Attachment 7 — Provider Participation and Operations Questionnaire

The information requested in this questionnaire should be provided in narrative form, answering specific questions in each section and providing enough information for the OHA to evaluate the response.

Page limits for this Provider Participations and Operations Questionnaire is 40 pages. Items that are excluded from the page limit will be noted in that requirement.

1. Governance and Organizational Relationships

a. Governance (recommended page limit 1 page)

This section will describe the Governance Structure, Community Advisory Council (CAC), and how the governance model will support a sustainable and successful organization that can deliver health care services within available resources, where success is defined through the triple aim. Please describe:

(1) The proposed Governance Structure, consistent with ORS 414.625.

(2) The proposed Community Advisory Council (CAC) in each of the proposed Service Areas and how the CAC was selected consistent with ORS 414.625.

(3) The relationship of the Governance Structure with the CAC, including how the Applicant will ensure transparency and accountability for the governing body's consideration of recommendations from the CAC.

(4) The CCO Governance Structure will reflect the needs of Members with severe and persistent mental illness and Members receiving DHS Medicaid-funded LTC services and supports through representation on the Governing Board or CAC.

b. Clinical Advisory Panel (recommended page limit ½ page)

An Applicant is encouraged but not required to establish a Clinical Advisory Panel as a means of assuring best clinical practices across the CCO's entire network of Providers and facilities.

(1) If a Clinical Advisory Panel is established, describe the role of the Clinical Advisory Panel and its relationship to the CCO governance and organizational structure.

(2) If a Clinical Advisory Panel is not established, the Applicant should describe how its governance and organizational structure will achieve best clinical practices consistently adopted across the CCO's entire network of Providers and facilities.

c. Agreements with Type B Area Agencies on Aging and DHS local offices for APD (APD) (recommended page limit ½ page)

While DHS Medicaid-funded LTC services are legislatively excluded in HB 3650 from CCO responsibility and will be paid for directly by the Department of Human Services, CCOs will still be responsible for providing physical and Behavioral Health services for individuals receiving DHS Medicaid-funded LTC services and will be responsible for coordinating with the DHS Medicaid-funded LTC system. To implement and formalize coordination and ensure relationships exist between CCOs and the local DHS Medicaid-funded LTC Providers, CCOs will be required to work with the local Type B AAA or DHS' APD local office to develop a Memorandum of Understanding (MOU) or contract, detailing their system coordination agreements regarding Members receiving DHS Medicaid-funded LTC services.

(1) Describe the Applicant's current status in obtaining MOU(s) or contracts with Type B AAAs or DHS local APD office.

(2) If MOUs or contracts have not been executed, describe the Applicant's efforts to do so and how the Applicant will obtain the MOU or contract.

d. Agreements with Community Partners Relating to Behavioral Health Services (recommended page limit 1 page)

To implement and formalize coordination, CCOs will be required to work with local mental health authorities and Community Mental Health Programs to develop a Memorandum of Understanding (MOU) or contract, detailing their system coordination agreements regarding Members receiving mental health services.

(1) Describe the Applicant's current status in obtaining MOU(s) or contract(s) with LMHAs and CMHPs throughout its proposed Service Area.

(2) If MOUs or contracts have not been executed, describe the Applicant's efforts to do so and how the Applicant will obtain the MOU(s) or contract(s).

(3) Describe how the Applicant has established and will maintain relationships with social and support services in the Service Area, such as:

- DHS Child Welfare and Self Sufficiency field offices in the Service Area
- Oregon Youth Authority (OYA) and Juvenile Departments in the Service Area
- Department of Corrections and local Community corrections and law enforcement, local court system, problem solving courts (drug courts/mental health courts) in the Service Area, including for individuals with mental illness and substance abuse disorders
- School districts, education service districts that may be involved with students having special needs, and higher education in the Service Area
- Developmental disabilities programs
- Tribes, tribal organizations, Urban Indian organizations, Indian Health Services and services provided for the benefit of Native Americans and Alaska Natives
- Housing organizations
- Community-based Family and Peer support organizations
- Other social and support services important to communities served

2. Member Engagement and Activation (recommended page limit 1½ pages)

Members should be actively engaged partners in the design and implementation of their treatment and care plans through ongoing consultations regarding cultural preferences and goals for health maintenance and improvement. Member choices should be reflected in the selection of their Providers and in the development of Treatment Plans while ensuring Member dignity and culture will be respected.

