Attachment 2 - Application Checklist

The checklist presented in this Attachment 2 is provided to assist Applicants in ensuring that Applicant submits a complete Application. Please complete and return with Application. This Application Checklist is for the Applicant's convenience and does not alter the Minimum Submission requirements in Section 3.2.

	Application Submission Materials, Mandatory Except as Noted
☑	Attachment 1 – Letter of Intent
☑	Attachment 2 – Application Checklist
☑	Attachment 3 – Applicant Information and Certification Sheet
☑	Executive Summary
☐	Full County Coverage Exception Requests (Section 3.2) **(Optional)**
☑	Reference Checks (Section 3.4.e.)
☑	Attachment 4 – Disclosure Exemption Certificate
☑	Attachment 4 – Exhibit 3 - List of Exempted Information.
☑	Attachment 5 – Responsibility Check Form
☑	Attachment 6 – General Questionnaire
☑	Attachment 6 – Narratives
☑	Attachment 6 – Articles of Incorporation
☑	Attachment 6 – Chart or listing presenting the identities of and interrelationships between the parent, Affiliates and the Applicant.
☑	Attachment 6 – Subcontractor and Delegated Entities Report
☑	Attachment 7 – Provider Participation and Operations Questionnaire
☑	Attachment 7 – DSN Provider Report
☑	Attachment 8 – Value-Based Payments Questionnaire
☑	Attachment 8 – RFA VBP Data Template
☑	Attachment 9 – Health Information Technology Questionnaire
☑	Attachment 10 – Social Determinants of Health and Health Equity Questionnaire
☑	Attachment 11 – Behavioral Health Questionnaire
☑	Attachment 12 – Cost and Financial Questionnaire
☑	Attachment 12 – Pro Forma Workbook Templates (NAIC Form 13H)
☑	Attachment 12 – NAIC Biographical Certificate (NAIC Form 11)
☑	Attachment 12 – UCAA Supplemental Financial Analysis Workbook Template
☑	Attachment 12 – Three years of Audited Financial Reports
☑	Attachment 13 – Attestations
☑	Attachment 14 – Assurances
☑	Attachment 15 – Representations
☑	Attachment 16 – Member Transition Plan
☑	Redacted Copy of Application Documents for which confidentiality is asserted. All redacted items must be separately claimed in Attachment 4. **(Optional)**

Attachment 3 - Application Information and Certification Sheet

Legal Name of Proposer: Columbia Pacific CCO, LLC

Address: 315 SW 5th Avenue
Portland, OR 97204

State of Incorporation: Oregon **Entity Type:** LLC

Contact Name: Mimi Haley **Phone:** 503.416.3679 **Email:** haleym@careoregon.org

Oregon Business Registry Number: 852741-90

Any individual signing below hereby certifies they are an authorized representative of Applicant and that:

1. Applicant understands and accepts the requirements of this RFA. By submitting an Application, Applicant acknowledges and agrees to be bound by (a) all the provisions of the RFA (as modified by any Addenda), specifically including RFA Section 6.2 (Governing Laws) and 6.4 (Limitation on Claims); and (b) the Contract terms and conditions in Appendix B, subject to negotiation and rate finalization as described in the RFA.
2. Applicant acknowledges receipt of any and all Addenda to this RFA.
3. Application is a firm offer for 180 days following the Closing.
4. If awarded a Contract, Applicant agrees to perform the scope of work and meet the performance standards set forth in the final negotiated scope of work of the Contract.
5. I have knowledge regarding Applicant's payment of taxes. I hereby certify that, to the best of my knowledge, Applicant is not in violation of any tax laws of the state or a political subdivision of the state, including, without limitation, ORS 305.620 and ORS chapters 316, 317 and 318.
6. I have knowledge regarding Applicant's payment of debts. I hereby certify that, to the best of my knowledge, Applicant has no debts unpaid to the State of Oregon or its political subdivisions for which the Oregon Department of Revenue collects debts.
7. Applicant does not discriminate in its employment practices with regard to race, creed, age, religious affiliation, gender, disability, sexual orientation, national origin. When awarding subcontracts, Applicant does not discriminate against any business certified under ORS 200.055 as a disadvantaged business enterprise, a minority-owned business, a woman-owned business, a business that a service-disabled veteran owns or an emerging small business. If applicable, Applicant has, or will have prior to Contract execution, a written policy and practice, that meets the requirements described in ORS 279A.112 (formerly HB 3060), of preventing sexual harassment, sexual assault and discrimination against employees who are members of a protected class. OHA may not enter into a Contract with an Applicant that does not certify it has such a policy and practice. See https://www.oregon.gov/DAS/Procurement/Pages/hb3060.aspx for additional information and sample policy template.
8. Applicant and Applicant's employees, agents, and subcontractors are not included on:
   a. the "Specially Designated Nationals and Blocked Persons" list maintained by the Office of Foreign Assets Control of the United States Department of the Treasury found at: https://www.treasury.gov/ofac/downloads/sdnlist.pdf., or
   b. the government wide exclusions lists in the System for Award Management found at: https://www.sam.gov/portal/

9. Applicant certifies that, to the best of its knowledge, there exists no actual or potential conflict between the business or economic interests of Applicant, its employees, or its agents, on the one hand, and the business or economic interests of the State, on the other hand, arising out of, or relating in any way to, the subject matter of the RFA, except as disclosed in writing in this Application. If any changes occur with respect to Applicant's status regarding conflict of interest, Applicant shall promptly notify OHA in writing.

10. Applicant certifies that all contents of the Application (including any other forms or documentation, if required under this RFA) and this Application Certification Sheet are truthful and accurate and have been prepared independently from all other Applicants, and without collusion, Fraud, or other dishonesty.

11. Applicant understands that any statement or representation it makes, in response to this RFA, if determined to be false or fraudulent, a misrepresentation, or inaccurate because of the omission of material information could result in a "claim" {as defined by the Oregon False Claims Act, ORS 180.750(1)}, made under Contract being a "false claim" {ORS 180.750(2)} subject to the Oregon False Claims Act, ORS 180.750 to 180.785, and to any liabilities or penalties associated with the making of a False Claim under that Act.

12. Applicant acknowledges these certifications are in addition to any certifications required in the Contract and Statement of Work in Attachment 10 at the time of Contract execution.

Signature: _____ **Title:** Executive Director, CPCCO **Date:** 4/19/19

(Authorized to Bind Applicant)

State of OR)

) ss:

County of Multnomah

Signed and sworn to before me on 4-19-19 (date) by Mimi Haley (Affiant's name).

Lorinda S. Koller

Notary Public for the State of OR

My Commission Expires: 2/22/20

OFFICIAL STAMP
LORINDA SUE KOLLER
NOTARY PUBLIC-OREGON
COMMISSION NO. 947695
MY COMMISSION EXPIRES FEBRUARY 22, 2020

Attachment 4 - Disclosure Exemption Certificate

Erin Fair Taylor ("Representatve"), representing Columbia Pacific CCO, LLC ("Applicant"), hereby affirms under penalty of False Claims liability that:

1. I am an officer of the Applicant. I have knowledge of the Request for Application referenced herein. I have full authority from the Applicant to submit this Certificate and accept the responsibilities stated herein.
2. I am aware that the Applicant has submitted an Application, dated on or about April 22, 2019 (the "Application"), to the State of Oregon in response to Request for Application #OHA-4690-18 for CCO 2.0 (the RFA). I am familiar with the contents of the Application.
3. I have read and am familiar with the provisions of Oregon's Public Records Law, Oregon Revised Statutes ("ORS") 192.311 through 192.478, and the Uniform Trade Secrets Act as adopted by the State of Oregon, which is set forth in ORS 646.461 through ORS 646.475. I understand that the Application is a public record held by a public body and is subject to disclosure under the Oregon Public Records Law unless specifically exempt from disclosure under that law.
4. I have checked Box A or B as applicable:

A. [X] The Applicant believes the information listed in Exhibit A to this Exhibit 4 is exempt from public disclosure (collectively, the "Exempt Information"), which is incorporated herein by this reference. In my opinion, after consulting with a person having expertise regarding Oregon's Public Records Law, the Exempt Information is exempt from disclosure under Oregon's Public Records Law under the specifically designated sections as set forth in Exhibit A or constitutes "Trade Secrets" under either the Oregon Public Records Law or the Uniform Trade Secrets Act as adopted in Oregon. Wherever Exhibit A makes a claim of Trade Secrets, then Exhibit A indicates whether the claim of trade secrecy is based on information being:

1. A formula, plan, pattern, process, tool, mechanism, compound, procedure, production data, or compilation of information that:
   - **i.** is not patented,
   - **ii.** is known only to certain individuals within the Applicant's organization and that is used in a business the Applicant conducts,
   - **iii.** has actual or potential commercial value, and
   - **iv.** gives its user an opportunity to obtain a business advantage over competitors who do not know or use it.

Or

2. Information, including a drawing, cost data, customer list, formula, pattern, compilation, program, device, method, technique or process that:
   - **i.** Derives independent economic value, actual or potential, from not being generally known to the public or to other persons who can obtain economic value from its disclosure or use; and
   - **ii.** Is the subject of efforts by the Applicant that are reasonable under the circumstances to maintain its secrecy.

B. [ ] Exhibit A has not been completed as Applicant attests that are no documents exempt from public disclosure.

5. The Applicant has submitted a copy of the Application that redacts any information the Applicant believes is Exempt Information and that does not redact any other information. The Applicant represents that all redactions on its copy of the Application are supported by Valid Claims of exemption on Exhibit A.
6. I understand that disclosure of the information referenced in Exhibit A may depend on official or judicial determinations made in accordance with the Public Records Law.

Representative's Signature

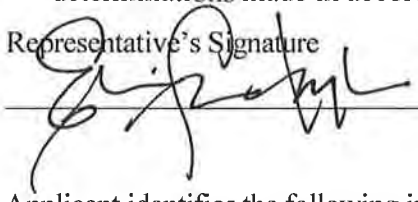


Exhibit A to Attachment 4

Applicant identifies the following information as exempt from public disclosure under the following designated exemption(s):

Section Redacted	ORS or other Authority	Reason for Redaction
Attachment 7, 7.12.f.(6)	ORS 192.501(2) (Trade Secret Exemption)	1. This section describes contractual price arrangements with CPCCO's PBM. Information in this section includes cost data and specific contractual provisions that is not patented; is only known to certain individuals in the organization; has actual commercial value; and gives user a business advantage over those who do not know it.
Attachment 8, 8.C.1 VBP Data Excel Spreadsheet Attachment 8.C.4; and 8.C.5	Uniform Trade Secrets Act, as adopted by Oregon	2. These sections describe VBP and payment arrangements in detail. This information includes formulae and cost data that derives independent economic value, is not readily ascertained by other means by others who can obtain economic value from its disclosure and is the subject of reasonable efforts to maintain its secrecy.
Attachment 12 12.D.2; and 12.D.3	ORS 192.501(2) (Trade Secret Exemption)	3. These sections describe PBM services and specific payment arrangements. Information in this section includes cost data and specific contractual provisions that are not patented; is only known to certain individuals in the organization; has actual commercial value; and gives user a business advantage over those who do not know it
Attachment 12 12.F.6 - Including Excel Pro Forma Workbooks, UCCA Excel Workbook & NAIC Biographical Affidavits	Uniform Trade Secrets Act, as adopted by Oregon	4. This section contains all Pro Forma Workgroup Templates & NAIC Biographical Affidavits and the UCCA Supplemental Financial Analysis Workbook Template includes formulae and cost data that derives independent economic value, is not readily ascertained by other means by others who can obtain economic value from its disclosure and is the subject of reasonable efforts to maintain its secrecy.
Attachment 13, 13.B.(1)(h)	ORS 192.501(2) (Trade Secret Exemption)	5. This Attestation asks Applicant to indicate whether it will make Provider contracts available to OHA in unredacted form. CPCCO attested "Yes," but CPCCO also asserts that Provider contracts or agreements produced are exempt from public disclosure because they include cost data and specific contractual provisions that are not patented; are to certain individuals in the organization; have actual commercial value; and give users a business advantage over those who do not know it

Attachment 5 - Responsibility Check Form

OHA will determine responsibility of an Applicant prior to award and execution of a Contract. In addition to this form, OHA may notify Applicant of other documentation required, which may include but is not limited to recent profit-and-loss history, current balance statements and cash flow information, assets-to-liabilities ratio, including number and amount of secured versus unsecured creditor claims, availability of short and long-term financing, bonding capacity, insurability, credit information, materials and equipment, facility capabilities, personnel information, record of performance under previous contracts, etc. Failure to promptly provide requested information or clearly demonstrate responsibility may result in an OHA finding of non-responsibility and rejection.

1. Does Applicant have available the appropriate financial, material, equipment, facility and personnel resources and expertise, or ability to obtain the resources and expertise, necessary to demonstrate the capability of Applicant to meet all contractual responsibilities?

YES ☒ **NO** ☐**.**

2. Within the last five years, how many contracts of a similar nature has Applicant completed that, to the extent that the costs associated with and time available to perform the contract remained within Applicant's Control, Applicant stayed within the time and budget allotted, and there were no contract claims by any party? Number: 2

How many contracts did not meet those standards? Number: 0 If any, please explain.

Response:

3. Within the last three years has Applicant (incl. a partner or shareholder owning 10% or more of Applicant's firm) or a major Subcontractor (receiving 10% or more of a total contract amount) been criminally or civilly charged, indicted or convicted in connection with:

- obtaining, attempting to obtain, or performing a public (Federal, state, or local) contract or subcontract,
- violation of federal or state antitrust statutes relating to the submission of bids or proposals, or
- embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, or receiving stolen property?

YES ☐ **NO** ☒

If "YES," indicate the jurisdiction, date of indictment, charge or judgment, and names and summary of charges in the response field below.

Response:

4. Within the last three years, has Applicant had:

- any contracts terminated for default by any government agency, or
- any lawsuits filed against it by creditors or involving contract disputes?

YES ☐ **NO** ☒

If "YES," please explain. (With regard to judgments, include jurisdiction and date of final judgment or dismissal.)

Response:

5. Does Applicant have any outstanding or pending judgments against it?

YES ☐ **NO** ☒.

Is Applicant experiencing financial distress or having difficulty securing financing? **YES** ☐ **NO** ☒.

Does Applicant have sufficient cash flow to fund day-to-day operations throughout the proposed Contract period?

YES ☒ **NO** ☐

If "YES" on the first question or second question, or "NO" on the third question, please provide additional details.

Response:

6. Within the last three years, has Applicant filed a bankruptcy action, filed for reorganization, made a general assignment of assets for the benefit of creditors, or had an action for insolvency instituted against it?

YES ☐ **NO** ☒.

If "YES," indicate the filing dates, jurisdictions, type of action, ultimate resolution, and dates of judgment or dismissal, if applicable.

Response:

7. Does Applicant have all required licenses, insurance and/or registrations, if any, and is Applicant legally authorized to do business in the State of Oregon?

YES ☒ **NO** ☐.

If "NO," please explain.

Response:

8. Pay Equity Certificate. This certificate is required if Applicant employs 50 or more full-time workers and the prospective Contract price is estimated to exceed $500,000. [This requirement does not apply to architectural, engineering, photogrammetric mapping, transportation planning or land surveying and related services contracts.] Does a current authorized representative of Applicant possess an unexpired Pay Equity Certificate issued by the Department of Administrative Services?

YES ☒ **NO** ☐ **N/A** ☐.

Submit a copy of the certificate with this form.

Response: Attached is CareOregon's Certificate (CareOregon provides HR services on behalf of CPCCO)

AUTHORIZED SIGNATURE

By signature below, the undersigned Authorized Representative on behalf of Applicant certifies to the best of his or her knowledge and belief that the responses provided on this form are complete, accurate, and not misleading.

Applicant Name:	RFA: OHS-4690-19-0
Columbia Pacific CCO, LLC	Project Name: CCO 2.0

Signature: _____ **Title:** Executive Director **Date:** _____

(Authorized to Bind Applicant)

Certificate of Completion

The State of Oregon, Other, Non State Employees,
hereby certifies that

CareOregon CareOregon

Has successfully completed the following:

DAS - CHRO - Overview of Pay Equity

On *4/19/2019*

Subcontractors and Delegated Entities Report

Identify any work required under the CCO contract that has been subcontracted or delegated to an entity other than the contracted CCO.

Reporting Year **Reporting Quarter**

Subcontractor/Affiliate Name	**Tax ID #** **(SSN/FEIN)**	**Correspondence Address**		
		Street Address / P.O. Box	*City*	*State*
CareOregon, Inc. (parent company to CPCCO)	93-0933975	315 SW 5th Avenue	Portland	OR

Advantage Dental	93-1195386	442 SW Umatilla Avenue, Suite 200	Redmond	Oregon
ODS	93-043877	601 SW 2nd Avenue	Portland	OR

Willamette Dental Group	93-0699253	6950 NE Campus Way	Hillsboro	OR
Capital Dental Care	93-1064094	3000 Market St, NE, Suite 228	Salem	OR
Tillamook County Transportation District, d.b.a, NW Connector		3600 Third Street, Suite A	Tillamook	OR

CCO Name: Columbia Pacific CCO, LLC (CPCCO)

		Subcontractor/Affiliate Physical Address						
Zip	*Country*	*Street Address*	*City*	*State*	*Zip*	*Country*	**Parent Company Name** *(if applicable)*	*State*
97204	USA	315 SW 5th Avenue	Portland	OR	97204	USA	N/A	N/A

97756	USA	442 SW Umatilla Avenue, Suite 200	Redmond	Oregon	97756	USA	DentaQuest	MA	
97204	USA	601 SW 2nd Avenue	Portland	OR	97204	USA	Delta Dental	CA	

97214	USA	6950 NE Campus Way	Hillsboro	OR	97214	USA	N/A	N/A
97301	USA	3000 Market St, NE, Suite 228	Salem	OR	97301	USA	Interdent	CA
97141	USA	3600 Third Street, Suite A	Tillamook	OR	97141	USA	N/A	N/A

Country	**Service Type(s)**	**Subcontractor/Affiliate Owner(s) Business Name or Individual's Last Name**	**Subcontractor/Affiliate Owner(s) Individual's First Name** *(if applicable)*
N/A	Health Plan Administration	N/A	N/A

USA	Dental Health Plan Admnistration	N/A	N/A
USA	Dental Health Plan Admnistration	N/A	N/A

USA	Dental Health/Health Plan Admnistration	N/A	N/A
USA	Dental Health Plan Admnistration	N/A	N/A
USA	NEMT	N/A	N/A

Percent Ownership	Payment Methodology	Payment Methodology: Other	Subcontract Begin Date			Subcontract End Da	
			Month	Day	Year	Month	Day
100% (CareOregon is the sole Member of CPCCO, LLC)	Subcapitation for management of physical and behavioral health services	Billed charges for administrative functions; CCO Quality Pool Metrics & Incentives	Septembe r	1	2012	Evergreen	

0%	Sub-Capitation for Assigned Population	CCO Quality Pool Metrics & Incentive Payments	January	1	2019	December	31

0%	Sub-Capitation for Assigned Population	CCO Quality Pool Metrics & Incentive Payments	January	1	2019	December	31

0%	Sub-Capitation for Assigned Population	CCO Quality Pool Metrics & Incentive Payments	January	1	2019	December	31
0%	Sub-Capitation for Assigned Population	CCO Quality Pool Metrics & Incentive Payments	January	1	2019	December	31
0%	Subcapitation for NEMT services		July	1	2018	December	31

te Year	Date of most recent Compliance Review	Downstream Delegation of Services	Describe the work being Subcontracted or Delegated
	Ongoing internal audit & compliance reviews; EQR performed on CareOregon's functions on behalf of CPCCO was July, 2018.	CPCCO uses NCQA standards for delegation oversight. NCQA waives review of oversight when the organization is owned by or under common control with another organization that performs the function. Instead, CPCCO and CareOregon maintain mutually agreed-upo documents that describe & measure functions performed.	Benefit administration of physical & behavioral health services, claims payment, care coordination, utilization management, member and provider communications, network development and oversight, audit and compliance, pharmacy, HIT, program development, grievances and appeals, delegation oversight, and risk and financial management and reporting. CareOregon also provides general administrative support to CPCCO, including, but not limited to human resources and legal.

