7) The Authority shall interpret and apply this rule to satisfy federal procurement and contracting requirements in addition to state requirements applicable to contracts with CCOs. The Authority must seek and receive federal approval of CCO contracts funded by federal funds.
(8) Except where inconsistent with the preceding sections of this rule, the Authority adopts the following Department of Justice (DOJ) Model Public Contract Rules (as in effect on June 30, 2018) to govern RFAs and contracting with CCOs:
(a) General Provisions Related to Public Contracting: OARs 137-046-0100, 137-046-0110, and 137-046-0400 through 137-046-0480;
(b) Public Procurements for Goods or Services: OARs 137-047-0100, 137-047-0260 through 137-047-0670, 137-047-700 to 137-047-0760 (excluding provisions governing judicial review), and 137-047-0800;
(c) In applying the DOJ Model Rules to RFAs under this rule:
(A) An application is a proposal under the DOJ Model Rules;
(B) An RFA is an RFP under the DOJ Model Rules;
(C) Certification as a CCO is pre-qualification under the DOJ Model Rules if the Authority requires certification as a condition to contract;
(D) Provisions of the Public Contracting Code referenced in the DOJ Model Rules are incorporated herein;
(E) Definitions in the DOJ Model Rules govern this rule except where a term is defined in section (1) of this rule.
(9) Judicial review of the Authority's decisions relating to a solicitation protest, certification, or contract award is governed by the Oregon Administrative Procedures Act (APA). The RFA may establish when an Authority decision may be considered a final order for purposes of APA review.

STATUTORY/OTHER AUTHORITY: ORS 414.615, 414.625, 414.635, 414.651, 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

AMEND: 410-141-3015

RULE TITLE: Criteria for Coordinated Care Organizations

NOTICE FILED DATE: 10/11/2018

RULE SUMMARY: The Division needs to amend these rules to provide direction and clarification to incumbent Coordinated Care Organizations and potential applicants that may respond to the CCO 2.0 Request for Applications (RFA). Changes are needed to existing rules that are reflective of the original CCO procurement to provide a framework within current OARs to support the CY 20 CCO procurement.

RULE TEXT:

Pursuant to OAR 410-141-3010, the Authority may include a readiness review process as part of the RFA and require successful completion of the readiness review process as a condition to contracting.

(1) Applicants shall submit applications to the Authority describing their capacity and plans for meeting the goals and requirements established for the Oregon Integrated and Coordinated Health Care Delivery System including being prepared to enroll all eligible individuals within the CCO's proposed service area. The Authority shall use the RFA procurement process described in OAR 410-141-3010.

(2) In addition to the requirements for CCOs expressed in the laws establishing Health System Transformation, the Authority interprets the qualifications and expectations for CCO contracting within the context of the Oregon Health Policy Board's adopted reports and policies.

(3) Applicants shall describe their demonstrated experience and capacity for:

(a) Managing financial risk and establishing financial reserves;

(b) Meeting the following minimum financial requirements:

(A) Maintaining restricted reserves of $250,000 plus an amount equal to 50 percent of the entity's total actual or projected liabilities above $250,000;

(B) Maintaining a net worth in an amount equal to at least 5 percent of the average combined revenue in the prior two quarters of the participating health care entities.

(c) Operating within a fixed global budget;

(d) Developing and implementing alternative payment methodologies that are based on health care quality and improved health outcomes;

(e) Coordinating the delivery of physical health care, mental health and Substance Use Disorder (SUD) services, oral health care, and covered long-term care services;

(f) Engaging community members and health care providers in improving the health of the community and addressing regional, cultural, socioeconomic, and racial disparities in health care that exist among the entity's enrollees and in the entity's community.

(4) In selecting one or more CCOs to serve a geographic area, the Authority shall:

(a) For members and potential members, optimize access to care and choice of providers, and where possible choice among CCOs;

(b) For providers, optimize choice in contracting with CCOs; and

(c) Allow more than one CCO to serve the geographic area if desirable to optimize access and choice under this subsection.