a. Describe the ways in which Members (and their families and support networks, where appropriate) are meaningfully engaged as partners in the care they receive as well as in organizational Quality Improvement activities.

b. Describe how the Applicant will ensure a comprehensive communication program to engage and provide all Members, not just those Members accessing services, with appropriate information related to benefits and accessing physical health, Behavioral Health and oral health services, including how it will:

- Encourage Members to be active partners in their health care, understanding to the greatest extent feasible how the approach to activation accounts for the social determinants of health;

- Engage Members in culturally and linguistically appropriate ways;
- Educate Members on how to navigate the coordinated care approach and ensure access to advocates including Peer wellness and other Traditional Health Worker resources;
- Encourage Members to use effective wellness and prevention resources and to make healthy lifestyle choices in a manner that is culturally and linguistically appropriate;
- Provide plain language narrative that informs patients about what they should expect from the CCO with regard to their rights and responsibilities; and
- Meaningfully engage the CAC to monitor and measure patient engagement and activation.

3. Transforming Models of Care (recommended page limit 1 page)

Transformation relies on ensuring that Members have access to high quality care: "right care, right place, right time". This will be accomplished by the CCO through a Provider Network capable of meeting Health System Transformation (HST) objectives. The Applicant is transforming the health and health care delivery system in its Service Area and communities – taking into consideration the information developed in the Community health assessment – by building relationships that develop and strengthen network and Provider participation, and Community linkages with the Provider Network.

a. Patient-Centered Primary Care Homes

Integral to transformation is the Patient-Centered Primary Care Home (PCPCH), as currently defined by Oregon's statewide standards in OAR. These standards advance the Triple Aim goals of better health, better care, lower costs by focusing on effective wellness and prevention, coordination of care, active management and support of individuals with Special Health Care Needs, a patient and Family-centered approach to all aspects of care, and an emphasis on whole-person care in order to address a patient's physical, oral and Behavioral Health care needs.

(1) Describe Applicant's PCPCH delivery system.

(2) Describe how the Applicant's PCPCH delivery system will coordinate PCPCH Providers and services with DHS Medicaid-funded LTC Providers and services.

(3) Describe how the Applicant will encourage the use of Federally Qualified Health Centers (FQHC), Rural health clinics, migrant health clinics, school-based health clinics and other safety net providers that qualify as Patient-Centered Primary Care Homes.

b. Other models of patient-centered primary health care

(1) If the Applicant proposes to use other models of patient-centered primary health care in addition to the use of PCPCH, describe how the Applicant will assure Member access to Coordinated Care Services that provides effective wellness and prevention services, facilitates the coordination of care, involves active management and support of individuals with Special Health Care Needs, is consistent with a patient and Family-centered approach to all aspects of care, and has an emphasis on whole-person care in order to address a patient's physical, oral and Behavioral Health care needs.

(2) Describe how the Applicant's use of this model will achieve the goals of Health System Transformation.

4. Network Adequacy (recommended page limit 3 pages)

Applicant's network of Providers must be adequate to serve Members' health care and service needs, meet access to care standards, including time and distance standards and wait time to appointment, and allow for appropriate choice for Members, and include Traditional Health Workers including Community Health Workers, Personal Health Navigators and certified, qualified interpreters.

a. Evaluation Questions

(1) How does Applicant intend to assess the adequacy of its Provider Network? Please include specific data points used to inform the assessment and the methodology for how adequacy will be evaluated.

(2) How does Applicant intend to establish the capacity of its Provider Network? Please include specific data points used to inform the assessment and the methodology for how capacity will be evaluated.

(3) How does Applicant intend to remedy deficiencies in the capacity of its Provider Network?

(4) How does Applicant intend to monitor Member wait times to appointment? Please include specific data points used to monitor and how that data will be collected.

(5) How will Applicant ensure sufficient availability of general practice oral health Providers and oral health specialists such as endodontists? Please provide details on how the full time equivalent availability of Providers to serve Applicant's prospective Members will be measured and periodically validated.