2019	October, 2018	N/A	CPCCO delegates the administration of the oral health benefit, including dental provider network development and oversight, utilization management, credentialing, care coordination, claims payment and adjudication, initial intake and investigation of grievances, and assisting CPCCO in any appeals of DCO's NOABD.
2019	October, 2018	N/A	CPCCO delegates the administration of the oral health benefit, including dental provider network development and oversight, utilization management, credentialing, care coordination, claims payment and adjudication, initial intake and investigation of grievances, and assisting CPCCO in any appeals of DCO's NOABD.

			CPCCO delegates the administration of the oral health benefit, including dental provider network development and oversight, utilization management, credentialing, care coordination, claims payment and adjudication, initial intake and investigation of grievances, and assisting CPCCO in any appeals of DCO's NOABD.
2019	October, 2018	N/A	
			CPCCO delegates the administration of the oral health benefit, including dental provider network development and oversight, utilization management, credentialing, care coordination, claims payment and adjudication, initial intake and investigation of grievances, and assisting CPCCO in any appeals of DCO's NOABD.
2019	October, 2018	N/A	
			CPCCO delegates the administration of the NEMT benefit to TCTD, including transportation network development, ride coordination, credentialing, and claims administration.
2019	N/A - will have a review in June	N/A	

Secretary of State
Corporation Division
255 Capitol Street NE, Suite 151
Salem, OR 97310-1327

Phone:(503)986-2200
www.filinginoregon.com

Registry Number: 852741-90
Type: DOMESTIC LIMITED LIABILITY COMPANY

Next Renewal Date: 04/27/2013

CAREOREGON, INC.
315 SW FIFTH AVE
PORTLAND OR 97204

Acknowledgment Letter

The document you submitted was recorded as shown below. Please review and verify the information listed for accuracy.

Document
ARTICLES OF ORGANIZATION

Filed On
04/27/2012

Jurisdiction
OREGON

Name
COLUMBIA PACIFIC CCO, LLC

Registered Agent
CAREOREGON, INC.
315 SW FIFTH AVE
PORTLAND OR 97204

ROBCON
ACK
04/27/2012

852741-90

FILED

APR 27 2012

OREGON
SECRETARY OF STATE

ARTICLES OF ORGANIZATION
OF
COLUMBIA PACIFIC CCO, LLC

The undersigned individual of the age of eighteen years or more, acting as organizer under the Oregon Limited Liability Company Act (the "Act"), adopts the following articles of organization:

I.

The name of the limited liability company is Columbia Pacific CCO, LLC.

II.

The duration of the limited liability company is perpetual.

III.

The name of the initial registered agent is CareOregon, Inc.

IV.

The address of the initial registered office of the limited liability company is 315 SW Fifth Avenue, Portland, Oregon 97204. The Corporation Division may mail notices to the registered agent's address.

V.

The name and address of the organizer is David E. Ford, 315 SW Fifth Avenue, Portland, Oregon 97204.

VI.

The limited liability company will be managed by managers.

Dated: April 27, 2012.

David E. Ford

David E. Ford, Organizer

Person to Contact about this Filing:
Brenda Ayers
503-226-1191

6.A.1.m. Provide a chart (as a separate document, which will not be counted against page limits) identifying Applicant's contact name, telephone number, and email address for each of the following:

- ***The Application generally,***
- ***Each Attachment to the RFA (separate contacts may be furnished for parts),***
- ***The Sample Contract generally,***
- ***Each Exhibit to the Sample Contract (separate contacts may be furnished for parts),***
- ***Rates and solvency,***
- ***Readiness Review (separate contacts may be furnished for parts), and***
- ***Membership and Enrollment***

Please see chart below:

	Contact Name	Telephone Number	Email Address
Application Generally	Mimi Haley	503.416.3679	haleym@careoregon.org
Each Attachment to RFA	Erin Fair Taylor	503.416.1797	faire@careoregon.org
Sample Contract Generally	Monica Martinez	503.416.4934	martinezm@careoregon.org
Each Exhibit to the Sample Contract	Monica Martinez	503.416.4934	martinezm@careoregon.org
Rates and Solvency	Teresa Learn	503.416.1415	learnt@careoregon.org
Readiness Review	Erin Fair Taylor	503.416.1797	faire@careoregon.org
Membership and Enrollment	Jim Gardner	503.416.5824	gardnerj@careoregon.org

Attachment 6 - General Questions

6.A. Background Information about the Applicant

6.A.1. Questions

Describe the Applicant's Legal Entity status, and where domiciled.

Columbia Pacific CCO, LLC (CPCCO) is a limited liability corporation (LLC) with its principle place of business at the CareOregon, Inc. headquarters, 315 SW 5th Avenue, Portland, OR 97204. CPCCO also maintains a local office in Seaside, OR.

6.A.1.a. Describe Applicant's Affiliates as relevant to the Contract.

CareOregon, Inc. is the sole member of CPCCO. It is also the entity that performs most CCO administrative functions, health plan operations, and benefit administrative functions. CareOregon maintains CPCCO's physical and behavioral health networks and oversees the benefit administration for these service types on behalf of CPCCO. CPCCO also contracts with Advantage Dental, Capitol Dental, ODS Community Health, and Willamette Dental to administer the dental benefit and ensure access to dental care services. Finally, CPCCO contracts with Tillamook County Transportation District to ensure access to non-emergent medical transportation (NEMT) services for CPCCO members.

6.A.1.b. Is Applicant invoking alternative dispute resolution with respect to any Provider? (see OAR 410-141-3268)? If so, describe.

No.

6.A.1.c. What is the address for the Applicant's primary office and administration located within the proposed Service Area?

CPCCO operates a local office at 135 N. Roosevelt, Suite 101, Seaside, OR 97138. However, most of CPCCO's administrative activities happen out and about in the local communities rather than at an office location. For example: CPCCO maintains Community Advisory Councils in each of the three counties; board meetings rotate around the service area; and panel coordinators are embedded with primary care teams. Most of the back-office administrative work, including but not limited to claims administration, customer service, finance, communications and contracting, are based in the CareOregon building at 315 SW 5th Avenue, Portland, OR 97204.

6.A.1.d. What counties are included in this Service Area? Describe the arrangements the Applicant has made to coordinate with county governments and establish written agreements as required by ORS 414.153.

Columbia, Clatsop and Tillamook counties are included in the CPCCO service area. Through CareOregon, CPCCO has had direct service contracts in place with each of the local public health departments for years. The contracts are amended as needed and are current as of this writing. The contracts include the full array of services included in ORS 414.153 including, but not limited to, services provided for sexually transmitted diseases, immunizations, family planning and maternity case management.

6.A.1.e. Prior history:

6.A.1.e.(1) Is Applicant the Legal Entity that has a contract with OHA as a CCO as of January 1, 2019 (hereinafter called "Current CCO")?

Yes.

6.A.1.e.(2). If no to 1, is Applicant the Legal Entity that had a contract with OHA as a CCO prior to January 1, 2019?
N/A.

6.A.1.e.(3). If no to 1 and 2, is Applicant an Affiliate with or a Risk Assuming Entity of a CCO that has a current or prior history with OHA?
N/A.

6.A.1.e.(4). If no to 1, 2, and 3, what is Applicant's history of bearing health care risk in Oregon?
N/A.

6.A.1.f. Current experience as an OHA contractor, other than as a Current CCO. Does this Applicant (or an Affiliate of Applicant) currently have a contract with the OHA as a licensed insurer or health plan third party administrator for any of the following (hereinafter called "Current OHA Contractor")? If so, please provide that information in addition to the other information required in this section.

- **Public Employees Benefit Board** - No
- **Oregon Educators Benefit Board** - No
- **Adult Mental Health Initiative** - No
- **Cover All Kids** - YES; CPCCO holds a contract to administer the Cover All Kids benefits for eligible enrollees.
- **Other (please describe)** - N/A

6.A.1.g. Does the Applicant (or an Affiliate of Applicant) have experience as a Medicare Advantage contractor? Does the Applicant (or an Affiliate of Applicant) have a current contract with Medicare as a Medicare Advantage contractor? What is the Service Area for the Medicare Advantage plan?
Yes. CareOregon operates a Medicare Advantage plan (CareOregon Advantage). The service area includes Clackamas, Columbia, Jackson, Multnomah, Tillamook, and Washington counties.

6.A.1.h. Does Applicant have a current Dual Special Needs Coordination of Benefits Agreement with OHA to serve Fully Dual Eligible Members?
Yes. CareOregon's Medicare Advantage plan is a Dual Special Needs Plan (D-SNP).

6.A.1.i. Does the Applicant (or an Affiliate of Applicant) hold a current certificate of authority for transacting health insurance or the business of a health care service contractor, from the Department of Consumer and Business Services, Division of Financial Regulation?
No. CareOregon maintains a license with DCBS to offer a Medicare product only.

6.A.1.j. Does the Applicant (or an Affiliate of Applicant) hold a current contract effective January 1, 2019, with the Oregon Health Insurance Marketplace?
No.

6.A.1.k. Describe Applicant's demonstrated experience and capacity for 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 Applicant's enrollees and in Applicant's Community.
CPCCO was initially awarded a contract in 2012 to operate as a CCO. In the intervening seven years, CPCCO has developed deep relationships with community members and providers in its tri-county service area to improve health and reduce disparities. CPCCO uses committees, councils, learning collaboratives, leadership meetings and outreach vehicles to engage community members

and health care providers to improve health outcomes for OHP members and their communities. The following provide examples of ways CPCCO has engaged the community, demonstrating our experience and capacity.

Overall organizational input and guidance from community members and providers. Three local Community Advisory Councils (CACs), one for each county in the CPCCO service area, meet monthly and one Regional Community Advisory Council meets quarterly, all comprised of members and local service providers. The CACs provide direct community input into CPCCO decisions. See attachments 6, 7 and 10 for more detail. A regional, multidisciplinary Clinical Advisory Panel meets bi-monthly. These meetings seek clinical input into specific initiatives such as opioid prescribing and addictions programs, and into opportunities to improve access, member engagement, equity and quality.

Local input, including engagement on specific health topics. Collaborations with local community health coalitions in each county, such as in Clatsop County, where CPCCO is staffing one of five national community health improvement collaboratives, *Way to Wellville*, that convenes local leaders to focus on social/emotional health (ACEs) for children and prevention/intervention for specific populations (i.e. adults with hypertension). CPCCO staff participate as active members of the Tillamook County Wellness initiative and the Columbia County Health Coalition; Tillamook is currently focused on diabetes prevention and Columbia on suicide prevention.

Provider Collaboratives and Engagement. CPCCO convenes numerous collaboratives. The Patient and Population Centered Primary Care Collaborative, including all PCPCH-certified primary care clinics in the CPCCO service area, meets on a bi-monthly basis to share best practices in transforming clinics to fully integrated medical homes, including with behavioral health. Monthly behavioral health peer-to-peer meetings of integrated primary care behavioral clinicians promotes the adoption of behavioral health as a routine part of primary care. Bi-monthly or quarterly meetings between CPCCO and clinical and administrative leadership of the nine largest primary care clinics discuss data and qualitative information on issues such as quality metrics and improvement, local clinic initiatives and pilot programs. The cross regional learning collaborative for primary care meets monthly to help engage clinical operational staff in health improvements. CPCCO has also supported communities of practice, in each county to ground clinicians in evidence-based practice and engage them to improve health outcomes.

Broad community outreach and data gathering for all community members. More than 25 events have been sponsored and with open invitations to all residents of each community. The events share information on community health needs identified through primary and secondary data collection and gather community priorities for health improvements included in the 2014 and 2019 CPCCO Regional Community Health Improvement Plans (RHIP). See Attachment 10.

6.A.1.l. Identify and furnish résumés for the following key leadership personnel (by whatever titles designated):

- **Chief Executive Officer** Mimi Haley
- **Chief Financial Officer** Teresa Learn
- **Chief Medical Officer** Safina Koreishi
- **Chief Information Officer** Nate Corley
- **Chief Administrative or Operations Officer** Amy Dowd

6.A.1.m. Provide a chart (as a separate document, which will not be counted against page limits) identifying Applicant's contact name, telephone number, and email address for each of the following:

- ***The Application generally,***
- ***Each Attachment to the RFA (separate contacts may be furnished for parts),***

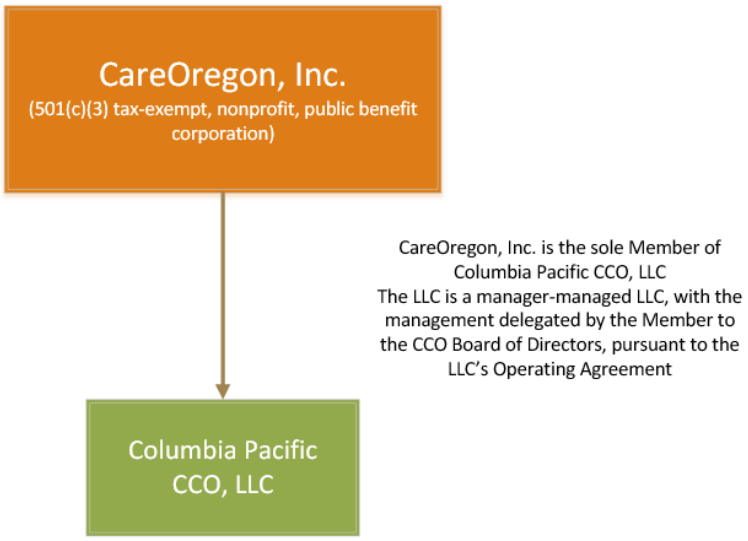
- ***The Sample Contract generally,***
- ***Each Exhibit to the Sample Contract (separate contacts may be furnished for parts),***
- ***Rates and solvency,***
- ***Readiness Review (separate contacts may be furnished for parts), and***
- ***Membership and Enrollment***

Please see chart provided as separate document.

6.A.2.Required Documents: Background Narrative; Résumés (excluded from pages limit); Contact list (excluded from pages limit)

6.B. Corporate Organization and Structure
6.B.1.a. Provide a certified copy of the Applicant's articles of incorporation, or other similar legal entity charter document, as filed with the Oregon Secretary of State or other corporate chartering office.
Please see the attached copy of CPCCO's articles of incorporation.

6.B.1.b. Provide an organization chart listing of ownership, Control or sponsorship, including the percentage Control each person has over the organization.
CareOregon, Inc. is the sole member of Columbia Pacific CCO, LLC. Since CareOregon, Inc. is a non-profit, public benefit corporation, it has no owners.



6.B.1.c. Describe any licenses the corporation possesses.
CPCCO does not possess any licenses.

6.B.1.d. Describe any administrative service or management contracts with other parties where the Applicant is the provider or Recipient of the services under the contract. Affiliate contracts are excluded in this item and should be included under Section C.
CPCCO only contracts with CareOregon for administrative or management services.

2. Required Documents: Articles of Incorporation (excluded from page limit); Narrative b-d.

6.C. Corporate Affiliations, Transactions, Arrangements
6.C.1.a. Provide an organization chart or listing presenting the identities of and interrelationships between the parent, the Applicant, Affiliated insurers and reporting entities, and other Affiliates. The organization chart must show all lines of ownership or Control up to Applicant's ultimate controlling person, all subsidiaries of Applicant,

and all Affiliates of Applicant that are relevant to this Application. When interrelationships are a 50/50% ownership, footnote any voting rights preferences that one of the entities may have. For each entity, identify the corporate structure, two–character state abbreviation of the state of domicile, Federal Employer's Identification Number, and NAIC code for insurers. Schedule Y of the NAIC Annual Statement Blank—Health is acceptable to supply any of the information required by this question. If a subsidiary or other Affiliate performs business functions for Applicant, describe the functions in general terms.

CareOregon, Inc. is the sole member of Columbia Pacific CCO, LLC. CareOregon, Inc. is a non-profit, public benefit corporation.

Name	Relationship to Applicant	Corporate Structure	State of Domicile	FEIN	NAIC code
CareOregon, Inc.	Sole Member of Applicant	Non-profit, public benefit corporation	OR		
Columbia Pacific CCO, LLC	Applicant	Limited Liability Corporation	OR		

6.C.1.b. Describe of any expense arrangements with a parent or Affiliate organization. Provide detail of the amounts paid under such arrangements for the last two years. Provide footnotes to the operational budget when budgeted amounts include payments to Affiliates for services under such agreements.

CPCCO has three different financial arrangements with its parent, CareOregon: a delegation agreement, a management services agreement and a community risk share arrangement. Under the delegation agreement, CPCCO delegates the physical health benefit to CareOregon. By 2020, CPCCO will also be delegating the behavioral and NEMT benefit to CareOregon. The physical health delegation expense was $112.9 million and $104.7 million in 2018 and 2017 respectively. Under the management services agreement, CareOregon provides administrative services to the CCO such as accounting, human resources, information systems support and leased employees. These MSA expenses were $1.7 million and $1.5 million in 2018 and 2017 respectively. Under the community risk share arrangement, CareOregon shares half of the surplus it generates with the CCO and contracted providers. Surplus shared by CareOregon under this arrangement was $1.4 million and $0 in 2018 and 2017, respectively.

6.C.1.c. Describe Applicant's demonstrated experience and capacity for: Managing financial risk and establishing financial reserves, and Meeting the minimum financial requirements for restricted reserves and net worth in OAR 410-141-3350.

Managing financial risk and establishing financial reserves

CPCCO is wholly owned by and delegates all physical and behavioral health risk to CareOregon, which has 25 years of successfully managing Medicaid risk in Oregon. CareOregon bears risk for 250,000 members across multiple CCOs and closely monitors its reserves to be sure they meet industry standard risk-based capital levels. CareOregon has long term expertise in estimating IBNR and other risk related financial estimates as well as in calculating risk-based capital as required by regulated insurance companies in Oregon. CareOregon manages and mitigates its risk in numerous ways such as through reinsurance policies, clinical management, provider contracting, payment integrity efforts and other practices and arrangements. In addition to the financial reserves maintained at CareOregon, CPCCO holds reserves to meet the OHA requirements. CPCCO has consistently met these requirements over the seven years serving as a CCO.

Meeting the minimum financial requirements for restricted reserves and net worth in OAR 410-141-3350.

CPCCO has served as a CCO for seven years and has consistently met the minimum restricted

reserve and net worth requirements as outlined in the OARs. When CPCCO grew as a result of the ACA expansion, CPCCO made sure to increase its reserve requirements accordingly. CPCCO holds a management services agreement with CareOregon to prepare all financial reporting and so has long term experience in calculating and monitoring the reserve requirements. Also, as a wholly owned entity of CareOregon, CPCCO has the ability to look to CareOregon to meet reserve requirements when needed.

6.C.2. Required Documents: Item a., an organization chart or listing (excluded from page limit); Narrative for Items b and c

6.D.Subcontracts

6.D.1.a. Please identify and describe any business functions the Contractor subcontracts or delegates to Affiliates.