(5) Evaluation of CCO applications shall account for the developmental nature of the CCO system. The Authority recognizes that CCOs and partner organizations need time to develop capacity, relationships, systems, and experience to fully realize the goals envisioned by the Oregon Integrated and Coordinated Health Care Delivery System. The Authority shall thoroughly review how the application describes community involvement in the governance of the CCO and the CCO's strategic plan for developing its community health assessment and community health improvement plan:

(a) In all cases, CCOs shall have plans in place to meet the criteria laid out in these rules and the application process and to make sufficient progress in implementing plans and realizing the goals set forth in contract;

(b) Each criterion is listed followed by the elements that are addressed during the initial evaluation described in this rule without limiting the information that is requested in the RFA.
(6) Each CCO shall have a governance structure that meets the requirements of ORS 414.625. The applicant shall:
(a) Clearly describe how it meets governance structure criteria from ORS 414.625, how the governance structure makeup reflects community needs and supports the goals of health care transformation, how the criteria are used to select governance structure members, and how it assures transparency in governance;
(b) Identify key leaders who are responsible for successful implementation and sustainable operation of the CCO;
(c) Describe how its governance structure reflects the needs of members with serious and persistent mental illnesses and members receiving DHS Medicaid-funded, long-term care services and supports.
(7) Each CCO shall convene a community advisory council (CAC) that meets the requirements of ORS 414.625. The applicant shall clearly describe how it meets the requirements for selection and implementation of a CAC consistent with ORS 414.625, how the CAC is administered to achieve the goals of community involvement, and the development, adoption, and updating of the community health assessment and community health improvement plan.
(8) CCOs shall partner with their local public health authority, hospital system, type B AAA, APD field office, and local mental health authority to develop a shared community health assessment that includes a focus on health disparities in the community:
(a) Since community health assessments evolve over time as relationships develop and CCOs learn what information is most useful, initial CCO applicants may not have time to conduct a comprehensive community assessment before operating as a CCO;
(b) The applicant shall describe how it develops its health assessment, meaningfully and systematically engaging representatives of critical populations and community stakeholders and its community advisory council to create a health improvement plan for addressing community needs that builds on community resources and skills and emphasizes innovation.
(9) The CCO shall describe its strategy to adopt and implement a community health improvement plan consistent with OAR 410-141-3145.
(10) Dental care organizations: Each CCO shall have a contractual relationship with any DCO in its service area.
(11) CCOs shall have agreements in place with publicly funded providers to allow payment for point-of-contact services including immunizations, sexually transmitted diseases and other communicable diseases, family planning, and HIV/AIDS prevention services. Applicants shall confirm that these agreements have been developed unless good cause can be shown:
(a) CCOs shall also have agreements in place with the local mental health authority consistent with ORS 414.153. Applicants shall confirm that these agreements have been developed unless good cause can be shown;
(b) The Authority shall review CCO applications to ensure that statutory requirements regarding county agreements are met unless good cause is shown why an agreement is not feasible.
(12) CCOs shall provide integrated, personcentered care and services designed to provide choice, independence, and dignity. The applicant shall describe its strategy:
(a) To assure that each member receives integrated, personcentered care and services designed to provide choice, independence, and dignity;
(b) For providing members the right care at the right place and the right time and to integrate and coordinate care across the delivery system.
(13) CCOs shall develop mechanisms to monitor and protect against underutilization of services and inappropriate denials, provide access to qualified advocates, and promote education and engagement to help members be active partners in their own care. Applicants shall describe:
(a) Planned or established policies and procedures that protect member rights including access to qualified peer wellness specialists, peer-delivered services specialists, personal health navigators, and qualified community health workers where appropriate;
(b) Planned or established mechanisms for a complaint, grievance, and appeals resolution process, including how that