(6) Describe how Applicant will plan for fluctuations in Provider capacity, such as a Provider terminating a contract with the Applicant, to ensure that Members will not experience delays or barriers to accessing care

b. Requested Documents

Completion of the DSN Provider Report (does not count towards page limitations)

5. Grievance & Appeals (recommended page limit 1½ pages)

Please describe how Applicant intends to utilize information gathered from its Grievance and Appeal system to identify issues related to each of the following areas:

a. Access to care (wait times, travel distance, and subcontracted activities such as Non-Emergent Medical Transportation).

b. Network adequacy (including sufficient number of specialists, oral health and Behavioral Health Providers).

c. Appropriate review of prior authorized services (consistent and appropriate application of Prior Authorization criteria and notification of Adverse Benefit Determinations down to the Subcontractor level).

6. Coordination, Transition and Care Management (recommended page limit 5 pages)

a. Care Coordination:

(1) Describe how the Applicant will support the flow of information between providers, including DHS Medicaid-funded LTC care Providers, mental health crisis services, and home and Community-based services, covered under the State's 1915(i) State Plan Amendment (SPA) for Members with severe and persistent mental illness, as well as Medicare Advantage plans serving Fully Dual Eligible Members, in order to avoid duplication of services, medication errors and missed opportunities to provide effective preventive and primary care.

(2) Describe how the Applicant will work with its providers to develop the partnerships necessary to allow for access to and coordination with social and support services, including crisis management services, and Community prevention and self-management programs.

(3) Describe how the Applicant will develop a tool for Provider use to assist in the culturally and linguistically appropriate education of Members about Care Coordination, and the responsibilities of both Providers and Members in assuring effective communication.

(4) Describe how the Applicant will work with Providers to implement uniform methods of identifying Members with multiple diagnoses and who are served with multiple healthcare and service systems.

(5) Describe how Applicant will implement an intensive Care Coordination and planning model in collaboration with Member's PCPCH and other service providers such as Community Developmental Disability Programs and brokerages for Members with developmental disabilities, that effectively coordinates services and supports for the complex needs of these Members.

(6) Describe how the Applicant will meet state goals and expectations for coordination of care for Members with severe and persistent mental illness receiving home and Community-based services covered under the State's 1915(i) SPA and Members receiving DHS Medicaid-funded LTC services, given the exclusion of DHS Medicaid-funded LTC services from Global Budgets.

(7) Describe the evidence-based or innovative strategies the Applicant will use within their delivery system network to ensure coordinated care, including the use of Traditional Health Workers, especially for Members with intensive Care Coordination needs, and those experiencing health disparities.

(8) Assignment of responsibility and accountability: The Applicant must demonstrate that each Member has a Primary Care Provider or primary care team that is responsible for coordination of care and transitions.

(a) Describe the Applicant's standards that ensure access to care and systems in place to engage Members with appropriate levels of care and services beginning not later than 30 days after Enrollment with the CCO.

(b) Describe how the Applicant will provide access to primary care to conduct culturally and linguistically appropriate health screenings for Members to assess individual care needs or to determine if a higher level of care is needed.

(9) Comprehensive Transitional Care: The Applicant must ensure that Members receive comprehensive Transitional Care so that Members' experiences and outcomes are improved. Care coordination and Transitional Care should be culturally and linguistically appropriate to the Member's need.

(a) Describe the Applicant's plan to address appropriate Transitional Care for Members facing admission or discharge from Hospital, Hospice or other palliative care, home health care, adult foster care, skilled nursing care, residential or outpatient treatment for mental health or substance use disorder, the Oregon State Hospital or other care settings. This includes transitional services and supports for children, adolescents and adults with serious Behavioral Health conditions facing admissions or discharge from residential treatment settings and the state Hospitals.

(b) Describe the Applicant's plan to coordinate and communicate with Type B AAA or APD to promote and monitor improved transitions of care for Members receiving DHS Medicaid-funded LTC services and supports, so that these Members receive comprehensive Transitional Care.

(c) Describe the Applicant's plan to develop an effective mechanism to track Member transitions from one care setting to another, including engagement of the Member and Family Members in care management and treatment planning.

(10) Individual care plans: As required by ORS 414.625, the Applicant will use individualized care plans to address the supportive and therapeutic needs of Members with intensive Care Coordination needs, including Members with severe and persistent mental illness receiving home and Community-based services covered under the State's 1915(i) State Plan Amendment. Care plans will reflect Member or Family/caregiver preferences and goals to ensure engagement and satisfaction.