CPCCO delegates the management of the physical health, behavioral health and non-emergent medical transportation benefit to CareOregon. This delegation agreement includes claims administration, pharmacy, utilization management and benefit determination, network management, customer and provider services, communications, audit and compliance functions, contract administration, financial management, reporting, care coordination, HIT and program development.

In addition, CPCCO maintains a management services agreement with CareOregon to provide administrative functions such as human resources, audit and compliance, finance, information services, regulatory affairs, and overall CCO administration and reporting.

6.D.1.b. What are the major subcontracts Applicant expects to have? Please provide an example of subcontracted work and describe how Applicant currently monitors Subcontractor performance or expects to do so under the Contract. (example of subcontracted work does not count toward page limit)

Yes, subcontracts are expected. Please see information following document.

6.D.2. Required Documents: Narrative for Items a and b

6.E.Third Party Liability

6.E.1.a. How will Applicant ensure the prompt identification of Members with TPL across its Provider and Subcontractor network?

CPCCO, through CareOregon, has a coordination of benefits policy that addresses our procedure of coordinating benefits as a payor of last resort for our Medicaid & Medicare members in accordance with state and federal laws.

6.E.1.b. How will Applicant ensure the prompt identification of Members covered by Medicare across its Provider and Subcontractor network?

CPCCO, through CareOregon, has a system in place in which it loads any OIC (Other Insurance Coverage) information from the state or CMS files into our claims processing system. We also contract with a vendor which processes our MSP (Medicare as a Second Payer) files. CPCCO, in coordination with CareOregon, does our own internal investigation in accordance with the coordination of benefits policy that addresses CareOregon's procedure of coordinating benefits as a payor of last resort for our Medicaid & Medicare members in accordance with state and federal laws.

6.E.2. Required Documents: Narrative for Items a and b

6.F.Oversight and Governance

6.F.1.a. Applicant's governing board, how board members are elected or appointed, how the board operates, and decisions that are subject to approval by a person other than Applicant.

CPCCO's board is comprised of local community members who live and/or work for organizations, agencies, or governmental bodies in Clatsop, Columbia and Tillamook counties, in accordance with the CCO governance requirements. In addition, as sole member of CPCCO, in accordance with CPCCO's operating agreement, CareOregon maintains up to two designated member seats on CPCCO's board. The board endeavors to maintain a balance between representatives from each of the three counties in its service area so that all geographic areas are represented. Board members are appointed by the nominating committee of the CPCCO board and then elected by a majority of the board.

The board meets in-person eight times per year, with an optional additional three telephonic meetings, at locations throughout the northwest region. Agendas for each board meeting are approved in advance by the board's executive committee.

The Board Roster is the following:

First	Last	Organization	Note	County
Jon	Betlinski	OHSU	Behavioral Health Provider Vice-Chair	All
Henry	Heimuller	Columbia County	County Commissioner	Columbia
Eric	Hunter	CareOregon	Member Director	N/A
Debbie	Morrow	Consumer	Past Chair	Clatsop
Bruin	Rugge	OHSU Family Medicine @ Scappoose	Primary Care Provider Clinical Advisory Panel Chair	Columbia
Kendall	Sawa	Providence Health System		Clatsop
Nicole	Williams	Columbia Memorial Hospital		Clatsop
Erin	Fair Taylor	CareOregon	Member Director Secretary	N/A
Marlene	Putman	Tillamook Health & Human Services	Past Chair	Tillamook
Bill	Baertlein	Tillamook County	County Commissioner	Tillamook
Sherrie	Ford	Columbia Health Services	Chair	Columbia

As outlined in CPCCO's operating agreement, the following are "Matters Requiring Approval of the member [CareOregon] and the Board of Directors:"

a. A material change in the nature of the purpose or business of the Company (CPCCO);
b. The institution of proceedings to have the Company adjudicated bankrupt or insolvent;
c. Any transaction by the Company to merge or consolidate with another;
d. Any transaction or election to convert the Company to another form of entity;
e. The sale of all or substantially all of the Company's assets, provided that the sale of all or substantially all of the Company's assets in connection with a dissolution of the Company may be approved by the member without the approval of the Board of Directors;
f. The admission of an additional member to the Company, provided that the member may transfer its Membership Interest in the Company to an affiliate of the Member and admit such transferee as a member of the Company without the approval of the Board;

g. The issuance, by the Company of additional Membership Interests in the Company;
h. The incurrence of indebtedness other than trade payables incurred in the ordinary course of the Company's business;
i. The compensation, if any, of a Director;
j. The entry into, or material amendment or modification of, any contract or agreement when the aggregate liability of the Company under such contract or agreement is in excess of $25,000, including, but not limited to, any contract with the Oregon Health Authority, any provider contract, or any capitation agreement;
k. The establishment of a subsidiary or acquisition of equity interests in any other organization;
l. Approval of the Company's budget with respect to any fiscal year or other period;
m. Approval of any material variance from the Company budget;
n. Engagement of legal counsel or accountants; or
o. Election, appointment or removal of a Director (other than a Member Director) or an Officer.

6.F.1.b. Please describe Applicant's key committees including each committee's composition, reporting relationships and responsibilities, oversight responsibility, monitoring activities and other activities performed.
CPCCO has five board committees, a Regional Community Advisory Council (CAC), three county-specific CACs, and a regional Clinical Advisory Panel. These include:

Executive Committee: The executive committee is made of up all officers or board committee chairs; it may act on behalf of the full board, within the powers granted to the executive committee by the full board, typically on matters that may arise between full board meetings. The board has also delegated the power to this committee to operate as CPCCO's compliance committee. In this capacity, the executive committee interacts with the CPCCO's compliance officer, reviews and recommends the compliance policy and plan to the full board and may act upon any concerns the compliance officer raises to the board. The executive committee reports to the full board. Executive committee members include:

- Sherri Ford - Chair
- Jon Betlinski - Vice Chair
- Erin Fair Taylor - Secretary
- Bruin Rugge - Clinical Advisory Panel Chair
- Debbie Morrow - Nominating Committee Chair

Finance Committee: The finance committee meets monthly to review the financial performance of CPCCO and CareOregon, as its largest risk-baring entity. The finance committee may also review and approve CPCCO's audited financials, as well as approve and recommend to the full board any changes to contracts or policies that create an aggregate liability greater than $25,000. Finance committee members include:

- Eric Hunter
- Kendall Sawa
- Sherrie Ford
- Erin Fair Taylor

Nominating Committee: CPCCO operates an ad hoc nominating committee to collect nominations and vet potential board members. The nominating committee makes recommendations for new board members to the full board for its approval. Nominating committee members include:

- Debbie Morrow (chair)
- Sherrie Ford
- Eric Hunter

Clinical Advisory Panel (CAP): Since 2013, CPCCO has operated a CAP to oversee the clinical strategy of the CCO. The CAP seeks to include providers from across all CCO-served provider types, including primary care, mental health, oral health, specialty care and chemical dependency. In addition, the CAP recruits participants from all three counties in the CPCCO service area and from each of the major providers in the service area, wherever possible. The CAP members include:

- Roxanna Abbott, DO - Legacy St. Helens Medical Director
- Laurence Colman, MD, MPH - GOBHI Practicing Psychiatrist
- Mary Ann Dearborn, LCSW, CPS, Tillamook Family Counseling Center, Quality Improvement
- Dominique Greco, MD - Providence Medical Group Seaside Family, Medical Director
- Kevin Heidrick, PA-C - Yakima Valley Farmworkers Clinic, Chief Medical Officer
- Steven Krager, MD, MPH - Columbia Health Services, Medical Director
- Julie Owens, PharmD, M - Providence Seaside Hospital, Pharmacy Manager
- Miriam Parker, LCSW - Columbia Community Mental Health, Transitions of Care Manager
- Bruin Rugge, MD - OHSU, Director of Family Medicine
- Joe Skariah, DO, MPH - OHSU, Family Practice Residency Director
- Lisa Steffy, DO - TCCHC. Medical Director
- Denise Weiss, RN - The Rinehart Clinic, Director of Quality
- Brian Garvey, MD – OHSU Scappoose, Medical Director

Equity Committee. The equity committee is open to any interested board member. It was recently constituted by the board of directors as a key equity strategy in its 2019-21 strategic plan. It is currently soliciting members and is intended to direct the development of the CPCCO equity plan, including board and staff trainings; board statement of commitment to equity; board-led initiatives to address regional, cultural, socioeconomic, racial and ethnic disparities; language access plans; and CPCCO policies to address equity, diversity and inclusion.

6.F.1.c. The Composition, reporting responsibilities, oversight responsibility, and monitoring activities of Applicant's CAC.

The local CACs vary in composition by county. Clatsop County has 100% OHP consumer membership; consumer membership totals 75% and 51% for Columbia and Tillamook counties, respectively. Two representatives of each local CAC participate in the Regional CAC, as does OHA's Innovator Agent. The Regional CAC reports to the Board of Directors and each meeting includes bi-directional communication between the Board and CAC, with an annual joint meeting of the two bodies. Local CACs develop and oversee local community health improvement programs, initiatives, grants, health needs assessments and participation in local health coalitions. They also make recommendations for CPCCO grant funds to the Regional CAC. In addition to approving such grants, the Regional CAC makes recommendations to the Board regarding community prevention, community engagement in quality outcomes, and CPCCO performance improvement projects. (See also Attachment 6, F.1.c.)

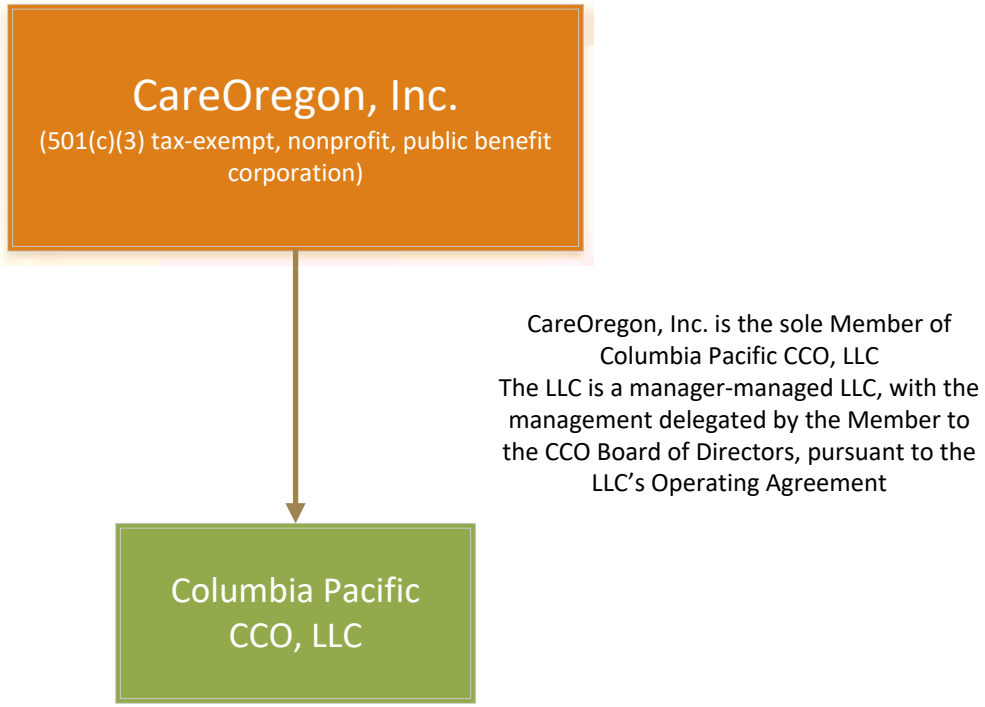
6.F.2. Requested Documents: Narrative for Items a, b, and c

Additional Required Information

6.D.1.b. What are the major subcontracts Applicant expects to have? Please provide an example of subcontracted work and describe how Applicant currently monitors Subcontractor performance or expects to do so under the Contract. (example of subcontracted work does not count toward page limit)

CPCCO expects to subcontract for dental services with the four dental care organizations (DCOs) to which it currently delegates the management of oral health services: Advantage Dental, Capitol Dental, ODS Community Health, and Willamette Dental. CPCCO also expects to subcontract with Tillamook County Transportation District for the management of the non-emergent medical transportation benefit. In each of these subcontracts, the primary subcontracted function will be the support and maintenance of a high-quality network within which CPCCO members may access services.

CareOregon maintains a delegation oversight team to perform ongoing monitoring and evaluation of contract performance and to ensure that subcontractors are adhering to the requirements under their subcontracts as well as the CCO contract. In addition, the delegation oversight team works closely with the audit and compliance team to ensure that the entire body of work is compliant with state and federal laws and regulations and that work is routinely audited. The results of any audits, including any findings of the delegation oversight team and the audit and compliance team are shared regularly with the CPCCO board of directors, so that they are aware of any areas of risk or concern. Monitoring may include but is not limited to "secret shopper" calls and time-to-next-appointment or time-to-follow-up-appointment surveys.



CareOregon, Inc. is the sole Member of Columbia Pacific CCO, LLC
The LLC is a manager-managed LLC, with the management delegated by the Member to the CCO Board of Directors, pursuant to the LLC's Operating Agreement

MIMI HALEY

503-319-8218

SUMMARY OF QUALIFICATIONS

Medicaid and Medicare Programs ● Health Plan Operations ● Government and Regulatory Affairs
Community and Public Relations ● Mission and Community Benefit

PROFESSIONAL EXPERIENCE

CAREOREGON, Portland, OR 2012 – Present
Executive Director, Columbia Pacific CCO
Accountable for all aspects of start-up and ongoing performance of the contract with OHA for the Coordinated Care Organization in Clatsop, Columbia and Tillamook Counties.

GROUP HEALTH COOPERATIVE, Seattle, WA 2004 – 2012
Executive Director, Government Programs (2006 – 2012)
Director, Federal Relations (2004-2006)
Accountable for achieving organizational objectives in Medicare and Medicaid lines of business, including strategy, program operations, financial performance and compliance. Accountable for planning, programs and reporting community activities as a charitable purpose tax-exempt organization.

WOODLAND PARK ZOO, Seattle, WA 2003-2004
Director, Marketing and Communications
Accountable for public affairs strategies, communications and marketing for the award, winning education, conservation and recreation attraction.

PACIFICARE HEALTH SYSTEMS, Mercer Island, WA 1995 – 2002
Vice President, Public Affairs PacifiCare Northwest Region (1999 – 2002)
Director, Regulatory Affairs PacifiCare of Washington (1995 – 1998)
Led all public affairs functions as the northwest regional executive for Oregon and Washington.

KAISER PERMANENTE NO. CALIFORNIA, Oakland, CA 1986 – 1995
Executive Director, Health Plan Regulatory and Benefits (1992 – 1985)
Assistant to the Physician in Chief, San Francisco Medical Center (1988 – 1992)
Senior Planning Analyst, Regional Office (1986 – 1988)
Progressive accountability across the Health Plan, Hospital and Permanente Medical Group entities.

EDUCATION

Master of Business Administration
Master of Public Health
University of California at Berkeley

Bachelor of Arts, History *Magna Cum Laude*
Yale University

Teresa K. Learn, CPA

(503) 501-6710 : teresaklearn@gmail.com

Chief Financial Officer

Health care finance leader with expertise in Medicaid and Medicare. Strong background in accounting and finance. Works across the organization to build consensus and produce results. Demonstrated accomplishments in:

Financial analysis	Rate setting	Strategic planning
Budgeting and forecasting	Risk adjustment	Effective presenter
Financial reporting	Revenue optimization	Team building
Cost savings efforts	Solutions driven	Clear communicator

Experience

CareOregon, Portland, OR Dec 2004 – Present

A $1.4 billion health plan providing Medicaid and Medicare coverage in Oregon to 250,000 members through three coordinated care organizations and a licensed insurance entity.

Chief Financial Officer

Sep 2012 – Present

- Led the financial turnaround effort bringing the company back to profitability
- Report monthly to multiple Finance Committees and regular interactions with the Board
- Oversees all finances for the organization and its seven entities
- Directs the Medicare line of business

Controller

May 2006 – Aug 2012

- Managed the accounting department
- Led the effort to create multiple new entities and set up new records and financial reporting
- Provided and sold financial and accounting services to outside entities

Budget Manager

Dec 2004 – Apr 2006

- Worked to optimize rate increases for the organization
- Directed and prepared the annual budget

Cascade Physicians, PC, Portland, OR Oct 1996 – Dec 2004

18 physician internal medicine group and managed care entity.

Controller

- Managed the accounting department and all financial matters
- Co-led leadership team that oversaw all company operations
- Started up a laboratory and relocated the administrative office

Kelly Galloway and Co, Ashland, KY Feb 1994 – July 1996
Manager

- Managed the computer network and all administrative functions for 25-person accounting firm

Consultant, Ashland, KY July 1993 – Jan 1994

- Helped high technology company develop a business plan

Hybritech, San Diego, CA Jun 1990 – May 1993
Analyst

- Directed annual and long range business plan for $140 million biotech company
- Led team of ten peers and worked closely with senior management

Ernst & Young, San Francisco and Chicago Aug 1985 – Apr 1990
Audit Manager

- Served a broad spectrum of clients in insurance, manufacturing, finance and non-profit sector
- Managed complex audit engagements and supervised up to eight audit team members
- Helped smaller clients develop their accounting departments

Education

University of California, Berkeley
B.S. in Business Administration, May 1985
Concentrations: Accounting and Finance
Honors: Beta Alpha Psi (Accounting Honors Society)

Activities and Interests

2011 – 2017 **Board Member and Finance Committee Chair**, Neighborhood Health Center
2011 – 2017 **Finance Committee Ch**air, Oregon Health Care Quality Corp
2007 – 2009 **Secretary**, Financial Executives International
1993 – Present **Member**, American Institute of Certified Public Accountants
1985 **President**, Beta Alpha Psi

NATE CORLEY

503-416-7919 nathan_corley@yahoo.com

Experienced Information technology leader with a demonstrated history of improving operational efficiency and IS-to-Business alignment within Healthcare delivery systems.

EXPERIENCE

CareOregon Portland, OR 2016 - Present

CareOregon is a non-profit organization providing health plan services to approximately 270,000 lives within the Oregon Medicaid and Medicare-dual population. CareOregon's mission is the building of individual well-being and community health through shared learning and innovation.

Vice President, I.S. and Analytics

Reporting to the Chief Operations Officer, I am fortunate to hold accountability for strategic planning and operational oversight of all information services and analytics functions across CareOregon. I am also the representative of CareOregon's technology interests within our community partners, state agencies, and providers.

Key accomplishments include:

Rationalization of application and infrastructure contracts resulting in consecutive year-over-year reductions in discretionary spend (budget years 2017, 2018, and 2019).

Improved resiliency and survivability through re-architecture of our wide area network, relocation of our on premise data center to a co-location facility. Migrated Active Directory and Exchange from owned hardware to cloud solutions (Azure). Established remote connectivity and improved customer experience via Office 365, Skype, and Windows 10 enterprise implementations.

Led the technology services onboarding of Housecall Providers, a CareOregon partner since 2017 which manages a Physician practice to provide in-home primary care and Hospice services (reduced IS spend, improved reliability, and increased service offerings). Led IS resources to support the onboarding of ~80,000 lives into CareOregon following the shutdown of another Oregon CCO (with 6 weeks' notice).

Continuously improved internal and customer facing IS processes through establishment of IS Project Management office – Establishing transparent intake, resource management, and project status delivery. Developed a 'right size' approach to ITIL incident management and change management.