process shall be communicated to members and providers.
(14) CCOs shall operate in a manner that encourages patient engagement, activation, and accountability for the member's own health. Applicants shall describe how they plan to:
(a) Actively engage members in the design and, where applicable, implementation of their treatment and care plans;
(b) Ensure that member choices are reflected in the development of treatment plans, and member dignity is respected.
(15) CCOs shall assure that members have a choice of providers within the CCO's network, including providers of culturally and linguistically appropriate services and their providers participating in the CCO and shall:
(a) Work together to develop best practices for care and service delivery to reduce waste and improve health and wellbeing of all members;
(b) Be educated about the integrated approach and how to access and communicate within the integrated system about a member's treatment plan and health history;
(c) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-making, and communication;
(d) Be permitted to participate in the networks of multiple CCOs;
(e) Include providers of specialty care;
(f) Be selected by the CCO using universal application and credentialing procedures, objective quality information, and are removed if the providers fail to meet objective quality standards;
(g) Establish and demonstrate compliance with 42 CFR part 438, subpart K regarding parity in mental health and substance use disorder benefits in alignment with contractual requirements;
(h) Describe how they will work with their providers to develop the partnerships necessary to allow for access to and coordination with medical, mental health and mobile crisis services, Substance Use Disorder (SUD) service providers, and dental care when the CCO includes a dental care organization, and facilitate access to community social and support services including DHS Medicaid-funded long-term care services, mental health crisis services, and culturally and linguistically appropriate services;
(i) Describe their planned or established tools for provider use to assist in the education of members about care coordination and the responsibilities of both parties in the process of communication.
(16) CCOs shall assure that each member has a consistent and stable relationship with a care team that is responsible for providing preventive and primary care and for comprehensive care management in all settings. The applicant shall demonstrate how it will support the flow of information, identify a lead provider or care team to confer with all providers responsible for a member's care, and use a standardized patient follow-up approach.
(17) CCOs shall address the supportive and therapeutic needs of each member in a holistic fashion using patientcentered primary care homes and individualized care:
(a) Applicants shall describe their model of care or other models that support patient-centered primary care, adhere to ORS 414.625 requirements regarding individualized care plans particularly for members with intensive care coordination needs, and screen for all other issues including mental health;
(b) Applicants shall describe how its implementation of individualized care plans reflects member or family and caregiver preferences and goals to ensure engagement and satisfaction.
(18) CCOs shall assure that members receive comprehensive transitional health care including appropriate followup care when entering or leaving an acute care facility or long-term care setting to include warm handoffs as appropriate based on requirements in OAR 309-032-0860 through 0870. Applicants shall:
(a) Describe their strategy for improved transitions in care so that members receive comprehensive transitional care, and members' experience of care and outcomes are improved;
(b) Demonstrate how hospitals and specialty services are accountable to achieve successful transitions of care and establish service agreements that include the role of patient-centered primary care homes;
(c) Describe their arrangements, including memorandum of understanding, with Type B Area Agencies on Aging or the Department's offices of Aging and People with Disabilities concerning care coordination and transition strategies for members.

(19) CCOs shall provide members with assistance in navigating the health care delivery system and accessing community and social support services and statewide resources including the use of certified or qualified health care interpreters, community health workers, and personal health navigators. The applicant shall describe its planned policies for informing members about access to personal health navigators, peer wellness specialists, peer-delivered services specialists, and community health workers.
(20) Services and supports shall be geographically located as close to where members reside as possible and are, when available, offered in non-traditional settings that are accessible to families, diverse communities, and underserved populations. Applicants shall describe:
(a) Delivery system elements that respond to member needs for access to coordinated care services and supports;
(b) Planned or established policies for the delivery of coordinated health care services for members in long-term care settings;
(c) Planned or established policies for the delivery of coordinated health care services for members in residential treatment settings or long term psychiatric care settings.
(21) CCOs shall prioritize working with members who have high health care needs, multiple chronic conditions, mental illness, or Substance Use Disorder (SUD) services including members with serious and persistent mental illness covered under the state's 1915(i) State Plan Amendment. The CCO shall involve those members in accessing and managing appropriate preventive, health, remedial, and supportive care and services to reduce the use of avoidable emergency department visits and hospital admissions. The applicant shall describe how it will:
(a) Use individualized care plans to address the supportive and therapeutic needs of each member, particularly those with intensive care coordination needs;
(b) Reflect member or family and caregiver preferences and goals to ensure engagement and satisfaction.
(22) CCOs shall participate in the learning collaborative described in ORS 442.210. Applicants shall confirm their intent to participate.
(23) CCOs shall implement to the maximum extent feasible patientcentered primary care homes including developing capacity for services in settings that are accessible to families, diverse communities, and underserved populations:
(a) The applicant shall describe its plan to develop and expand capacity to use patient-centered primary care homes to ensure that members receive integrated, person-centered care and services and that members are fully informed partners in transitioning to this model of care;
(b) The applicant shall require its other health and services providers to communicate and coordinate care with patientcentered primary care homes in a timely manner using health information technology.
(24) CCOs' health care services shall focus on achieving health equity and eliminating health disparities. Applicants shall:
(a) Describe its strategy for ensuring health equity (including interpretation and cultural competence) and elimination of avoidable gaps in health care quality and outcomes, as measured by gender identity, race, ethnicity, language, disability, sexual orientation, age, mental health and addictions status, geography, and other cultural and socioeconomic factors;
(b) Engage in a process that identifies health disparities associated with race, ethnicity, language, health literacy, age, disability (including mental illness and substance use disorders), gender identity, sexual orientation, geography, or other factors through community health assessment;
(c) Collect and maintain race, ethnicity, and primary language data for all members on an ongoing basis in accordance with standards jointly established by the Authority and the Division.
(25) CCOs are required to use alternative payment methodologies consistent with ORS 414.653. The applicant shall describe its plan to implement alternative payment methods alone or in combination with delivery system changes to achieve better care, controlled costs, and better health for members. Use of alternative payment methodologies shall be reported through the All Payer All Claims (APAC) data reporting system annually as prescribed in OAR 409-025-0120 and 409-025-0130.
(26) CCOs shall use health information technology (HIT) to link services and care providers across the continuum of care to the greatest extent practicable. The applicant shall describe:

(a) Its initial and anticipated levels of electronic health record adoption and health information exchange infrastructure and capacity for collecting and sharing patient information electronically and its HIT improvement plan for meeting transformation expectations;
(b) Its plan to ensure that each network provider participates in a health information organization (HIO) or is registered with a statewide or local direct-enabled health information service provider.
(27) CCOs shall report on outcome and quality measures identified by the Authority under ORS 414.638, participate in the APAC data reporting system, and follow expectations for participation in annual TQS reporting to the Authority as detailed in the MCE contract and external quality review with the Authority contracted External Quality Review Organization as outlined in CFR 42 §438.350, §438.358, and §438.364. The applicant shall provide assurances that:
(a) It has the capacity to report and demonstrate an acceptable level of performance with respect to Authority-identified metrics;
(b) It submits APAC data in a timely manner pursuant to OAR 409-025-0130.
(28) CCOs shall be transparent in reporting progress and outcomes. Applicants shall:
(a) Describe how it assures transparency in governance;
(b) Agree to provide timely access to certain financial, outcomes, quality, and efficiency metrics that are transparent and publicly reported and available on the Internet.
(29) CCOs shall use best practices in the management of finances, contracts, claims processing, payment functions, and provider networks. The applicant shall describe:
(a) Its planned or established policies for ensuring best practices in areas identified by ORS 414.625;
(b) Whether the CCO uses a clinical advisory panel (CAP) or other means to ensure clinical best practices;
(c) Plans for an internal quality improvement committee that develops and operates under an annual quality strategy and work plan that incorporates implementation of system improvements and an internal utilization review oversight committee that monitors utilization against practice guidelines and treatment planning protocols and policies.
(30) CCOs shall demonstrate sound fiscal practices and financial solvency and shall possess and maintain resources needed to meet their obligations:
(a) Initially, the financial applicant shall submit required financial information that allows the DCBS Division of Financial Regulation on behalf of the Authority to confirm financial solvency and assess fiscal soundness;
(b) The applicant shall provide information relating to assets and financial and risk management capabilities.
(31) CCOs may provide coordinated care services within a global budget. Applicants shall submit budget cost information consistent with its proposal for providing coordinated care services within the global budget.
(32) CCOs shall operate, administer, and provide for integrated and coordinated care services within the requirements of the medical assistance program in accordance with the terms of the contract and rule. The applicant shall provide assurances about compliance with requirements applicable to the administration of the medical assistance program.
(33) CCOs shall provide covered Medicaid services other than Department of Human Services Medicaid-funded long-term care services to members who are dually eligible for Medicare and Medicaid.

STATUTORY/OTHER AUTHORITY: 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: 414.610 - 414.685