(a) Describe the Applicant's standards and procedures that ensure the development of individualized care plans, including any priorities that will be followed in establishing such plans for those with intensive Care Coordination needs, including Members with severe and persistent mental illness receiving home and Community-based services covered under the State's 1915(i) SPA.

(b) Describe the Applicant's universal screening process that assesses individuals for critical risk factors that trigger intensive Care Coordination for high needs Members; including those receiving DHS Medicaid-funded LTC services.

(c) Describe how the Applicant will factor in relevant Referral, risk assessment and screening information from local Type B AAA and APD offices and DHS Medicaid-funded LTC Providers; and how they will communicate and coordinate with Type B AAA and APD offices

(d) Describe how the Applicant will reassess high-needs Members at least semi-annually or when significant changes in status occur to determine whether their care plans are effectively meeting their needs in a person-centered, person-directed manner.

(e) Describe how individualized care plans will be jointly shared and coordinated with relevant staff from Type B AAA and APD with and DHS Medicaid-funded LTC Providers and Medicare Advantage plans serving Fully Dual Eligible Members.

(11) Describe the Applicant's plan for coordinating care for Member oral health needs, prevention and wellness as well as facilitating appropriate Referrals to oral health services.

(12) Describe Applicant's plan for coordinating Referrals from oral health to physical health or Behavioral Health care.

b. Care Integration (recommended page limit 1½ pages)

(1) Oral Health

(a) Describe the Applicant's plan for ensuring delivery of oral health services is coordinated among systems of physical, oral, and Behavioral Health care.

(b) Describe Applicant's plan for ensuring that preventive oral health services are easily accessible by Members to reduce the need for urgent or emergency oral health services.

(2) Hospital and Specialty Services

Adequate, timely and appropriate access to Hospital and specialty services will be required. Hospital and specialty service agreements should be established that include the role of Patient-Centered Primary Care Homes.

Describe how the Applicant's agreements with its Hospital and specialty care Providers will address:

(a) Coordination with a Member's Patient-Centered Primary Care Home or Primary Care Provider

(b) Processes for PCPCH or Primary Care Provider to refer for Hospital admission or specialty services and coordination of care.

(c) Performance expectations for communication and medical records sharing for Hospital and specialty treatments, at the time of Hospital admission or discharge, for after-hospital follow up appointments.

(d) A plan for achieving successful transitions of care for Members, with the PCPCH or Primary Care Provider and the Member in central treatment planning roles.

c. DHS Medicaid-funded Long Term Care Services (recommended page limit 2 pages)

CCOs will be responsible for the provision of health services to Members receiving DHS Medicaid-funded LTC services provided under the DHS-reimbursed LTC program. DHS Medicaid-funded LTC services include, but are not limited to, in-home supports/services, Adult Foster Care, Residential Care Facilities, Assisted Living Facilities, DHS Medicaid-funded LTC Nursing Facility state plan, State Plan Personal Care for APD, Adult Day Services, Contract Nursing Program, administrative examinations and reports, non-medical transportation (except in some areas where contracted to transportation brokerages) and PACE state plan (including Medicare benefits).

(1) Describe how the Applicant will:

(a) Effectively provide health services to Members receiving DHS Medicaid-funded LTC services whether served in their own home, Community-based care or Nursing Facility and coordinate with the DHS Medicaid-funded LTC delivery system in the Applicants Service Area, including the role of Type B AAA or the APD office;

(b) Use best practices applicable to individuals in DHS Medicaid-funded LTC settings including best practices related to Care Coordination and transitions of care;

(2) Describe how Applicant will use or participate in any of the following models for better coordinating care between the health and DHS Medicaid-funded LTC systems, or describe any alternative models for coordination of care:

(a) Co-Location: co-location of staff such as Type B AAA and APD case managers in healthcare settings or co-locating Behavioral Health specialists in health or other care settings where Members live or spend time.

(b) Team approaches: Care Coordination positions jointly funded by the DHS Medicaid-funded LTC and health systems, or team approaches such as a multi-disciplinary care team including DHS Medicaid-funded LTC representation.

(c) Services in Congregate Settings: DHS Medicaid-funded LTC and health services provided in congregate settings, which can be limited to one type of service, such as "in home" Personal Care Services provided in an apartment complex, or can be a comprehensive model, such as the Program of All-Inclusive Care for the Elderly (PACE).