Implemented numerous targeted application solutions in support of enterprise strategies including: New care management platform (GSI), alternative payment integration within our Provider Portal, and expansion of the provider portal to include functions directly accessible by members.

Current in-flight activities include the re-architecture of CareOregon's data warehouse and analytics infrastructure while implementing Arcadia's data integration platform, and optimization of our primary claims management solution (QNXT) in anticipation of the Oregon Health Authority "CCO 2.0" rollout.

EXPERIENCE (CONTINUED)

Providence Health and Services Portland OR | Anchorage AK | Seattle WA 2007 - 2016

Providence Health and Services (during this time frame) consisted of 40+ Hospitals and 300 clinics across California, Oregon, Washington, Alaska, and Montana employing ~100,000 staff and clinicians.

Senior Director Service Operations (Enterprise) April 2014 -> March 2016
Lead the Identity and Access management, Enterprise monitoring, Asset management, and ITIL operations teams. Executed the re-launch of our ITSM application suite. Continued maturation of Enterprise Service Desk and Network Operations Center teams.

Director Service Desks, One IS (Enterprise) December 2012 -> April 2014
Consolidated 5 federated service desks to a central function in support of our continued EMR deployment (totally 35 hospitals and 300 clinics).

Centralized our network operations center (NOC) at our primary DC site, while providing "lights out" support to 13 additional enterprise datacenters across the western states.

Director of Epic Production Support (Enterprise) February 2012 -> December 2012
Developed the first enterprise-wide incident intake team to support phase 1 of Providence's Epic deployment (8 Hospitals, 50 clinics, 3 states). Implemented standard operational guidance and performance reporting for issue intake, triage, and routing for the legacy / federated service desk staff. Developed high-functioning partnerships with clinical and IS leaders at all levels.

Manager PACS and HCS (Oregon Region) December 2010 -> February 2012
Managed the daily and ongoing activities of labor, budget, and critical functions for the Diagnostic Imaging (PACS), and Home and Community Services (HCS) application teams. Accountable for application analyst support for 8 Hospitals and 80 clinics across Oregon.

Manager I.T. Engineering (Alaska Region) May 2007 -> December 2010
Responsible for direct leadership of Desktop Engineering team, and shared leadership of Network, Server, and Storage Engineering teams. Accountable for infrastructure and desktop support for 4 Hospitals and 6 ambulatory sites within Alaska.

Technical Architect (Enterprise) July 2006 -> May 2007
Responsible for collaboratively establishing IT strategies and standards. Acted as an internal technology advocate during vendor negotiations. Lead technical, business, and clinical teams through RFPs, SOWs, SLAs, and other technology evaluations in support of regional and enterprise programs.

Intel Corporation Portland, OR 2000 - 2007

Database Administrator June 2004 -> June 2006
Scoping, design and implementation of MSSQL and Oracle databases in support of supply chain and re-seller relationships. Supervised onshore and offshore contract staff.

Systems Engineer April 2000 -> June 2004
Designed, built, and maintained systems in support of Intel's financial close processes.

EDUCATION

Alaska Pacific University
Master of Business Administration
Concentration: Health Services Administration

Safina Koreishi MD, MPH

1829 SE 42nd Ave
Portland, OR 97215
(503) 577-4571
koreishis@careoregon.org

Education

Portland State University. Masters in Public Health Policy and Health Administration. September 2006-June 2009. GPA 4.0.

Oregon Health Sciences University Preventive Medicine Residency. July 2005- June 2009. Board Certification October, 2009.

Oregon Health Sciences University Family Medicine Residency. July 2005-June 2008. Board Certification July 2008.

State University of New York at Buffalo School of Medicine. August 2001- May 2005. Doctor of Medicine, Summa Cum Laude honors.

Washington University in St. Louis. B.A. Biology and Anthropology, 2001. GPA 3.75. Magna Cum Laude honors in biology.

Professional Experience

CareOregon, Medical Director of Columbia Pacific CCO. Portland, OR. April 2015-Present

- Responsible for developing and implementing clinical strategy within the CCO to meet quality metrics, improve access, and decrease cost. (Columbia, Tillamook and Clatsop Counties).

Assistant Professor, Oregon Health Sciences University. Family Medicine. June 2015- Present.

Neighborhood Health Center. Portland, OR. November 2011- Present

- **Interim Medical Director-** April 2014-March 2015
- **Associate Medical Director and Medical Director of Clinical Quality**- November 2011-March 2014. Responsible for leading and implementing medical home infrastructure, focusing on clinical quality improvement, and clinical/EMR processes.
- Family Physician providing clinical care. Nov 2011-March 2015

Rosewood Family Health Center, Yakima Valley Farm Workers Clinic. Portland, OR. August 2009-October 2011.

- Family Physician providing full-spectrum family medicine, including OB and inpatient
- Chair of the patient self-management committee working to incorporate new models of care into practice

Oregon Health Sciences University Preventive Medicine Residency. July 2005-June 2009

- Associate Medical Director of CareOregon, managed care organization for Oregon Health Plan. July 2008- June 2009.
- Practicum experience at Multnomah County Public Health Department- health officer-in-training. July 2008- June 2009.
- **Preventive Medicine Chief Resident**. July 2008-June 2009.

Oregon Health Sciences University Family Medicine Residency. July 2005-June 2008.

Other Activities

Teaching:

- **Family Medicine resident precepting at OHSU Scappoose Clinic;**
- **Preceptor for Preventive Medicine resident project work July 2016-2017;**
- **Preceptor for Family Medicine resident capstone project on One Key Question December 2016-present.**

Oregon Opioid Taper Guidelines Task Force. March 2019-Present

Governor's Opioid Task Force. 2017-Present

Prescription Drug Overdose Prevention Implementation Workgroup. January 2017-present. State level work group to help implement opioid and pain best practices throughout the state.

Northwest Addiction Technology Transfer Center Board. January 2016- June 2017

Public Health Advisory Board, State of Oregon. January 2016- January 2017. Governor appointed position to advise the state public health strategy and direction.

Council of Clinical Innovators Fellowship. July 2015- June 2016. Leadership fellowship through Oregon Health Authority; focused on clinical burnout and well-being.

Clinician Vitality Steering Committee. Jan 2014- Present. Involved in the development of a state-wide steering committee addressing the issue of clinical burnout, resilience and vitality.

Research Experience

Principal Investigator: Health literacy and Patient-Provider Communication. Oregon Health Sciences University. Clifford Coleman, MD, MPH, Valerie King, MD, MPH, Jennifer DeVoe, MD, PhD, Michael Klobes.

Research Assistant. Systematic Analysis of Elective Induction. Oregon Health Sciences University. Valerie King, Ariel Smits. January 2006-2008.

Papers and Presentations

Multiple presentations at the county and state level on CPCCO's opioid strategy. 2016-2019

Systems-level Approach to Address the Opioid Epidemic. Presentation, Institute for Healthcare Improvement. Orlando, FL. December, 2016.

Partnering with a Local Payer to Improve Regional Access for Treating Opiate Dependence in a Family Medicine Residency Clinic. STFM Conference on Practice Improvement. Newport, CA. December, 2016.

Key-Note Lecture: A Call to Action, Opioid Crisis. North Coast Opioid Summit. Seaside, OR. April, 2016.

Addressing Prescription Opiates: An Alternative Design to Addressing the Opiate Epidemic. Poster presentation. Institute for Healthcare Improvement. Orlando, FL. December 2015.

Practicing Patient-Centered, Evidence-Based Care . Lecture presentation. Oregon Primacy Care Association Conference. April 24,2014

Clinician Burnout and Resilience dialogue. Lecture presentation. Oregon Primacy Care Association Conference. April 24,2014

The Combined Impact-Opioid Prescribing Practices and Population Health: Guide Rails for Providers. Lecture presentation. Oregon Primacy Care Association Conference. September 23,2013

Implementing a Medical Home Pilot within a Community Health Center. Lecture Presentation. OCHIN Learning Forum. November, 2012

Partnering between a health plan and community health centers to implement the patient-centered medical home. Lecture Presentation. APHA October 2012

Honors and Awards

Award of Excellence. Awarded to highest graduating GPA. Portland State University. June, 2009.

Minority Constituent to the National Conference of Special Constituents. Oregon Chapter of American Academy of Family Physicians. April 2009

Summa Cum Laude. Latin Honors. University at Buffalo School of Medicine. May, 2005.

Humanism in Medicine Award. Arnold P. Gold Foundation. University at Buffalo School of Medicine. May, 2005

Mark A. Petrino Award. Awarded for demonstration of interest and aptitude for the general practice of medicine. University at Buffalo School of Medicine. May 2005.

American Medical Women's Association Glascow-Rubin Certificated of Commendation for Academic Achievement. University at Buffalo School of Medicine. May, 2005.

Alpha Omega Alpha. Honor Medical Society. Inducted spring, 2005.

Dean's Letter of Commendation. University at Buffalo School of Medicine, 2002-2005. Honors in the first, second, third and forth year coursework.

AOA grant for community service. Awarded a $2500 grant to support the Lighthouse Free Medical Clinic. (The writing of the grant was a group effort of six medical students).

Magna Cum Laude in biology. Washington University in St. Louis, 2001

Amy Dowd
4433 Southwest Tunnelwood Street, Portland, OR 97221
585-738-0260 Amy.Dowd@ymail.com

Experience

Chief Operations Officer, *CareOregon*, Portland, OR, '19 - present

Responsible for Health Plan Operations, Information Systems, and Brand, Marketing & Communications for CareOregon.

Corporate AVP, National Marketplace Operations, *Molina Healthcare, Inc.*, Long Beach, CA, '16 – '19

Accountable for various centralized operations, audit, compliance, and payment integrity functions for Molina Healthcare supporting government programs in fourteen states and subsidiary health plans.

CEO, *New Mexico Health Insurance Exchange*, *BeWellnm*, Albuquerque, NM, '14 – '16

Developed nationally-recognized low-cost operating model for a state public exchange to sell health insurance plans with premium assistance.

Founding Executive Director/CEO, *Idaho Health Insurance Exchange*, *Your Health Idaho*, Boise, ID '13 - '14

Reporting to a 19-member Board of Directors, successfully met aggressive timelines for Idaho to establish a state public exchange to sell health insurance plans with premium assistance.

National Practice Health Care Consultant, Performance Improvement *Ernst & Young LLP*, Portland, OR '11 - '13

Advised three of the largest national health plans on state programs and ACA compliance and implementation. Served as Federal and State Programs Portfolio Lead, Health Insurance Exchanges Advisor, and Project Management Competency Lead to promote project management training, methodology, and tools across the portfolio of service offerings of the firm.

Director, Operations Division, *Excellus BlueCross BlueShield*, Rochester, NY '04 - '10

Responsible for individual, small, and large group commercial operations for regional health plan.

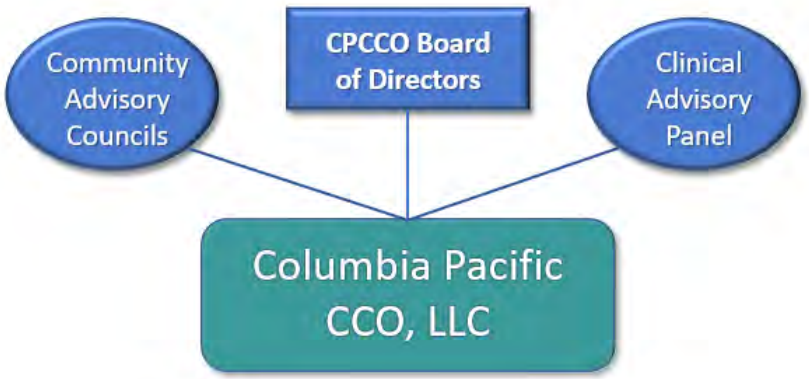
Education and Certification

Bachelor of Science, *Cum Laude*, Environmental Studies, '92, State University of New York College of Environmental Science and Forestry at Syracuse University, Syracuse, New York

Project Management Professional (PMP) Certification Since '00
Project Management Institute, Newtown Square, Pennsylvania

Attachment 7 — Provider Participation and Operations Questionnaire

7.1.a. Governance (recommended page limit 1 page)
7.1.a.(1) The proposed Governance Structure, consistent with ORS 414.625.



For the 2020-24 contract term, CPCCO will continue the governance structure that has been in place since 2012. This includes a governance board made up of leaders representing local elected officials, providers, community non-profits, public health and key stakeholders across the CPCCO service area. In addition to the Board of Directors, the CPCCO governance structure includes three local Community Advisory Councils (CACs), one for each county, and a Regional CAC. CPCCO has had a regional Clinical Advisory Panel (CAP) as part of its governance structure since 2013. These have served CPCCO well in terms of setting priorities, identifying opportunities important to the community, and ensuring engagement and buy-in to the development and investment in new programs and services. For these reasons, all will remain in place going forward.

7.1.a.(2) CAC in each Service Area and how selected consistent with ORS 414.625.
CPCCO has three local advisory councils and one regional advisory council. These will be ongoing in 2020 and beyond. The local councils are comprised of varying percentages of OHP consumers (either members or direct family of members) varying between 51% and 100% of the composition of each CAC. Other council members are local elected officials, individuals who are key community stakeholders, such as social safety net providers, and representatives of clinics that CPCCO contracts with for healthcare services.

Members are selected by a Nominating Committee, comprised of members of each local CAC. Recruitment occurs through a variety of mechanisms, including flyers, ads in local papers, existing CAC member referrals, CPCCO CAC Coordinator staff referrals, and word of mouth. Special attention has been paid to ensure that OHP member perspectives are paramount in those CACs where there is also non-OHP participation. Over the last five years, CPCCO staff have developed processes and materials that create a supportive, responsive, trauma-informed learning environment for advisory council members to make informed decisions and recommendations, and these will be continued going forward.

The Regional CAC is comprised of the Chair and Co-Chair of each local CAC and makes recommendations to the CPCCO Board of Directors regarding investing in community-based health improvement activities that address the priority areas of the regional Community Health Improvement Plan (RHIP), and community-based projects that support OHP member engagement in improvement of health and well-being in the service region. Additionally, the Regional CAC makes the final recommendation of the priority areas of focus for CPCCO's five-year RHIP to the Board of Directors.

7.1.a.(3) Relationship of Governance Structure with CAC, transparency and accountability for consideration of recommendations from the CAC.

The Regional CAC reports to the CPCCO Board of Directors, and each Board and local CAC meeting includes bi-directional communication between the two, with an annual joint meeting of the two bodies. Local CACs develop and oversee county-specific community health improvement programs, initiatives, grants, health needs assessments, and participation in local health coalitions. They also make recommendations for CPCCO community benefit grant funds to the Regional CAC, which makes final decisions about where to invest targeted community benefit funds. In addition to approving grants, the Regional CAC makes recommendations to the Board regarding prevention activities, public health opportunities, health equity, community engagement in quality outcomes, and CPCCO Performance Improvement Projects.

7.1.a.(4) CCO Governance Structure reflects the needs of Members with SPMI and receiving DHS Medicaid-funded LTC through representation on Governing Board, CAC.

In anticipation of the new required membership on the governing Board or CACs in 2020, CPCCO will recruit, orient and provide supports and information to ensure that members with severe and persistent mental illness and members receiving DHS Medicaid-funded LTC services can fully engage in the CCO's activities at each governing body. CPCCO currently coordinates care for those on CCO-G ("mental health only"), and it serves CareOregon Advantage Dual SNP members (D-SNP) and those with other Medicare primary coverage who enroll in the CPCCO for their Medicaid benefits. We will leverage this experience to better coordinate the member engagement activities for those who are dually eligible, who are engaged in long term care services, or who have special mental health care needs to ensure full and equitable participation in the CPCCO governance structure.

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

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

CPCCO has had a Clinical Advisory Panel (CAP) since 2013, comprised of multidisciplinary clinical leaders throughout the region. The CAP is accountable to the CCO Board of Directors, providing strategic leadership and direction for clinical transformation initiatives that will set CPCCO on a course to achieve the "Quadruple Aim" (the Triple Aim plus the aim of ensuring a healthy clinical workforce). The CAP is critical for alignment across providers and provider types – it is the linchpin to ensure the full suite of CCO covered services are understood, communicated, coordinated, and integrated to the greatest extent possible. It strategically aligns transformation efforts and priorities with its members' constituent organizations, the CPCCO CAC and the CPCCO Board. Further, it helps to ensure that these efforts have the active support of clinical and administrative champions at the highest organizational levels and across communities. The CAP currently meets (and will continue to meet) approximately 10 times per year. In addition, the CAP meets jointly with the Finance Committee of the Board twice per year to identify and align both committees' work on those programs, initiatives, investments, metrics, and goals that result in better clinical outcomes and greater financial sustainability across the CCO service area.

Key responsibilities for the CAP include:

- Setting clinical targets for evidence-based, transformational efforts and ensuring adoption of best clinical practices across its provider network;
- Reviewing and recommending care models that increasingly reward accountability for improved outcomes;

- Identifying opportunities to improve population health in the CPCCO service area;
- Identifying strategies to decrease unnecessary utilization; and
- Recommending to the CCO Board priority programs for funding by the CCO based upon its assessment of data, clinical evidence, best practice, and community need.

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

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

CPCCO has a current, executed MOU with the AAA office of NorthWest Senior & Disability Services (NWSDS-AAA) and the local APD office for Columbia County.

7.1.c.(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.

N/A.

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

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

CPCCO has strong relationships with the three CMHPS in our region and will replace the current MOU with direct contracts as we integrate the benefit during Q2 2019. CPCCO will renew MOUs with the LMHAs (Columbia, Clatsop, and Tillamook county governments). All local CMHPs and LMHAs participated in development of CPCCO's RHIP and Community Health Assessment (CHA) and various project specific planning. We are poised to continue and deepen those collaborations as we execute integrated direct contracts beginning June 1, 2019 for provision of treatment services. This includes funding specialty mental health and substance use disorder treatment and investments into the crisis and safety net systems to ensure viability to serve members and the entire community.

7.1.d.(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).

As stated in 7.1.d.(1) above, contracts will be executed with an effective date of June 1, 2019. We do not foresee any barriers.

7.1.d.(3) Describe how the Applicant has established and will maintain relationships with social and support services in the Service Area.