(d) Clinician/Home-Based Programs: increased use of Nurse Practitioners, Physician Assistants, or Registered Nurses who perform Assessments, plan treatments, and provide interventions to the person in their home, Community-based or Nursing Facility setting.

d. Utilization management

Describe how the Applicant will perform the following UM activities tailored to address the needs of diverse populations including Members receiving DHS Medicaid-funded LTC services, Members with Special Health Care Needs, Members with intellectual disability and developmental disabilities, adults who have serious mental illness and children who have serious emotional disturbance.

(1) How will the authorization process differ for Acute and ambulatory levels of care; and

(2) Describe the methodology and criteria for identifying over- and under-utilization of services

7. Accountability (recommended page limit 1½ pages)

Accountability for each aspect of the Triple Aim—better health, better care and lower costs—is a central tenet of Health System Transformation. CCOs will be held accountable for their performance on outcomes, quality, health equity and efficiency measures identified by OHA through a public process in collaboration with culturally diverse stakeholders.

During the development of CCO 2.0, OHA committed to shared accountability for Health System Transformation across the state. This included a commitment to Members, Providers, and to CCOs that performance expectations would be clear and that the monitoring and enforcement of those requirements would be applied consistently, transparently and equitably.

Accountability for the performance of Contract requirements is critical to the success of Health System Transformation. The quality outcomes of CCO performance are publicly measured and reported through both the State performance and core metrics and CCO incentive metrics. In addition to public accountability for quality, health equity and efficiency, Successful Applicants will remain accountable for the performance of Contract requirements. This includes accountability for the performance of subcontracted and delegated activities, the oversight and monitoring of subcontracted entities, and the timely and complete submission of reporting deliverables.

CCO 2.0 Accountability Standards include:

- Standardized requirements for Contract deliverables including formatting, structure, timeliness, completeness, and accuracy
- A clear relationship between performance issues and contract enforcement mechanisms
- An escalation process for resolving performance issues
- Consistent and fair application of contract enforcement mechanisms
- Prioritizing the resolution of performance issues which impact Member access and care
- Efforts to improve the clarity and consistency of OHA guidance to CCOs on issues where misinterpretation or ambiguity may exist

a. Describe any quality measurement and reporting systems that the Applicant has in place or will implement in Year 1.

b. Will the Applicant participate in any external quality measurement and reporting programs (e.g. HEDIS reporting related to NCQA accreditation, federal reporting for Medicare Advantage lines of business)?

c. Explain the Applicant's internal quality standards or performance expectations to which Providers and Subcontractors are held.

d. Describe the mechanisms that the Applicant has for sharing performance information with Providers and contractors for Quality Improvement.

8. Fraud, Waste and Abuse Compliance (recommended page limit ½ page)

a. Please describe how Applicant currently engages in activities designed to prevent and detect Fraud, Waste and Abuse.

b. Please describe how Applicant intends to monitor and audit its Provider Network, Subcontractors, and delegated entities for potential Fraud, Waste and Abuse activities.

9. Quality Improvement Program (recommended page limit 1 page)

Oregon will continue to develop and maintain a Transformation and Quality Strategy to assess and improve the quality of CCO services and to ensure compliance with established standards. CCO accountability measures and related incentives will be core elements of the state's Quality Strategy.

Oregon will continue its robust monitoring of CCO system performance and will continue to assure that established standards for quality assessment and improvement are met.

a. Please describe policies, processes, practices and procedures you have in place that serve to improve Member outcomes, including evidence-based best practices, emerging best practices, and innovative strategies in all areas of Health System Transformation, including patient engagement and activation.

b. Please describe your experience and plan to emphasize and implement wellness and health improvement activities and practices within your organization for Members and staff, including partners and contracts in place to strengthen this aspect of health care.

c. Outline your experience, staffing, policies, procedures, and capacity to collect the necessary electronic and other data that will be required for meeting regular performance benchmarks to evaluate the value of Health Services delivered by your CCO. Describe how CCO accountability metrics serve to ensure quality care is provided and serve as an incentive to improve care and the delivery of services.

d. Describe your policies and procedures to ensure a continuity of care system for the coordination of care and the arrangement, tracking and documentation of all Referrals and Prior Authorization.

10. Medicare/Medicaid Alignment (recommended page limit ½ page)

a. Is Applicant under Enrollment and/or Marketing sanction by CMS? If so, please describe?

b. Is Applicant currently Affiliated with a Medicare Advantage plan? If no, how will Applicant ensure they are contracted or Affiliated with a Medicare Advantage plan prior to the Effective Date of the Contract?

11. Service Area and Capacity (not counted towards overall page limit)

a. List the Service Area(s) the Applicant is applying for and the maximum number of Members the Applicant is proposing to accept in each area based upon the Applicant's Community health assessment and plan for delivery of integrated and coordinated health, mental health, and substance use disorder treatment services and supports and oral health services.

b. Does Applicant propose a Service Area to cover less than a full County in any County? If so, please describe how:

(1) Serving less than the full county will allow the Applicant to achieve the transformational goals of CCO 2.0 (as described in this RFA) more effectively than county-wide coverage in the following areas:

- Community engagement, governance, and accountability;
- Behavioral Health integration and access;
- Social Determinants of Health and Health Equity;
- Value-Based Payments and cost containment; and
- Financial viability;

(2) Serving less than the full county provides greater benefit to OHP Members, Providers, and the Community than serving the full county; and

(3) The exception request is not designed to minimize financial risk and does not create adverse selection, e.g. by red-lining high-risk areas.

OHA reserves the right to set the maximum number of Members an Applicant may contract to serve and define the area(s) an Applicant may serve based upon OHA's evaluation of the Applicant's ability to serve Members, including dually eligible Members, OHA's needs and the needs of its Members. OHA may require an Applicant to accept OHA's additional Service Area request(s) as a condition of receiving an award or a Notice to Proceed as OHA and its Members' needs warrant. Applicants must apply for Service Area on a county-wide basis. An Applicant that requests to cover less than a full County will be required to provide additional information and its reasoning for the request in its Application. OHA will consider requests during Application evaluation. These Applicant requests and subsequent OHA responses do not limit OHA in any way from requiring additional changes to an Applicant's proposed Service Area based on OHA's needs and the needs of its Members. Applicants should submit this information in an Excel document according to naming conventions identified elsewhere in this RFA.

Service Area Table

County (List each desired County separately)	**Maximum Number of Members-Capacity Level**

In some areas the patterns of care may be such that Members seek care in an adjoining county. Applicant may choose to contract with Providers located outside the Service Area covered to ensure sufficient access to care for Members. The Service Area places no restriction on the location or distribution of an Applicant's Provider Network. The Applicant will receive rates for each county. If a

prospective Applicant has no Provider Panels, the Applicant must submit information that supports their ability to provide coverage for those Members in the Service Area(s) they are applying. In determining Service Area(s) Applicants must consider the allowable driving distance and time to Primary Care Physicians (PCP) and any other Provider type outlined in contract or OAR 410-141-3220.

12. Standards Related To Provider Participation (recommended page limit 5 pages)

a. Standard #1 - Provision of Coordinated Care Services

The Applicant has the ability to deliver or arrange for all the Coordinated Care Services that are Medically Necessary and reimbursable.

In the context of the Applicant's Community health assessment and approach for providing integrated and coordinated care, to assess whether the Applicant has the ability to deliver services, the delivery system network data must be submitted in the required formats and evaluated.

Based upon the Applicant's Community health assessment and plan for delivery of integrated and coordinated health, mental health, and substance use disorder treatment services and supports and oral health services, 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:

- Acute Inpatient Hospital Psychiatric Care
- Addiction treatment
- Ambulance and emergency Medical Transportation
- Assertive Community Treatment
- Community Health Workers
- Community prevention services
- Dialysis services
- Family Planning Services
- Federally Qualified Health Centers
- Health Care Interpreters (qualified/certified)
- Health education, health promotion, health literacy
- Home health
- Hospice
- Hospital
- Imaging
- Intensive Case Management
- Mental health Providers
- Navigators
- Non-Emergent Medical Transportation

- Oral health Providers
- Palliative care
- Patient-Centered Primary Care Homes
- Peer specialists
- Pharmacies and durable medical Providers
- Rural health centers
- School-based health centers
- Specialty Physicians
- Substance use disorder treatment Providers
- Supported Employment
- Tertiary Hospital services
- Traditional Health Workers
- Tribal and Urban Indian Health Services
- Urgent care center
- Women's health services
- Others not listed but included in the Applicant's integrated and coordinated service delivery network.