CPCCO works with the social and support services in two primary ways. First, CPCCO has ***direct relationships*** with social service and support organizations, such as:

- CPCCO works directly with DHS branch offices to ensure that children in custody receive their behavioral health assessments in a timely way
- CPCCO facilitates a regular meeting with APD to share information for care coordination of complex members in long term care
- CPCCO works directly with law enforcement and corrections to help members in crisis and to reduce jail recidivism
- CPCCO collaborates with Northwest Oregon Housing Associates and Community Action teams to increase housing stock and supports

Second, CPCCO ***directs and supports its provider network***, (primarily CMHPs) to collaborate closely with social service and support agencies in their local communities at a member level. For instance:

- By raising awareness and understating of Adverse Childhood Experiences (ACEs), trauma informed practices and resilience building efforts across systems and organizations including jails, law enforcement, family courts, and drug courts CPCCO creates resilient communities engaged in a trauma informed network which is supported by a robust community investment plan. CPCCO will ensure that local providers work with the local drug courts to facilitate evaluations and timely treatment. CPCCO also ensures that providers partner with the local court system to ensure that there is coordination between the providers and members who are impacted by the judicial system. CPCCO can directly attend when needed and ensures that there is provider representation on the Local Public Safety Coordinating Council that includes problem solving for individuals with mental illness and substance abuse disorders.
- CPCCO leadership has a seat on the board of Northwest Early Learning Hub and works closely with schools and ESD leadership to enhance child focused initiatives and the spread of trauma informed schools in the region. By building on the platform started in 2017, CPCCO will work to develop a common understanding of the way in which trauma, chronic stress, and adversity affect brain development, individual behaviors, and children's capacity to learn. CPCCO will continue to work educators in the region to support the implementation of trauma informed practices.
- CPCCO provides care coordination to American Indian members that are Tribal Affiliated in the state and is contracted with culturally specific care providers for services through the Native American Rehabilitation Association and Native American Youth Association. There are no recognized tribes in the CCO service area so collaboration and coordination of care is at the member level. CPCCO completed a community health needs assessment survey as part of its community health improvement planning for 2020-2024. The survey asked residents to share their experience of health and well-being and their vision of the future related to the experience in the form of micro-narrative stories; 7.0% of micro-narratives were from participants who identified as American Indian/Alaskan Native. CPCCO intends to use these responses not only to develop improved supports for our communities but also to utilize the information to identify potential areas of culturally specific services.
- CPCCO will continue to grow its partnerships with organizations that support the growth of transitional and supporting housing for those with special needs and are working on recovery for addiction, substance abuse and mental illness. CPCCO currently provides financial support and technical assistance to four local housing programs through Helping Hands ReEntry of Tillamook and Clatsop Counties, and the three Community Action social safety net organizations, one in each county. We will develop supports and services for the social determinants of health with Northwest Oregon Housing Authority, and our contracted providers of behavioral health services. See Attachment 10 for more detail.
- CPCCO will work to improve areas of alignment with the National Alliance on Mental Illness for priorities in the RHIP to improve access to quality behavioral health services. We will also work with the Oregon Family Support Network to reduce entry into foster care and reduce absenteeism in schools. We will work to increase our collaborative efforts and

alignment with supporting families who have children with developmental and intellectual disabilities.

CPCCO will continue to support the growth of Youth Era which works closely with System of Care services in each county to support the shared community investment with other local organizations to develop youth "Drop" Centers in the service area. We will continue to support the growth of Jordan's Hope for Recovery, an organization that supports recovery at a grass roots level including harm reduction through needle exchange and distribution of Narcan.

See the Community Engagement Plan for a more comprehensive list of social and support services that CPCCO will be working with:

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

7.2.a. Members and their families and support networks are meaningfully engaged as partners in care they receive as well as in organizational Quality Improvement activities.

CPCCO believes that improved health outcomes and health equity can only be achieved when members are actively engaged as drivers in the care they receive and in improving organizational quality. We will ensure that opportunities for member engagement continue to occur throughout a member's experience with the CPCCO network of health care and community service providers, and that engagement activities meet members wherever they are.

New Members. Member engagement starts with the CCO Welcome Packet which encourages members to be active participants in their care. Members are informed of the CPCCO member incentive program which incentivizes healthy activities such as establishing care with a primary care provider, getting regular HbA1c testing for those with diabetes, getting an annual wellness check, engaging in preventative care activities and being up-to-date on immunizations.

In the Care Setting. Members are reached directly through decision support tools used by clinics to engage the patient in their own health. Members work with providers to design and implement their treatment and care plans, which include ongoing consultations regarding cultural preferences and goals for health maintenance and improvement. Member choices will be reflected in the selection of their providers and in the development of treatment plans that ensure member dignity and culture are respected. CPCCO has invested heavily in training health care and social service providers on trauma-informed care and resilience in the face of adverse childhood experiences (ACEs). CPCCO believes these approaches are essential for those working with OHP members and ensuring that the care is genuinely responsive to member needs and intentions.

In the Community. CPCCO has enacted several community- and population-specific efforts. For example, CPCCO funds the Rinehart Clinic's Comprehensive Diabetes Risk Reduction project focused on patients with diabetes, with culturally specific programing for Latino patients. The project uses a team-based care approach with 1) weekly or biweekly 1:1 RN visits, 2) individual sessions with a clinical pharmacist, and 3) full year of group visits/classes with vouchers for fresh produce and activity passes to the local recreation center, to address economic barriers to healthy behaviors. The need to address untreated substance use disorders is recognized throughout the region. CPCCO supports a pilot project that deploys five outreach and engagement peer recovery mentors in the three counties who connect with members who are reluctant to engage with services.

CPCCO is actively developing county-specific plans to link clinical and non-clinical supports for member engagement in care. For example, Tillamook County Community Health Center, the Oregon Food Bank, Tillamook Family Counseling Center, Tillamook YMCA, OSU Extension Service and Northwest Senior and Disability Services are partnering to implement a diabetes management program for members at the Tillamook YMCA. This engages members in their care through culturally and linguistically appropriate comprehensive diabetic risk management for three patient types (at-risk, pre-diabetic, and diabetic) for both Spanish and English-speaking CPCCO members.

CPCCO engages in broad efforts to get meaningful input from members and ensure that each member is empowered and encouraged to actively participate in their health care, such as the initiative completed in 2014 and 2018 that collected micro-narratives from community residents across the three counties. As described in Attachment 10.A.1.a, this participatory primary data collection survey combined quantitative and qualitative data from micro-narratives on health and well-being by individuals in the service region with an emphasis on collecting narratives from OHP members. The teller of the micro-narrative 'story' self-signifies the importance and meaning of the story, thereby allowing us both to hear the experiences of community members in their own voices, and to develop a framework for addressing our OHP members' health care needs and the social determinants of health and health equity. Throughout, CPCCO intentionally sought to collect and amplify voices and perspectives of all CCO members, but with a special focus on Latino and Tribal communities. The original pilot project in 2014 resulted in 300 micro-narratives. We collected 1,252 micro-narratives in 2018, a statistically significant sample, that will inform many aspects of our work to engage members and improve community health.

7.2.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:
CPCCO utilizes the CareOregon Communications department to produce multiple forms of members communication including mailings with care reminder postcards, outbound calls, text messaging, member newsletters, member apps, member portals, and social media. These communications are in English and Spanish, as the predominant foreign language in the CPCCO service area. All English notices include a language insert explaining in 15 languages that the member has the right to free interpretation services and written information in the language they speak. Materials are also available in large print and may be communicated orally through CareOregon's Customer Service department in nearly all languages.

CPCCO provides all new members with materials that outline how to engage in physical, dental, and behavioral health services and includes detailed information about what benefits and services are covered, contact information for accessing assistance with scheduling a first appointment, care schedules for well child visits and immunizations, and links to provider information. We have created an easy-to-read brochure that summarizes available benefits and how to access care. Members' CPCCO ID cards currently include CareOregon's CPCCO-specific Customer Service line, as well as the assigned dental plan and phone number. In the near future, we will also include the member's dental home on their ID card, wherever possible. The CPCCO websites feature service-specific pages that that provide succinct information on physical, behavioral, and oral health benefits and services. The member portal contains and will continue to contain information on our

network partners and benefits. Our well-trained customer service representatives will provide proactive information on all aspects of members' health care.

CPCCO also plans to expand its exclusive ***OHP & You*** 8-part series of workshops that provide an in-depth look at physical, behavioral, and dental benefits covered by CPCCO. Workshops are designed to benefit members and potential members by empowering and informing state OHP application assisters, Traditional Health Workers, and other professionals who help our members navigate the health system.

Engage Members in culturally and linguistically appropriate ways

CPCCO is committed to being responsive to member needs including engaging in culturally and linguistically appropriate ways. We work to understand our member population by analyzing and disaggregating our population data, collaborating with our clinical and community partners who work directly with members, and learning directly from the members about community needs through the Community Advisory Councils. We outreach and collaborate with culturally specific organizations as well such as the Migrant Education Council and Lower Columbia Hispanic Council. We develop targeted communications designed to motivate and engage members to participate in our plan and in their health, based on specific population needs addressed through the avenues described above.

Based on population need assessment through data assessment and community collaboration, we build clinical and community programs, and, as part of the core equity component to all our work, we incorporate clear, culturally appropriate engagement strategies. An example is engaging the Spanish speaking population in our narrative story collection work by using Spanish-speaking staff to collect the narratives directly from members rather than relying on interpreters and translation services, allowing us to obtain the most genuine, authentic stories from members in their native language.

Through our language access work, CPCCO arranges for the provision of interpretation assistance from two contracted certified and qualified language interpreters. These services are provided in face-to-face, telephonic and on-line encounters with CPCCO, and eligible physical, behavioral and oral health services at no charge to CPCCO members. We review our demographic data for language needs and do active outreach to ensure that members are aware of the language services that are available to them. Please refer to Attachment 10.E.1.a for a more detailed description.

CPCCO recognizes the importance of offering access to information through multiple channels and formats. We conduct outreach and connect with members through digital, physical and oral avenues. We use story-telling, plain language and pictures to be culturally and linguistically responsive to the needs of our members. CPCCO funds providers for culturally and linguistically appropriate services, such as the Rinehart clinic's diabetes prevention program, using a promotora who helps to engage patients who are Latina and Spanish speaking in the Wheeler area of Tillamook county.

Educate Members on how to navigate the coordinated care approach and ensure access to advocates including Peer wellness and other Traditional Health Worker resources

CPCCO is developing and implementing a community health worker (CHW)/traditional health worker (THW), peer recovery mentor, and peer support specialist strategy to ensure that members have access to culturally appropriate health navigators, health coaches and peer supports (see

Attachment 10.F.1). CPCCO has also developed the *OHP & You* curriculum to train *promotoras*, OHA Assisters, peer support specialists, and future CHWs/THWs.

Encourage Members to use effective wellness and prevention resources and to make healthy lifestyle choices in a manner that is culturally and linguistically appropriate

Healthy Hearts gave me the resources to get a BIG "slap me happy" life change…Healthy hearts helped me get free pool access, yoga classes, and events that I couldn't afford myself. The support, confidence, the movement has improved my emotional, mental and physical well-being.

Columbia Pacific CCO Member living in Clatsop County

CPCCO actively reaches out to members to provide information on benefits and encourage members to be active partners in their healthcare and to access health and wellness resources. In support of its new community needs assessment and improvement plan, CPCCO collected over 1,250 narrative stories from members that provides a rich database of potential supports CPCCO can provide to members to make healthy lifestyle choices. This data will be used extensively and augmented in 2020-24 to create meaningful, member-informed engagement with wellness and prevention resources.

In addition, the Welcome Packet sent to all new members explains all benefits and helps members understand services they can use to keep themselves healthy. CPCCO provides a member incentive to incentivize new patients to see their PCP during that calendar year. CPCCO will lead member engagement campaigns encouraging patients to use wellness centers that help them understand chronic issues such as pain, substance use disorder or anxiety and ways to live a healthy life. General health promotion also includes oral health and we are building comprehensive prenatal and diabetic strategies that will include embedded oral health content as another mechanism to engage members in oral health services.

The [partnership] with this to the county YMCA allows me to use the warm water therapy pool…And that helped me immensely gain a lot of strength…helped me with confidence as well.

Columbia Pacific CCO Member living in Tillamook County

CPCCO will continue to conduct annual member incentive programs that include many preventive general health services and a dental sealant incentive. Member incentives are used to encourage members to engage in a variety of prevention and health maintenance activities. For example:

- CPCCO's First Steps program offers members Amazon gift cards for attending prenatal appointments, completing dental appointments, quitting tobacco use, and other healthy activities. Members have reported that the gift cards are incredibly helpful in purchasing the many new items needed to prepare for a new baby in the home.
- The CPCCO dental incentive program will offer qualifying members a $15 gift card if an eligible member receives dental sealants at a dental visit during the year. All eligible families will receive information regarding dental sealants and preventive dental services.

Provide plain language narrative that informs patients about what they should expect from the CCO with regard to their rights and responsibilities;

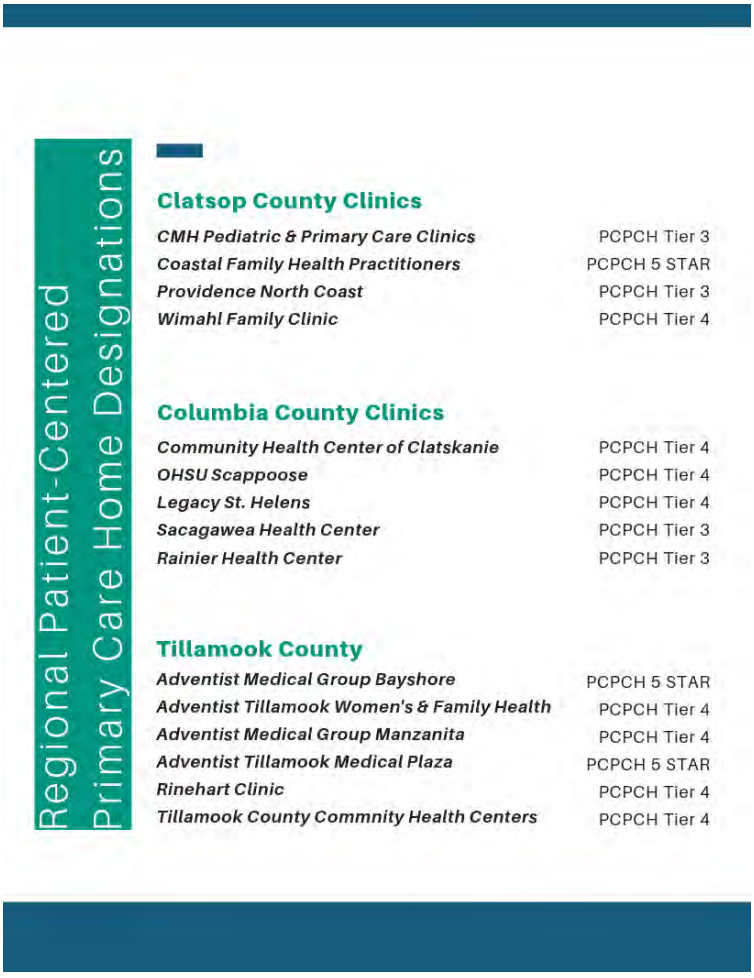
CareOregon and CPCCO staff actively contribute to the OHA Member Engagement, Outreach and Communications workgroup, which ensures that CCOs are aligned in terms of communicating in a clear and consistent way. CareOregon Communications staff who develop member rights and responsibilities language for the member handbook work closely with the Compliance team to ensure that the information is consistent with state and federal rules. Further, those

Communications staff have training in technical writing that ensures the language is in plain language, and readable at a 6th grade reading level.

Meaningfully engage the CAC to monitor and measure patient engagement and activation.
CPCCO will continue to benefit from CAC's work around member engagement. This will incorporate quarterly themes, environmental scans, content experts, member input as lived experience experts, health indicator data, SWOT analysis, and making community recommendations for addressing health at the community level. In addition, CareOregon's Member Services department conducts member satisfaction surveys on an ongoing basis, as well as member focus groups to better understand the specific needs, communication preferences, and language style preferences for specific sub-populations.

7.3. Transforming Models of Care (recommended page limit 1 page)
***7.3.a. Patient-Centered Primary Care* Homes**

7.3.a.(1). Describe Applicant's PCPCH delivery system.



The PCPCH Program is a key strategy for achieving the Quadruple Aim of health care transformation. CPCCO partners with a network of PCPCH-certified primary care clinics, designed to ensure members can readily access and receive high-quality patient-centered and evidence-based care from primary care providers invested in addressing the care needs of the individuals they serve. CPCCO's delivery system is comprised of Federally Qualified Health Center (FQHC) clinics, Rural Health Centers (RHC), and, in Columbia County, school-based health centers.

CPCCO strengthens the PCPCH delivery system by providing Primary Care coaching and continuous community-level learning opportunities through our recurrent coach-led Patient & Population Centered Primary Care Learning Collaboratives (PC3), behavioral health peer-to-peer meetings, and clinic-based one-on-one coaching and technical assistance support. These venues support action planning and accountability through quality improvement monitoring and data transparency that directly motivates and equips our primary care partners to increase their levels of medical home status and progress towards achieving the quadruple aim. Because we are closely connected with our delivery system, we fully understand

the strengths and challenges. As a result, we can respond to help providers improve and develop towards transformation. Our plan in the next five years is to continue to support all primary care clinics in moving towards PCPCH recognition and advancing PCPCH tiers within each clinic. CPCCO has a long history of assisting providers to develop the tools necessary to deepen their work as PCPCH medical homes. We will continue to provide robust technical assistance to support this. The CPCCO PCPCH program involves collaborative facilitated learning sessions bringing together the clinics (providers, quality improvement specialists, clinic managers, and staff) striving to improve their quality of care and PCPCH recognition. Technical assistance is also offered monthly on site to clinics and is always available virtually.

CPCCO provided a grant that funded the jump start for school based health centers and the community health center in Columbia County.

CPCCO has provided medical director support and operational support for FQHC when they were without clinical leadership, highlighting both the tenuous nature of some of the FQHC organizations as well as CPCCO's strong commitment to PCPCH success.

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

CPCCO meets the goals and expectations of care coordination with the PCPCH for members receiving LTC services through an individualized, strengths-based, person-centered approach to all care coordination efforts. Because these members meet the criteria for special health care needs, a health risk screening is conducted within 30 days of enrollment or as quickly as the member's health requires. CPCCO's Regional Care Team (RCT) care coordinators work collaboratively with members and their support systems, along with community providers, to help the member identify and articulate their goals for treatment and recovery as well as identify gaps in care. The member's recovery goals serve as the roadmap for helping determine the least restrictive, most integrated, physical, behavioral, oral and social services and supports available for each member. Issues, goals and interventions are documented in the member's individualized care plan and shared with the PCPCH and LTC provider. Care plans are developed by the assigned care coordinator and/or care team based on information gathered from the Initial Health Screening and available claims data. Care plans include goals with required estimated due dates for achieving member goals. Including the member in the development of the care plan and goals increases the expectation that the goals will be met.

CPCCO meets weekly with our PCPCH network in Columbia and Clatsop counties and twice a month in Tillamook to huddle around emerging care coordination needs. When these members need to be assessed for LTSS or are already involved with LTSS we reach out to the appropriate case worker. Through this process CPCCO is able to serve as a bridge between our PCPCH network and LTC providers. CPCCO and our PCPCH network also attends the inter-disciplinary case conferences that DHS hosts in each of our counties.

7.3.a.(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.

Located in the rural counties in northwest Oregon, the vast majority of clinics are FQHCs, RHCs or SBHCs. There are a few clinics affiliated with Independent Practice Associations (IPA) in the service area, but those collectively serve fewer than 800 members. CPCCO's mission of improving the access and quality of care in our communities specifically encourages the use of FQHCs, RHCs, and

SBHCs. CPCCO provides many collaborative grants and programs that increase the capacity of clinics for clinical performance improvement in order to encourage their use. CPCCO incentivizes FQHCs to provide high quality and patient-centered care through alternative payment models (APMs). Only recognized PCPCH clinics are eligible to participate in these monthly per member per month payments. The goal of the APMs is to sustain the elements required to offer patient-centered, team-based care that might not be adequately reimbursed through the fee-for-service payment model. In addition, CPCCO has partnered with CareOregon to create a four-tiered approach towards its network that facilitates member engagement with the highest performing providers while balancing the need to provide comprehensive primary care access for rural communities.

7.3.b. Other models of patient-centered primary health care

7.3.b.(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.