INSTRUCTIONS: Submit the information in about each Provider or facility using the DSN Provider Report Template in Excel for all Provider or facility types in Applicant's Provider Network. The DSN Provider Report does not count toward overall page limits.

Note: As part of the Readiness Review process, Applicants will need to provide signature pages and credentialing details for Physician and Provider contracts that the OHA reviewers select based upon the OHA DSN Provider Report and Facility tables that are a part of the initial Application submission.

b. Standard #2 – Providers for Members with Special Health Care Needs (recommended page limit 1 page)

In the context of the Applicant's Community health assessment and approach for providing integrated and coordinated care, Applicant shall ensure those Members who have Special Health Care Needs such as those who are aged, blind, disabled, or who have high health care needs, multiple chronic conditions, mental illness or substance use disorder or who are children/youths placed in a substitute care setting by Children, Adults and Families (CAF) and the Oregon Youth Authority (OYA) (or children receiving adoption assistance from CAF), or any Member receiving DHS-funded Medicaid LTC or home and Community-based services, have access to Primary Care and Referral Providers with expertise to treat the full range of medical, oral health, and Behavioral Health and Substance Use Disorders experienced by these Members.

From those Providers and facilities identified in the DSN Provider Report Template (Standard #1 Table), identify those Providers and specialists that have special skills or sub-specialties necessary to provide a comprehensive array of Medical Services to the elderly, disabled populations and children/youths in substitute care or Members who have high health care needs, multiple chronic conditions, mental illness or substance use disorder. In narrative form, describe their qualifications and sub-specialties to provide Coordinated Care Services to these Members.

c. Standard #3 – Publicly funded public health and Community mental health services (recommended page limit 1½ pages)

Under ORS 414.153, Applicants must execute agreements with publicly funded Providers for authorization of and payment for point-of-contact services (i.e. immunizations, sexually transmitted diseases and other communicable diseases) and for cooperation with the local mental health authorities unless cause can be demonstrated that such an agreement is not feasible.

Submit the following table in an Excel format, detailing Applicant's involvement with publicly funded health care and service programs. Include those publicly funded health care and service programs with which you have subcontracts. Table does not count toward overall page limits.

Publicly Funded Health Care and Service Programs Table

Name of publicly funded program	Type of public program (i.e. County Mental Health Department)	County in which program provides service	Specialty/Sub-Specialty Codes

Other formatting conventions that must be followed are: all requested data on Applicant's Provider Network must be submitted in the exact format found in the DSN Provider Report Template (Standard #1).

(1) Describe how Applicant has involved publicly funded providers in the development of its integrated and coordinated Application.

(2) Describe the agreements with counties in the Service Area that achieve the objectives in ORS 414.153(4). If any of those agreements are under negotiation, the Applicant must submit the executed agreement prior to OHA issuing the CCO Contract.

(3) If Applicant does not have signed agreements with counties, as providers of services or as required by ORS 414.153(4), describe good faith efforts made to obtain such agreements and why such agreements are not feasible.

d. Standard #4 – Services for the American Indian/Alaska Native Population (AI/AN) (recommended limit ½ page)

(1) Please describe your experience and ability to provide culturally relevant Coordinated Care Services for the AI/AN population.

e. Standard #5 – Indian Health Services (IHS) and Tribal 638 facilities (recommended limit 1 page)

(1) 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.

(2) Please describe your experience working with Indian Health Services and Tribal 638 facilities.

- Include your Referral process when the IHS or Tribal 638 facility is not a participating panel Provider.

- Include your Prior Authorization process when the Referral originates from an IHS or Tribal 638 facility that is not a Participating Provider.

f. Standard #6 – Pharmacy Services and Medication Management (recommended limit 5 pages)

(1) Describe Applicant's experience and ability to provide a prescription drug benefit as a Covered Service for funded Condition/Treatment Pairs.

(2) Specifically describe the Applicant's:

- Ability to use a restrictive formulary as long as it allows access to other drug products not on the formulary through some process such as Prior Authorization.
- Formulary development that includes FDA approved drug products for each therapeutic class and at least one item in each therapeutic class of over-the-counter medications sufficient to ensure the availability of covered drugs with minimal prior approval intervention by the providers of Pharmaceutical Services, e.g. pharmacies.
- Development of clinically appropriate utilization controls.
- Ability to revise a formulary periodically and a description of the evidence-based review processes utilized (including how information provided by the Oregon Pharmacy & Therapeutics Committee is incorporated) and whether this work will be subcontracted or performed internally.

(3) Describe Applicant's ability to ensure an adequate pharmacy network to provide sufficient access to all enrollees and how Applicant will communicate formulary choices and changes to the network and other medical professionals and how to make non-formulary, i.e. Prior Authorization, requests.

(4) Describe Applicant's capacity to process pharmacy claims using a real-time Claims Adjudication and Provider reimbursement system and capture all relevant clinical and historical data elements for claims paid in their entirety by the CCO and when the coordination of benefits is needed to bill Third Party Liability (TPL) when the CCO is the secondary coverage.

(5) Describe Applicant's capacity to process pharmacy Prior Authorizations (PA) within the required timeframes either with in-house staff or through a Pharmacy Benefits Manager and the hours of operation that prescribers or pharmacies will be able to submit Pas.

(6) Describe Applicant's contractual arrangements with a PBM, including:

- The contractual discount percentage(s) from Average Wholesale Price (AWP) or the percentage above Wholesale Acquisition Cost (WAC) the Contractor will receive from the PBM including rebate and incentive agreements or other funds received from the PBM by the CCO or any other type of any pricing arrangements between the CCO and PBM not based on a percentage discount from AWP or the percentage above WAC.
- The dispensing fees associated with each category or type of prescription (for example: generic, brand name, mail order, retail choice 90, specialty).
- The administrative fee to be paid to the PBM by CCO on a quarterly basis including a description of the associated administrative fee for each category or type and a description of the amount and type of any other administrative fees paid to PBM by Contractor.

(7) Describe Applicant's ability to engage and utilize 340B enrolled Providers and pharmacies as a part of the CCO including:

- Whether Applicant is currently working with FQHCs and Hospitals; and if so,
- How Applicant ensures the 340B program is delivering effective adjunctive programs that are being funded by the delta between what CCOs pay for their drugs and their acquisition costs; and
- How the Applicant is evaluating the impact of these adjunctive programs whether they are generating positive outcomes.

(8) Describe Applicant's ability and intent to use Medication Therapy Management (MTM) as part of a Patient-Centered Primary Care Home.

(9) Describe Applicant's ability to utilize E-prescribing and its interface with Electronic Medical Records (EMR).

(10) Describe Applicant's capacity to publish formulary and Prior Authorization criteria on a public website in a format useable by Providers and Members.

g. Standard #7 – Hospital Services (recommended limit 4 pages)

(1) Describe how the Applicant will assure access for Members to Inpatient and outpatient Hospital services addressing timeliness, amount, duration and scope equal to other people within the same Service Area.

- Indicate what services, if any, cannot be provided locally and what arrangements have been made to accommodate Members who require those services.
- Describe any contractual arrangements with out-of-state hospitals.
- Describe Applicant's system for monitoring equal access of Members to Referral Inpatient and outpatient Hospital services.

(2) Describe how the Applicant will educate Members about how to appropriately access care from Ambulance, Emergency Rooms, and urgent care/walk-in clinics, and less intensive interventions other than their Primary Care home. Specifically, please discuss:

- What procedures will be used for tracking Members' inappropriate use of Ambulance, Emergency Rooms, and urgent care/walk-in clinics, other than their Primary Care home.
- Procedures for improving appropriate use of Ambulance, Emergency Rooms, and urgent care/walk-in clinics.

(3) Describe how the Applicant will monitor and adjudicate claims for Provider Preventable Conditions based on Medicare guidelines for the following:

- Adverse Events; and
- Hospital Acquired Conditions (HACs).

(4) Describe the Applicant's Hospital readmission policy, and how it will enforce and monitor this policy.

(5) Please describe innovative strategies that could be employed to decrease unnecessary Hospital utilization.

(6) Please describe how you will coordinate with Medicare Providers and, as applicable, Medicare Advantage plans to reduce unnecessary ED visits or hospitalization for potentially preventable conditions and to reduce readmission rates for Fully Dual Eligible Members.