For our Columbia County residents who are experiencing mental illness, CPCCO has supported Columbia Community Mental Health (CCMH) and OHSU Scappoose Family Medicine to partner to provide primary care inside CCMH's Certified Community Behavioral Health Clinic (CCBHC). This model allows CCMH patients to receive onsite primary care in an integrated manner. Through the partnership, OHSU and CCMH have access to one another's EHR and may document integrated care plans into each. There is also an onsite pharmacy where patients can pick up their medications and receive vaccines or flu shots. CCMH's case managers attend the physical health appointments with the patients so that health maintenance behaviors, such as medication regimes for chronic conditions, are built into the patient's behavioral health treatment plan.

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

The CCBHC model brings health care directly to people who often have significant barriers to accessing care. Many of the patients who receive care through the CCBHC model have a diagnosis of a major mental illness that makes tracking appointments or establishing trust with a provider extremely difficult. This model targets a population of members that do not tend to get their healthcare needs met. Due to unmet healthcare needs and other social determinants of health, these individuals have a life expectancy that is 25 years shorter than average. One of CPCCO's core values is to ensure that individuals living with serious and persistent mental illness have equitable access to health care. The CCBHC model brings care to these members through the behavioral health care team they with whom they have already established trust. The patients have team-based care brought to them, rather than having to travel to a primary care office, which will change the health outcomes of a vulnerable population.

7.4. Network Adequacy (recommended page limit 3 pages)

7.4.a. Evaluation Questions

7.4.a.(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.

CareOregon's Network and Clinical Support department supports CPCCO's network adequacy monitoring and reporting. CareOregon applies the CMS time/distance network adequacy standards when analyzing the CPCCO provider network. The Quest Analytics Adequacy software is used to validate network adequacy following, CMS time and distance standards to regularly assess CPCCO's

network adequacy, demonstrating that **100% of CPCCO members** have access to at least one provider/facility, for each specialty type, within established requirements for that county. The Quest tool employs geocoding analysis that assists us with network evaluation and allows for researching and identifying non-contracted/available providers in a specific area (based on NPI and using "marketplace tool") as possible contracting opportunities.

The Network Adequacy Steering Committee (NASC) provides structured oversight and accountability to ensure CPCCO is compliant with network adequacy regulations as specified by the OHA and CMS. The committee is comprised of management from Provider Services, Contracting, Information Services and Legal/Regulatory Affairs.
The NASC meets quarterly and utilizes external software for data analysis to:

- Ensure consistent compliance with network adequacy for Medicare and Medicaid
- Develop contracting strategy to close network gaps
- Review results of network adequacy reports produced in accordance with network adequacy policies
- Oversee work of Provider Directory Workgroup
- Ensure enforcement and updating of Network Adequacy policies and procedures
- Reduce member complaints in relation to access to care

CareOregon routinely monitors wait times to appointments for primary care, specialty care, oral health, and behavioral health services. Monitoring will be prioritized for services that have historic access concerns based on CPCCO's request, member feedback, or concerns identified through routine monitoring. On a monthly basis, CareOregon conducts a capacity analysis that includes both provider to enrollee ratios as well as the percentage of contracted providers accepting new OHP members.

Grievance data is also analyzed within all service lines. On-call and after-hours provider schedules and logs are reviewed periodically to ensure providers are available or have coverage 24/7, including validating the hours of operation for each provider.

Availability of language services is analyzed by reviewing capacity reports that show the number of appointments requested and the number of appointments filled by language. Those reports are reviewed internally and with CPCCO's interpretation vendors. Action plans may include putting the vendor on a corrective action plan, adding additional capacity, and adding access to alternative interpretive modalities like video interpretation or adding another vendor for interpretation.

CPCCO has tracking and monitoring systems in place that ensure members have access to high quality, timely behavioral health services. CPCCO will require providers to report access metrics monthly and to engage in corrective action if the provider cannot see members within targeted timelines. This will provide real time information about capacity of routine services in our continuum of care, for both mental health and substance use disorder treatment. When capacity is limited, the CareOregon Behavioral Health Network, Quality and Compliance Committee will review applications for additional providers and either offer contracts to add needed capacity or solicit new providers to enter the region if no local providers are available. In order to improve access to members who live in remote areas, CPCCO will evaluate and deploy telemedicine services that members can access in their own homes via a cell phone. Finally, CPCCO tracks and monitors member access via turnaround times for prior authorization and concurrent review decisions at all

levels of care, both to ensure adherence to required timelines and to ensure that we are not causing any delays in access to treatment.

7.4.a.(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.

CPCCO has an existing provider network with sufficient capacity. In absence of explicit time and distance parameters from the Oregon Health Authority, CMS' Medicare Advantage Network Adequacy criteria are used for Medicaid plans.

- Provider Services runs network adequacy reports using network adequacy reporting software to compare existing contracted providers to membership. Reporting parameters concerning travel time and distance for members per CMS will be used for both Medicare and Medicaid plans and CCOs.
- Network Adequacy reports will be run at the beginning of each quarter or more frequently as needed if a material network change is expected or being evaluated.
- Provider Services teams will use the reports to identify network gaps. The Contracting team evaluates gaps in contracting and formulates and implements contracting strategy to close any gaps in contracting with providers. If a network gap is not able to be addressed due to a lack of providers in a needed specialty in the geographical area, or when a provider declines to contract with CareOregon, Provider Contracting will document the efforts taken to address the network gap and submit to the Network Adequacy Steering Committee for further action.
- Provider Services reports network adequacy findings to the Network Adequacy Steering Committee on a quarterly basis.
- The System Configuration team is responsible for ensuring the ongoing accuracy of the provider and member data submitted for loading into the network adequacy software. Data extracts are submitted on a quarterly basis during the last quarter of the month or as needed more frequently for material network changes.

Capacity

The initial contracting process for PCPs requires a minimum of 100 patients per clinical FTE when provider first contracts with CPCCO. Capacity beyond that is determined by the provider based on several variables that can affect utilization and acuity such as patient age and gender. Other variables include clinic administrative practices such as the use of EHR. Practices with sophisticated information systems may have more capacity.

CPCCO monitors the capacity of its network through a variety of methods. We believe that open access to primary care is essential for meeting the triple aim. For this reason, we work directly with our primary care clinics to prioritize access for assigned members. Member assignment to primary care providers employs capacity limits that are set based on extensive analysis of contracted capacity limits in the provider network, the number of providers in a given clinic, the ability to meet a credentialing and site review standards, and openness to accept new OHP members. We also monitor time to next available appointment. Existing contracted capacity analysis demonstrates network adequacy meeting CMS time and distance standards, demonstrating that 90 percent of members (or more) have access to at least one provider/facility, for each specialty type, within established time and distance requirements for counties within our service area. The Provider Services team regularly reviews the PCP capacity report to ensure PCP clinics have enough capacity for our enrolled membership.

7.4.a.(3) How does Applicant intend to remedy deficiencies in the capacity of its Provider Network?
When deficiencies are noted, we initiate contracting efforts with providers to fill the gaps and create additional capacity. Contracts are regularly reviewed and updated to ensure any negative impacts of network deficiencies are mitigated. Through CareOregon, CPCCO also has access to a broad state-wide network of providers for which our members can utilize NEMT services for necessary access. If deficiencies are noted during ongoing adequacy monitoring described above, we initiate contracting efforts with providers to fill the gaps and create additional capacity. In general, CPCCO assesses regional capacity, and gaps in care through data, community input and emerging best practice. We then analyze and discuss with our clinical advisory panel to assess what new clinical services and programs are needed in the region, and how we may be able to expand these services.

It is particularly challenging to provide access to a growing demand for specialty referrals, especially in rural areas. Simply put, the supply of specialists has not kept pace with demand. Many patients are left with a choice to travel to metro areas to complete a specialist appointment, which adds an additional challenge. In addition, wait times for certain specialties are beyond thirty days. Primary Care Medical Homes take the burden of coordinating travel and appointment times for patient specialty appointments. However, there is not an easy automated means of information sharing to assist with care coordination between PCPs and specialists to help manage the increasing demand and workload. Remedies to address deficiencies include:

Expanding Specialist Capacity
CPCCO is implementing **RubiconMD**, an e-consult platform PCPs can use to ask a national network of board certified specialists for guidance on diagnosis workups, treatment advice options and interpretation of labs and other diagnostics. To expand our provider capabilities for specialty referral and consultation, CPCCO has negotiated licenses for providers; in addition, all insurances and self-pay are able to access this service without charge. We hope this allows every patient to get the care they deserve regardless of affiliation with CPCCO. In addition, Rubicon now provides up to 20 hours of CME for completed consults, 0.5 hours of CME per consult. We view this as an upskilling tool for our providers to effectively manage patient needs.

CPCCO's Access Coordinator (AC) position is dedicated to streamlining specialty referrals on behalf of our members. The primary function of this role is to develop and maintain physician/specialist relationships to improve member access to care and provider network stability. The AC serves as the point person for assessing and identifying access to specialists for Primary Care Providers (PCP) and is the single point of contact for appointment scheduling and follow-up between the PCP, specialist and member. The AC works with members to determine and coordinate the specific needs of each member associated with an appointment which can include but is not limited to transportation needs, interpretation services, and preparation with the member prior to the appointment. The AC reviews every referral before moving it forward to the specialist to ensure that all diagnostic tests, imaging and notes are attached for review, thus creating efficiency for the specialist.

Upskilling Primary Care Providers
In addition, CPCCO has worked with our primary care providers to help them expand their skills and provide specialty level services within primary care:

- Hepatitis C treatment: Two of our primary care clinics are providing Hep C treatment within primary care and are planning to provide services to others within the county (outside of their own clinic).

- OSHU Scappoose offers sports medicine services and podiatry for their patients in the primary care setting, and we are working with them to expand their services beyond their organization
- We have funded and supported organizations to provide MAT services within primary care. Though this is slowly becoming standard of care, in recent years only one organization provided these services for Medicaid patients in our region. Now we have at least one in each county. We are partnering with Portland-based CODA to open an opioid treatment program in Seaside, making a critical service improvement by bringing methadone services to our area.

Telehealth

CPCCO supports telemedicine to give members a wider access to quality care and eliminate distance barriers to improve access to services in conjunction to guidelines by the Division of Medical Assistance Program (DMAP) and Centers of Medicare and Medicare Services (CMS). CPCCO has expanded what types of provider-to-member interactions it will consider for reimbursement; new avenues of service include phone, video conference and e-mail consultations.

Clinical Services Leadership Capacity

The reality of healthcare delivery in rural communities is that recruiting and retaining providers is a significant challenge, and many of our provider partners have struggled with provider capacity and medical leadership capacity. CPCCO has funded a shared recruiter in Clatsop County to help with recruitment, funded moving expenses for critical recruitments and reimbursed locum tenens costs on behalf of clinics. We have sponsored recruitment learning sessions in partnership with the Office of Rural Health, and our CPCCO medical director has directly helped support some organizations with medical direction during times when they were without staff. Currently, one of our major clinics has lost multiple providers, and CPCCO is helping to embed a panel coordinator in the clinic to offset some burden and allow the organization to still focus on quality improvement.

In addition to the examples above, some areas on which we plan to improve through the rest of 2019 and in years 1-3 of the new contract include:

- Expanding **palliative care services** within the region, especially for those who do not qualify for home health
- Expanding **behavioral health services** to include counseling within primary care. This will expand the current benefit.
- Exploring ways to offer **developmental pediatric consultation** within the region.

7.4.a.(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.

CPCCO will use both prospective and retrospective methods of monitoring wait time to appointments. We will leverage the work with the PCPCHs in our provider network (77% of CPCCO members are assigned to a

CPCCO 2018 Average Wait Times

New Patient to establish care
…Scheduled within an average of ***12 days***

Existing Patient appointments
…Scheduled within an average of ***4 days***

Urgent/Emergent Appointments
…Scheduled the ***same day***

PCPCH) to actively monitor empanelment and capacity as well as time to their next appointment. This is accomplished by having providers report on their analysis to third next available appointments and aggregating those results across the network to ensure we meet timeliness standards. CareOregon also conducts "secret shopper" calls to inquire about time to next appointment and other information to help keep the CCO abreast of wait times information. We will also support work between PCPs and specialty providers to implement closed loop referral systems and referral tracking to support members getting access.
Additionally, tools like PreManage are used by Population Health department, the Regional Care Teams, and other CCO staff and teams to provide real time view into how and where our members are accessing care and any identified opportunities for care coordination and member support are followed up by these teams. Our ENCC (both at the plan and at the provider level), and UM teams also monitor access through their interactions with our members.

7.4.a.(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.
CPCCO receives an annual DSN report from its delegated dental plan partners. CPCCO will geomap general practice providers and specialists alongside membership to ensure sufficient oral health access. Provider type is included on the DSN, and this will be used to ensure all plans have a sufficient network of specialists including pediatric providers, oral surgeons, endodontists, denturists, special needs providers and orthodontists. Capacity levels for each dental plan will be determined based on the full-time equivalent (FTE) availability of general practice providers coupled with a sufficient panel of each specialty provider type. Future DSN reports will include provider FTE, so capacity limits will be more closely, and accurately measured and validated at least annually. Data analytics will also be used to understand the distance traveled to receive dental care by members. This analysis will show the actual distances members were required to travel to a general dentist or specialist from their home locale. This data is particularly helpful in more rural areas of the CCO region as an additional measure of members' ability to access care within reasonable time and travel distances.

CPCCO will monitor available dental capacity weekly and require validation of provider FTE prior to any increase in dental plan capacity limits. In addition, the CCO will conduct annual oversight of the dental plan partners and ensure each dental plan is conducting routine timely access reporting of their provider network. CPCCO will also monitor dental utilization monthly to ensure members are accessing services.

7.4.a.(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
Under the oversight of the Network Adequacy Steering Committee, the overall CPCCO network is currently able to provide, and will maintain, capacity at a level that can absorb minor fluctuations in capacity. When fluctuations occur, CPCCO will develop a contingency plan to bridge any gaps created by a sudden fluctuation, which may include paying for services for providers that are not yet contracted or adjusting authorization requirements to ensure continued access. Because there are so few providers in the CPCCO service area (relative to more urban parts of the state), CPCCO staff and leaders stay in close communication with all clinic managers and clinical leaders.

CPCCO/CareOregon has even donated Medical Director time to clinics experiencing a gap in medical leadership. CPCCO has paid relocation fees and signing bonuses on behalf of clinics that

were not in a financial position to offer incentives to recruits. CPCCO has also paid for locum tenens providers to practice on a part-time or time-limited basis in clinics where there may be a workforce shortage. We will continue to offer creative solutions to the workforce challenges that may crop up in the service area.

CPCCO also works closely with its CAC, CAP, Board, and providers to identify and close gaps in availability of culturally responsive care providers across physical, behavioral, and oral health to ensure that we are addressing both clinical and cultural barriers to care.

7.4.b. Requested Documents

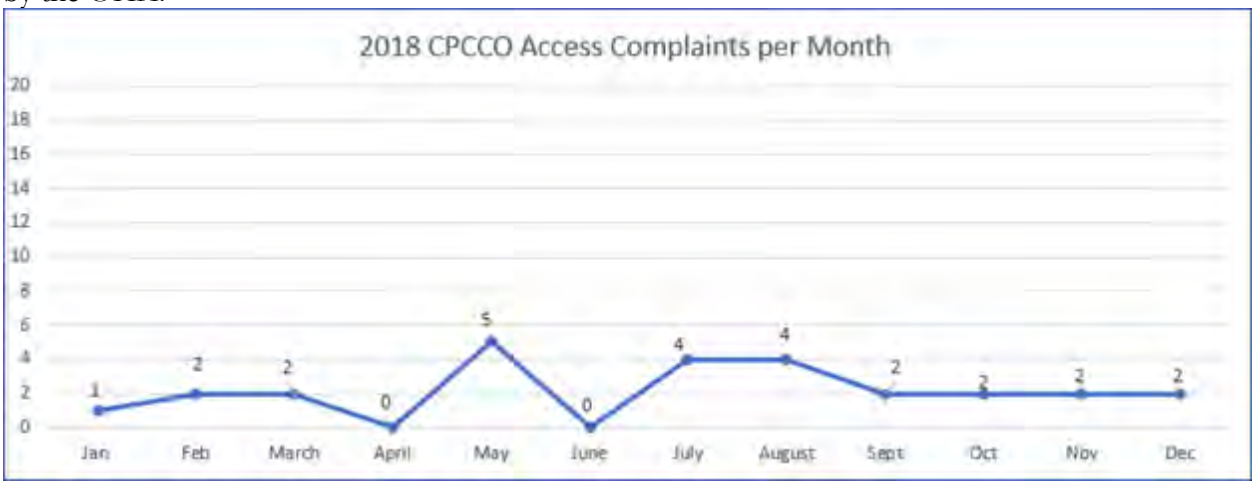
See attached Provider DSN Report

7.5. 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:

7.5.a. Access to care (wait times, travel distance, and subcontracted activities such as NEMT).

CareOregon manages the Grievance & Appeal system on behalf of CPCCO. CareOregon staff collect and respond to grievances related to access and classify the data into the categories required by the OHA.



The "Access" category and related sub-categories identify provider type and grievances related to excessive wait times and travel distance. These sub-categories are tracked over time and are analyzed by race/ethnicity and language. CPCCO leadership and Board receive reports on an ongoing basis and, in collaboration with CareOregon, identify trends and implement improvement strategies. Complaints about access can reflect both actual member experience and member perception. CPCCO relies on strong relationships with its network partners to identify access issues, and analyzes actual appointment availability from providers against access complaints received. Provider Services Representatives work collaboratively with providers to assess barriers to access.

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

In addition to the processes described above, CareOregon tracks member grievances related to access to second opinions. This generally occurs when a second opinion is requested out of the provider network. This can be an indication of not enough specialists in the network to provide the needed services. If we see an increased trend in grievances in the "request for second opinion" sub-category denied, we conduct further analysis to determine if this is a trend or an expected variation.

The CPCCO dental staff will track, trend and analyze dental specific grievances and appeals data quarterly. Grievance and appeals dashboards, and information gleaned from the analysis, will be shared and discussed with our dental partners during the quarterly dental leadership meetings. Strategies will then be developed and implemented within the dental plans for how to increase provider networks. Complaint trends specific to a dental partner or provider will be followed up on an individual basis and corrective action plans utilized if network adequacy or provider access and wait times are not resolved.

The CPCCO Behavioral Health Network, Quality and Compliance Committee (NQCC) meets monthly and reviews appeals and grievances that have been submitted. This committee tracks the reason for the grievances and when they relate to network quality, adequacy or capacity, this committee evaluates what strategies are needed to address the issue. At times, a clear pattern emerges indicating a lack of access to a specific type of service, and at other times it is a provider education issue. This committee ensure that any recommendations are followed up to ensure they were successful in addressing the identified issue. This committee will also review any reports of adverse incidents and determine if technical assistance is required.

7.5.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).
We conduct annual inter-rater reliability analyses to ensure consistent and appropriate application of the Prior Authorization criteria. This activity uses hypothetical case study at all levels of review, including administrative, nursing, and physician staff. We conduct quarterly audits of denial notices (NOABDs) to ensure OAR requirements are met and deficiencies identified. Deficiencies identified as process errors are reviewed with the teams, individual "one-off" errors are handled immediately with the individual. Training opportunities and updated quick guides are used to remediate team-wide concerns. The CareOregon Delegation Oversight Team applies these standards in CPCCO subcontractor and delegate audit protocols.

7.6. Coordination, Transition and Care Management (recommended page limit 5 pages)
7.6.a.(1) Describe how the Applicant will support the flow of information between providers in order to avoid duplication of services, medication errors and missed opportunities to provide effective preventive and primary care.
CPCCO has a comprehensive care coordination model in place to support its members, including those with severe and persistent mental illness and members receiving long-term care and HCBS services. Each county in our service area has a primary community-based Regional Care Team (RCT) team that is comprised of multidisciplinary care coordinators, a pharmacist, a community paramedic, and local providers. The RCT facilitates the flow of information between providers to support effective care coordination, reduce duplication of services and medication errors, and identify opportunities to provide effective preventive and primary care by leveraging technology to facilitate information sharing as well as processes that

facilitate cross collaboration and interdisciplinary care. To accomplish this information flow, CPCCO uses **GSI HealthCoordinator (GSI)**, an advanced care coordination platform that enables information sharing across multiple systems and providers, care team collaboration, interoperability with HIEs, and consistent identification of issues and barriers unique to each member. This platform supports:

- **Centralized triage and referral:** All care coordination referrals and case finding are vetted through a centralized triage process to reduce duplication and streamline integration across behavioral health and physical health settings. The RCT Triage Coordinator collates inpatient discharges, reviews ED utilization reports, and accepts incoming referrals directly from PCPCHs, other providers, community partners, and members.
- **Weekly Interdisciplinary Care Team (ICT) Huddle:** New referrals are reviewed at a weekly ICT. Decisions made during this meeting may include which care coordinator will take the lead on a case when care coordinators need to actively collaborate on a member. Providers participate in these weekly meetings in each of our counties including: the care coordinators from those hospitals, PCPCH care coordinators, community mental health care coordinators, and peer support specialists.
- **Case Conferences:** Case conferences are held twice a month as a forum to discuss complex cases. Case conferences include a Medical Director from our Utilization Management team, CPCCO's network Medical Director, an internal pharmacist who can review medications, the Regional Care Team staff, and any relevant care providers such as the PCP, behavioral health clinician, or specialist. When appropriate the member or their family is welcome to attend. The goal of case conferences is to develop an aligned care plan that ensures coordinated care, and avoids duplication of services, medication errors and missed opportunities to provide effective preventive and primary care.
- CMHP's also have care coordination functions in house. These staff will be integrated with care coordination at the plan level.

RCT staff also attend the DHS Medicaid -funded LTC care provider care meetings and regularly review the list of members enrolled in their care. When members are shared, case workers from DHS/LTC are invited to the weekly ICTs or case conferences.

To minimize gaps in information exchanges between providers, RCT care coordinators share relevant information, including individual care plans, across the health care system and other organizations involved in meeting a member's needs as appropriate, including particularly vulnerable populations such as members receiving long-term care (LTC) services or members with severe and persistent mental illness (SPMI). The primary care providers, particularly those certified as PCPCH, play a central role in coordinating the member's care needs. Recognizing that care coordination/case management is a core offering of the CMHP system, CPCCO involves key CMHC staff in the staffing/consults that involve members who have significant behavioral health issues.

In the future, we will continue to support the exchange of health information across health and social support organizations through the spread and optimization of health information technology, including PreManage and HIE (please see Attachment 9 for more information).

7.6.a.(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.

CPCCO has staff dedicated to working with our provider network and other community partners, including those that provide social and support services, to help providers engage with CPCCO's RCT and with each other. CPCCO has played a leadership role in Tillamook, Clatsop, and Columbia counties by convening stakeholders and facilitating cross-organizational discussions. CPCCO's County Based Collaborative Risk Shares were instrumental in launching our community based RCTs in 2017, and that partnership ensured provider participation in our RCTs from the beginning.

The Collaborative Risk Shares include primary care, community mental health providers, and hospital system partners from each county. In 2018, we evolved the Collaborative Risk Shares into Steering Committees and launched County Operations Workgroups that engage in continual process improvement of cross-organizational workflows within the county. These workgroups include key community partners such as EMS and community-based organizations that provide social and support services. Additionally, the CPCCO Population Health Manager connects directly with community partners and providers who work closely with our members to inform them of the services available. It has been our experience that community partners benefit from assistance navigating the complexity of the health plan structure and often lack clear guidance on how to access care coordination on behalf of members. This manager and the RCT Supervisor provide routine outreach to these partners to educate them on accessing these services.

Local CMHPs all provide 24/7 crisis services. Each county has mobile crisis capacity and those teams perform supports to access ongoing treatment when needed and coordination of care with involved partners.

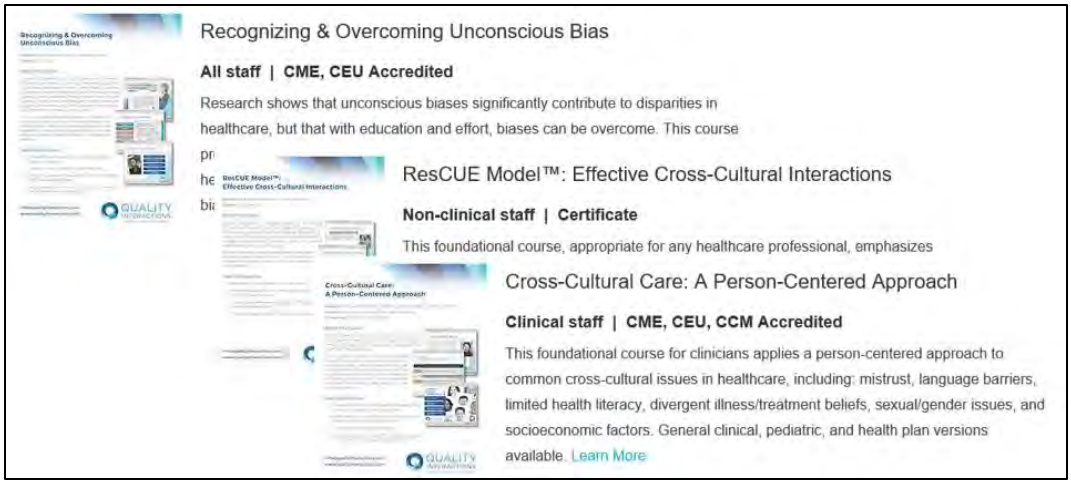
In addition, CPCCO is deeply entwined in the provider and community health services landscapes throughout our service area. CPCCO has four community-focused governance committees: three local CACs and one regional CAC, all of which have strong community representation. CPCCO has developed direct partnerships with all major clinics and safety net organizations in each county. The CCO is working with the three local Public Health departments, the state and other community agencies on improving rates of childhood immunizations and harm reduction programs, leveraging opportunities for risk assessment through home visiting programs (medical and housing), prevention of chronic disease and addictions, and integrating behavioral, medical and oral health services through co-location, alternative payment models and shared care plans. Through networking opportunities like these, providers develop relationships with other services that frequently interact with members to address underlying causes of poor health. These relationships result in increased referrals to appropriate social and support services as well as a strong foundation for coordinating the member's needs. (please see Attachment 10 for more information)

7.6.a.(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.

CPCCO expects that all providers use a culturally and linguistically appropriate approach when communicating with and educating members. However, language can be a major barrier to accessing health services for many. There is a well-documented body of evidence that shows a patient's inability to communicate meaningfully with their health care team leads to poor outcomes and increased spending. CPCCO has outreached directly to Limited English Proficiency (LEP) members and learned that interpretation has been a struggle in the region. Based on that feedback, the Clinical Advisory Panel established a goal to reduce health disparities and support culturally responsive services in our region. The first step in this plan is to provide education to our provider network on

Cultural Competence so that our network can provide effective, equitable, respectful quality care and services that are responsive to diverse cultural health beliefs, practices, preferred languages, health literacy and other communication needs. The "roadshow", beginning in Q1 and Q2 2019, will work to educate providers about the service and how to access it, member rights to meaningful language access, and best practices for clinic workflows effectively working with interpreters.

CPCCO has provided training to our Clinical Advisory Panel and our Patient & Population Centered Primary Care Learning Collaborative to build an understanding of interpretation services from the member perspective. The trainings focused on the ***CIFE*** interpretation model, a widely accepted tool that ensures complete, accurate, effective translation between provider and member. To ensure broad distribution of training, we are contracting with a national vendor to provide online trainings with Continuing Medical Education (CME) credits. These courses will be available to providers and the administrative staff for completion by the end of 2019 and into year 1. The vendor will provide reports at the organization and provider level to help determine if there are continued areas to focus our equity efforts. After an organization completes training, we will meet with them to review reports and determine if we can continue to focus on areas of concern highlighted in the report.



7.6.a.(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.

CPCCO uses a combination of predictive analytics, risk stratification, and clinical judgment along with national standards such as HEDIS to identify members with multiple diagnoses who receive services across multiple systems. CPCCO also proactively identifies members who are identified as rising risk and, in the absence of intervention, are likely to meet criteria in the future. We will continue to work to optimize effective data sharing among network providers and systems to establish and promote implementation of screening standards to identify members with multiple diagnoses and who are using services across multiple systems, with particular attention to disparities. We will leverage the interoperability of our GSI care coordination platform to promote structured assessments for consistent identification of issues and continue to work closely with our provider partners to promote implementation of uniform screening standards for improved care

coordination. For instance, in April 2019, we will be establishing a cohort in PreManage of rising risk members based on identification of multiple diagnoses; any providers using PreManage will be able to identify members who fall into this cohort in real-time in the future.

7.6.a.(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.

Effective care coordination aligns health goals and expectations of the member, their supports and their care teams. The PCPCH is central to care coordination; particularly for members with developmental disabilities and other special health care needs. Collaboration with the member's PCPCH and other care providers is a core principle of the CPCCO RCT care coordination model. Once a member enters care coordination with the RCT, a care plan is created in collaboration with the member and the member's primary care provider. For special populations, such as adults and youth with disabilities, RCT care coordinators work with the appropriate case managers from disability programs or brokerages. For children and youth, care coordination includes the youth and family, behaviorists, therapists, specialty providers, the schools or Early Intervention, System of Care/Wraparound and other community agencies in addition to the PCPCH. Our RCT plays a pivotal role in identifying the parties engaged in the member's care, creating a care plan, and ensuring effective, bi-directional communication among PCPCH, other providers, social support organizations, member and their supports. Clinical staff from the region's CMHPs participate on the RTC to ensure care coordination with behavioral health services.

7.6.a.(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.

Within CPCCO's RCT, the Behavioral Health Intensive Care Coordinator (BH ICC) is responsible for supporting members with SPMI including those in DHS Medicaid-funded long-term care and home and community-based services. The BH ICC works with members and those involved in the member's care using an individualized, strengths-based, recovery-focused, person-centered approach. Working collaboratively with members, their natural systems of support, peers, and community providers, the BH ICC develops care plans that include personalized goals for treatment and recovery, plans to address gaps in care, and estimated dates for achieving these goals. The member's recovery goals serve as the roadmap to determine the least restrictive, most integrated physical, behavioral, oral, and social services and supports available for each member. The BH ICC communicates openly and regularly with the member to assure that the services stay aligned with the member's recovery goals.

We also partner with our CMHPs to include a Community Engagement Specialist within our RCT structure. The role of this person is to work with members who have become overly dependent on institutional mental health supports to the extent that they have no social support network outside of those institutional structures. The Community Engagement Specialist maintains a small case load and works to get these members engaged in community activities outside of the behavioral health system. This can include religious communities, sports teams, or crafts groups depending on the interests of the member. See also 7.6.a.(1).

7.6.a.(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.

CPCCO uses evidence-based or innovative strategies to ensure members receive coordinated care, particularly those with Intensive Care Coordination needs and those experiencing health disparities. We do this by investing in our internal staffing models, technology and community-based supports.

RCT Care Coordination Model - CPCCO has developed its care coordination program to be comprehensive and span the entire care continuum, as opposed to a traditional program like telephonic disease management, or catastrophic case management for acute health care episodes. Instead, we believe, and the evidence supports, that care coordination requires infrastructure that benefits a broader population of members helping to address those in most acute need, but also avert the progression of disease and disability among those at risk of worsening health. An important distinction of the Regional Care Team model is the use of specially trained, multidisciplinary teams who coordinate closely with primary care teams to meet the needs of patients with multiple chronic conditions, contributing socioeconomic factors, and other medical complexity. The RCT model adapts to local needs and leverages data sharing to improve care quality and experience, while offering an opportunity to avert potentially avoidable healthcare costs.

Traditional Health Workers - CPCCO recognizes the value of Traditional Health Workers for our members. THWs, peer recovery mentors and peer support specialists represent a proven strategy for helping members engage in services, supporting effective access to health services. THWs can also increase the delivery of culturally and linguistically appropriate services and increase member retention. CPCCO began building out our Traditional Health Worker network in 2018 with a plan to expand our THW network broadly across the entire region over the next three years.

Payment Models - CPCCO is leveraging innovative payment models to advance care coordination. In 2018, CPCCO added a Cost of Care Incentive Payment to the primary care APM program. The Cost of Care APM measures emergency department and inpatient visits for Ambulatory Care Sensitive Conditions (ACSC). The measure is adapted from the Agency for Healthcare Research and Quality (AHRQ)'s PQI 90. PQI 90 is one of the measures that OHA monitors as part of the CCO waiver. ACSCs are conditions in which an acute event (ED or inpatient) could have been prevented with timely, high quality intervention in primary care. As such, they focus specifically on domains that are impactable by primary care clinics. In addition, the measure is aligned with work we have been doing with network partners by reinforcing concepts of population health management, care coordination and use of PreManage.

Likewise, we plan to update our APM funding to support our primary care clinics to integrate Community Health Workers into their treatment teams. Our current Behavioral Health Integration APM provides a good model that we can replicate for Community Health Workers. That APM provides startup funding for clinics to hire and train a behavioral health clinician and then provides a monthly PMPM based on population reach and clinical outcomes. In a similar vein, we will be building a Community Health Worker APM that will provide startup funding and then an ongoing PMPM based on assigned population engagement levels and clinical outcomes. Finally, as per our community engagement plan we will work to build sustainable funding models for our community-based organizations that employ THWs but are not traditional healthcare facilities with billing capabilities to support the integration and coordination of care beyond the clinical setting.

Addressing Disparities - We will continue to evaluate and invest in strategies that improve care coordination efforts across our system, especially for our members with intensive care needs and those experiencing health disparities, including the analytics mentioned earlier, geo-access mapping and applying health equity lens to identify opportunities to improve care coordination through culturally specific programs focusing on populations with high rates of disparities. An example of such investment is CPCCO's funding for a Mobile Health Clinic for Tillamook County Community Health Center (TCCHC). This mobile clinic will include a behavioral health suite, two exam chairs, a dental chair, a waiting room/reception area, and a wheelchair lift. The clinic will allow TCCHC to provide integrated oral, behavioral, and physical health services to remote areas of the county where transportation barriers are most prevalent. CPCCO's RCT will partner with the clinic to optimize member access and coordination.

7.6.a.(8).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.

CPCCO's standard requires that all members are assigned to a primary care provider (PCP) within 30 days of enrollment, with preference to PCPs certified as a PCPCH. With approximately 77% of our members assigned to PCPCH certified clinics possessing demonstrated care coordination expertise to help connect their patients to health and social support services, we rely on providers to engage members appropriately. CPCCO will support these providers with data and electronic tools to: 1) prioritize populations for additional supports, 2) ensure disparities are being adequately addressed and 3) use trauma informed approaches to operationalize these efforts.

Upon enrollment in CPCCO, new members receive a Welcome Packet that includes information about their benefits and how to contact Member Services if they have any questions. The packet also includes an Initial Health Screening for the members to complete and return. This information helps identify each member's individualized care needs and is used to connect members with the RCT. The coordinator helps the member engage with appropriate physical, behavioral and oral health providers and other support services. RCT care coordinators share pertinent information with PCPs and other members of the care team to facilitate care coordination and a holistic approach to providing care to each member.

7.6.a.(8).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.

CPCCO partners with primary care to conduct core quality health screenings such as PHQ, SBIRT, domestic violence screening, prenatal screening and assessment and these are done in a linguistically appropriate manner. Based on these assessments, members are asked to help create their care plan for the best care needed.

Information gathered from the Initial Health Screening described in the previous question above ensures that members who may be engaged with the RCT have their individual care needs are met at the appropriate level and are coordinated directly with the PCP.

In addition to continuing to develop a culturally and linguistically diverse workforce and utilizing interpretation services whenever necessary, CPCCO will work to improve our PCP assignment process to align patients with their individual cultural and linguistic needs with clinics serving those needs, if available. CPCCO expects its network providers to provide equitable, understandable, and

respectful care to members and, as noted elsewhere in this application, provides education to our provider network on Cultural Competence so that our network can provide effective, equitable, respectful, quality care and services that are responsive to diverse cultural health beliefs, practices, preferred languages, health literacy and other communication needs.

Finally, we upload the Program Eligibility Resource Codes (PERC) we receive from OHA with the new Member Eligibility files weekly to identify members who may be eligible for Intensive Care Coordination. Eligible members for ICC are sent a special letter explaining their right to ICC services and how to access them. The RCT staff reviews all ICC eligible members for an active care plan. If the member does not have a care plan, and RCT team member will contact the member via telephone to conduct both the Initial Health Assessment (if applicable) and a Care Coordination Intake Assessment to determine member needs and how best to connect them to services.

7.6.a.(9).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.

Hospital Transitions

In Columbia County where members utilize out of area hospitals, CPCCO has incorporated a Community Paramedic from Columbia River Fire and Rescue into our RCT. The Community Paramedic attends our weekly ICT Huddles and meets with the member face-to-face to assess member's readiness for discharge, ensure appropriate supports are in place for a smooth transition and create a plan to address potential barriers to follow up care. Post-discharge, the Community Paramedic offers a variety of services based on the member's needs, including: home visit with safety assessment, social determinants of health screening and referral to needed services, coordination of medication review by a CPCCO pharmacist, and scheduling and transport to primary, specialty (including mental health) and dental care services as appropriate. The Community Paramedic documents care plans in PreManage and also uses ImageTrend, which allows for secure messaging of care plans into other EHRs such as Epic.

In counties that do have area hospitals, care coordinators from each of those hospitals participate in our weekly ICT Huddles and collaborate on discharge planning. The ICT format allows hospital care coordinators to work directly with coordinators from our PCPCHs and behavioral care coordinators.

Other Treatment Facilities/Settings

For transitions between other treatment settings, CPCCO's RCT care coordinators work with the facility treatment teams to facilitate discharge or transitions between levels of care. CPCCO Care Coordinators will work with all individuals involved in the member's care including but not limited to:

LMHA/CMHP

- Commitment investigator/monitor
- CHOICE Contractor or Guardian (if applicable)
- Member and any other individual identified by the member as a support (i.e. Family)

- Primary Care Provider
- Other providers involved in the member's care (Psychiatric Provider, ACT team, MH therapist, case manager or treatment team)
- Skilled nursing facility

Behavioral Health

For Oregon State Hospital (OSH) discharges, the OSH Care Coordinator will remain in place to facilitate discharge and transition into the most appropriate, independent, and integrated community-based setting and to ensure treatment teams are set up and in place for continuity of medication and treatment. The OSH Care Coordinators will also ensure that member and community needs are met, providers (medical, behavioral health, and oral health) and, and that members have access to ACT services or another evidence-based intensive service for members who refuse ACT. The RCT, with Behavioral Health and Medical Director input, will review and sign off on all LTC/Oregon State Hospital referrals.

In behavioral health settings, our BH ICC coordinates with programs such as Wraparound, ICC, CHOICE, and Utilization Management to ensure coordination for member transitions to or from residential treatment or state hospital care. For youth and adult members being referred to Oregon State Hospital or residential treatment, Wraparound and CHOICE teams (respectively) are responsible for intensive care coordination services, starting at the time of the initial referral. Care coordinators from these programs partner with other health, social and community supports to explore every option to assure the least restrictive, most integrated setting possible that can safely and effectively meet the needs of the member.

Each CMHP has or is in the process of developing a "transitions of care team". This team works closely with staff from the Choices team for to provide supports members coming out of higher levels including but not limited to members discharging from the state hospital or acute care settings. Members moving between various levels of residential, detox, respite and adult foster homes will receive enhanced supports as needed.

We also partner with our CMHPs to include a Community Engagement Specialist within our RCT structure. The role of this person is to work with members who have become overly dependent on institutional mental health supports to the extent that they have no social support network outside of those institutional structures. The Community Engagement Specialist maintains a small case load and works to get these members engaged in community activities outside of the behavioral health system. This can include religious communities, sports teams, or crafts groups depending on the interests of the member.

7.6.a.(9).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.

CPCCO has a strong relationship with our ADP/AAA agencies. Initially fostered by OHA's LTC Innovator Agent for our region, the relationship and commitment to collaborate and share information about mutual members continues. Members of our RCT attend the DHS Medicaid-funded LTC care provider care meetings and regularly review the list of members enrolled in their care. When members are shared, we invite case workers from LTC to our weekly meetings or case conferences.

When a member receiving long-term care services and supports requires a transition of care, our RCT and the appropriate agency share information and identify needs to support the transition, including the appropriate setting for further care. If needed, the RCT will facilitate an interdisciplinary care coordination care conference pulling together those professionals and the member (if appropriate), to create a comprehensive plan for safe transfer across treatment settings.

7.6.a.(9).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.

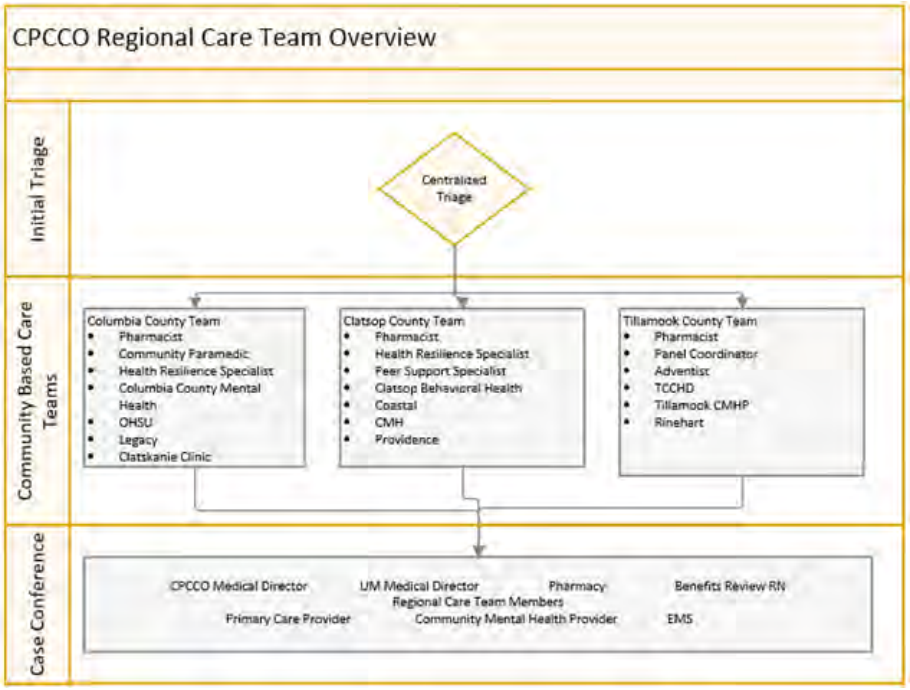
CPCCO uses the combination of PreManage and **GSI HealthCoordinator (GSI)** care coordination platform, which allows CPCCO to track member transitions between care settings and to seamlessly share care plans, send and receive secure messages, and promote post-discharge follow-up. GSI allows us to communicate with providers by sending the care plan to the provider portal or to providers' EMRs directly via secure messages (when authorized). RCT members document communication and care planning with the member, family members, provider, facility or other agency to ensure the plan is tracked and member needs are met as planned. GSI's interoperability capability allows information sharing and data aggregation across multiple systems and providers, including EMRs and PreManage, allowing for real-time alerts of care transitions. Providers can choose to document care plans and Case Conference documentation into their EMRs or receive them via GSI or PreManage.

7.6.a.(10).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.

As required by ORS 414.625, CPCCO's RCT works with the member and their supports, providers, appropriate agencies, and other community resources to develop an Individualized Care Plan (ICP) for members with intensive care needs, including members with severe and persistent mental illness receiving home and community-based services. The ICP ensures that the member's physical, mental, oral and general support needs are identified, that member and their family/caregiver preferences are incorporated in the plans, and prioritizes what is important to the individual to deliver services in a manner reflecting personal preferences and ensuring health and well-being.

RCT Triage Coordinators are responsible for monitoring ICPs. They will pull monthly reports of members who qualify for ICC and route care plans for review to the assigned RCT. Once care plans are reviewed and aligned, we communicate with providers and other care team members by sending the care plan to the provider portal or to providers' EMRs directly via secure messages (when authorized). Care plans will be reviewed, at minimum, on a semi-annual basis or more frequently as requested or indicated by a change in patient status.

7.6.a.(10).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.



Early identification of high needs members through a screening process is essential to providing effective care. All adult members are sent an Initial Health Screening at time of enrollment. This screening asks member's key questions regarding their health, social determinants of health, dental needs, and behavioral health needs. In addition to the information collected from the Initial Health Screening, CPCCO assesses the following data to identify and reach out to members who may need intensive care coordination support:

- We upload the Program Eligibility Resource Codes (PERC) we receive from OHA with the new Member Eligibility files weekly to identify members who may be eligible for Intensive Care Coordination and contact the member to conduct both the Initial Health Assessment (if applicable) and a Care Coordination Intake Assessment to determine member needs and how best to connect them to services.
- For special populations, such as adults and youth with Intellectual and Developmental Disabilities (IDD), care coordinators work with the appropriate case managers from IDD programs or brokerages. For children and youth, in addition to the PCPCH, care coordination includes the youth and family, behaviorists, therapists, specialty providers, the schools or Early Intervention and other community agencies. The RCT care coordinator is at the center of this information sharing which allows the member to experience a collaborative care plan.
- For members receiving LTC benefits, we utilize our standing care coordination meetings with APD staff to address any intensive Care Coordination needs.
- CPCCO uses a combination of predictive analytics, risk stratification, and clinical judgment to identify members who might require care coordination services. Our predictive analytics capability allows us to proactively identify members as rising risk and are at risk of decline without intervention. On a monthly basis, we review segmentation data that tracks member movement between cohorts into a high utilization cohort or who move from a lower risk cohort into a rising or high-risk cohort. The RCT Triage Coordinator will contact the member via phone and attempt to engage them in care coordination.

7.6.a.(10).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

As mentioned in 7.a.1, CPCCO works closely with our local aging and disability agencies to identify needs for interdisciplinary care coordination based on referral, risk assessment and screening

information gathered by the agencies. RCT members attend the DHS Medicaid-funded LTC care provider care meetings and regularly review the members enrolled in their care. When members are shared, we invite case workers from long term care to our weekly meetings or case conferences.

7.6.a.(10).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.

CPCCO's RCT works with the member and their supports, providers, appropriate agencies, and other community resources to develop an Individualized Care Plan (ICP) for members with intensive care needs, including members with severe and persistent mental illness receiving home and Community-based services. The ICP ensures that the member's physical, mental, oral and general support needs are identified, and that the member and their family/caregiver preferences are incorporated into the plans, and reflects what is important to the individual to ensure delivery of services in a manner reflecting personal preferences and ensuring health and well-being.
Member care plans will be reviewed semi-annually, at minimum, or more frequently if requested or indicated by a change in member status. Once the goals of the ICP have been accomplished, the intensive care coordination case is closed. If another need arises, members are re-engaged in care coordination services, at which time their health risk is reassessed, and the care plan revised.

7.6.a.(10).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.

Care plans are shared with providers, community partners (AAA, APD, DHS) and the member upon development, update, and resolution via ICT, care conference, fax, in-person, PreManage, Provider Portal, Member Portal, secure message through care management, and other ways if requested by authorized persons. There is a designated note-taker at each staffing meeting who documents the developed care plan, which is then sent out to all through secure email following the meeting to all relevant staff/providers. Follow up for members with care plans is continued at subsequent meetings until the situation is stabilized or resolved.

7.6.a.(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.

CPCCO works closely and collaboratively with dental partners and providers to coordinate members' oral health needs. CPCCO has developed oral health strategic priorities and holds quarterly leadership meetings with its dental plan partners to align strategies to more seamlessly serve the local communities. Priority populations such as young children, pregnant women and diabetic patient management and coordination are central to that collaboration. CPCCO also works collaboratively with the OHA Dental Sealant Program to partner with local community agencies to augment school-based services in Tillamook and Clatsop counites. We have also partnered with local programs to facilitate and offer onsite oral health preventive services at a variety of locally based events and initiatives. Our community-wide collaboration with providers and plan partners will build out more specific programs that continue to focus on priority populations and our collective goals related to improving and increasing access, utilization, engagement, education, community-based prevention services and the oral health-overall health connection.

Referrals to oral health services are facilitated via bidirectional communication between physical health and dental providers, using CCO infrastructure to facilitate that communication as necessary. The CPCCO dental team routinely receives requests for dental care coordination directly from

physical health providers via a dental services request functionality within the CCO Provider Portal. These requests, most often generated by primary care providers, can be for anything from suspected dental issues, to inclusion of oral health in diabetes management, to establishing a dental home. The CCO dental team receives these requests daily and subsequently assures the member receives further care coordination specific to their oral health needs. Currently in development is a related mechanism for dental and/or behavioral health providers to request the CCO facilitate or initiate care coordination with physical health, oral health or behavioral health so this functionality becomes tri-directional amongst the three primary health disciplines creating a more integrated and coordinated approach for the member.

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

CPCCO regional care teams are fully integrated and multidisciplinary teams including care coordinators with expertise in nursing, behavioral health, oral health, and system navigation. RCTs will accept care coordination referrals from oral health to physical and/or behavioral health care. The RCT then assesses the member's needs, creates a care plan, and works closely with the member's providers and other involved partners to refer and coordinate care for member's unmet physical or behavioral health needs. CPCCO is creating an online mechanism whereby oral health and behavioral health providers can submit a cross-discipline request for care coordination for their patients. This central "hub" for requests will ensure more cohesive and seamless care for members' health care needs across all disciplines. CPCCO also has a dental care coordinator who supports navigational and low acuity requests for care coordination to support member needs.

7.6.b. Care Integration (recommended page limit 1½ pages)

7.6.b.(1). Oral Health

7.6.b.(1).(a) Describe the Applicant's plan for ensuring delivery of oral health services is coordinated among systems of physical, oral, and Behavioral Health care.

Regional care teams (RCTs) are fully integrated and multidisciplinary teams that include a dental care coordinator. Members with complex needs or other identified risk factors will be supported by the care team, which will establish a comprehensive care plan that includes oral health. When members indicate dental needs on their initial health screening, a care plan issue will be created. The care coordinator will then further assess the needs, and work with the dental providers and partners to establish an appropriate dental home for the member to best meet their needs, based on the overall acuity or complexity of the member's situation. Dental specific care coordination and/dental care management will be available for all members who need assistance or support meeting their oral health needs, regardless of how, when, or where those needs are identified. Conversely, unmet physical or behavioral health care needs identified in the dental setting will also be managed by the RCT to assure these needs are fully assessed and addressed.

7.6.b.(1).(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.

CPCCO does not currently have any clinics with co-located oral health services, but would pursue aligned member assignment to the primary care and dental home if we have such an opportunity in the future. This will allow for alignment of primary care and dental care assignment and will make accessing oral health services much easier by members. Additional medical-dental provider partnerships will be developed in cases when co-location of medical and dental is not feasible, so that members can benefit from similar provider relationships and the creation of a health home. Mobile services will also be employed by CPCCO. These mobile sites will bring oral health services

to locations where members are, increasing ease of access. Current mobile services include a dental van partnered with Legacy Clinic in Columbia County and delivery of services in schools. In addition, CPCCO will partner with community agencies and health centers to provide mobile oral health prevention services during various activities throughout the year. CPCCO has also funded a Mobile Health Clinic operated by Tillamook County Community Health Center, which will offer dental services in addition to physical and behavioral health services.

CPCCO will also actively promote, train and support primary care sites in First Tooth. First Tooth trains primary care providers to deliver basic oral health prevention services (risk assessment, anticipatory guidance, fluoride varnish, referral to a dental home) in the primary care setting. Future iterations of our primary care alternative incentive payments will include oral health interventions like oral health assessment and fluoride varnish application in the primary care setting. Oral health interventions for children ages 0-5 are a key integration metric and will further promote setting-appropriate oral health services and engagement for members.

CPCCO will include a dental utilization metric in DCO contracts for dental services. This metric sets annual improvement targets to promote member engagement in dental services. This metric has led to increased engagement and utilization of services by members and will be a starting point for more robust alternative payment and/or incentives payments for engagement and oral health outcomes.

7.6.b.(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:

7.6.b.(2).(a) Coordination with a Member's Patient-Centered Primary Care Home or Primary Care Provider

Coordination with the member's PCPCH begins with the Initial Health Screening. All adult members are sent this screening at enrollment. The screening asks members key questions regarding their health, SDOH, dental and behavioral health needs. When issues are identified, the care coordinator creates a care plan and begins coordinating care with the member's PCPCH. Coordination can occur through many methods including telephone, electronic communication, or via an Interdisciplinary Care Team meeting for members with complex needs. Care coordination occurs across multiple systems including the PCPCH, behavioral health, SNF, and hospital. Using the collective platform of PreManage and EDIE increases efficiency and timeliness of these activities, as well as optimal targeting of high-risk populations by the right point of contact.

7.6.b.(2).(b) Processes for PCPCH or Primary Care Provider to refer for Hospital admission or specialty services and coordination of care.

CPCCO agreements with hospital and specialty care providers indicate that members can access specialty care without prior authorization to remove barriers to access to care. Ongoing care can be requested by the specialist. All authorization information is available to PCPCHs and Primary Care Providers so they can stay informed of services their members are receiving. Urgent/Emergent admissions do not require prior authorization. For pre-planned admissions, PCPCH or Primary Care Providers submit requests for inpatient services. These requests are reviewed for medical necessity and compliance with OHP guidelines for coverage. Each request is reviewed for presence of a contributing co-morbidity or need for a benefit exception.

The PCPCH has consistent access to care coordination support. We believe that there is no wrong door when accessing care coordination services. We consistently reach out to providers (Primary Care and Behavioral Health) to explain how to access care coordination services. We encourage providers to call the CPCCO RCT when a care coordination need is identified. Members themselves are empowered to request care coordination services and are informed of this process via new member welcome packets. CPCCO maintains very close relationships with our community-based organizations. We work collaboratively with these geographic or culturally specific organizations to address member's needs. The RCT care coordinators serve as a bridge between the agencies and providers caring for the member.

7.6.b.(2).(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.
CPCCO receives hospital notification via PreManage when members are admitted to inpatient facilities. CPCCO expects our primary care provider network to share records between hospital and specialty treatment providers especially at the time of hospital admission and discharge. The coordination of care and sharing of information is essential to the successful transition of the member from differing levels of care. Providers who use EPIC receive information regarding a member's care in the hospital or in specialty treatment utilizing Care Everywhere. This allows for the electronic flow of information between the PCPCH and other providers. Network providers that are utilizing PreManage can receive real-time notification of admission and discharge from facilities. PreManage allows for the creation of shared care guidelines which are made visible to all providers within the member's care team. The CPCCO RCT strives to connect all the pieces of the member's care and often assist the PCPCH, the hospital, and specialty provider in sharing information to optimize the member's health outcomes.

7.6.b.(2).(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.
CPCCO agreements with hospital and specialty care providers address shared planning for successful transition of care. When CPCCO members are hospitalized within the CPCCO region or in the Portland metro area, the CPCCO RCT will work collaboratively with the member's PCPCH and the facility discharge planners to assist member in their transition. The Care Coordinator will assess for transition needs with the member including confirmation of the member's understanding of their hospitalization, if they received a discharge plan in their native language and readiness for discharge. The Care Coordinator and facility staff ensure members have appropriate services in place to reduce readmission and improve health outcomes. Through the use of PreManage, PCPCHs can be notified in real time of discharge from hospital as well. The RCT care coordinator works collaboratively with the PCPCH ensuring a follow up appointment has been made and addresses other needs the PCPCH or member might need to assure a successful transition. A care plan is created within PreManage so all providers involved in the member's transition are notified of care coordination efforts across multiple systems.

When a member is discharged to a Skilled Nursing Facility (SNF), we work in collaboration with those facilities and the PCPCH to provide the best care coordination possible. Care coordination teams from CPCCO, the PCPCH and the SNF are notified that a member has entered a SNF via PreManage. Transitional care for the member begins at time of admission which ensures ample time for appropriate discharge planning. When the member is ready for discharge, the CPCCO RCT care and the SNF work together to address any issues including clinical and utilization management

barriers such as needed durable medical equipment. Information is shared with the PCPCH and follow up appointments with the PCPCH are established upon discharge from the facility.

7.6.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.
7.6.c.(1). Describe how the Applicant will:
7.6.c.(1).(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;
CPCCO currently provides health services to all members, including those receiving DHS Medicaid-funded LTC services. We have a signed and executed MOU with DHS Medicaid-funded Long-term Services and Supports (LTSS) providers through the AAA office of NorthWest Senior & Disability Services and the local APD office for Columbia County. We have strategized and developed the aligned Interdisciplinary Care Coordination Conferences (ICCCs) across all three counties. Communication between our AAA/APDs and our RCT results in an ICCC and the provision of care and services is agreed upon and provided to the member. Health services will include provision of behavioral health evaluation and consultation when indicated.

7.6.c.(1).(b) Use best practices applicable to individuals in DHS Medicaid-funded LTC settings including best practices related to Care Coordination and transitions of care;
The CPCCO RCT believes our use of the ICCCs is a best practice as it facilitates transitions of care between treatment settings and problem solves complex issues to find a resolution. The purpose of these ICCCs is to gather all care team members from all disciplines that are currently working with the member to communicate a shared understanding of the member's health and social service needs, including their preferences, goals, and any concerns about access to needed services. The ICCCs provide a forum to work collaboratively to address gaps and unmet needs of the member while respecting the member right to self-determination and the least restrictive intervention. ICCCs may be offered in clinic, at a social service office, in nursing facilities, residential settings and the member's home. A call-in option is always available.

7.6.c.(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:
7.6.c.(2).(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.
Given the geographic expansiveness of our region, co-location in health or other care settings is difficult. CPCCO has provided start-up funding and ongoing PMPM payments for co-located behavioral health consultants (BHC) in our primary care clinics. All our major PCPCHs have co-located BHCs. We also have community-based teams in each of our counties to optimize a team-based approach outlined below.

7.6.c.(2).(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.
CPCCO utilizes a team approach to our multi-disciplinary ICCCs. The ICCC team members can include health, long-term services and supports, behavioral health, other social services, other

community services providers, the member, and their natural supports. As members enroll in care coordination, teams look for current engagement with LTC or AAA/APD. This information can be located in the care team box of PreManage. If a member is engaged with these programs, the care coordinator facilitates an interdisciplinary care team meeting with the AAA/APD care manager, the primary care provider, member, and any other relevant team member needed to coordinate care. The outcomes of that meeting are documented in the member's care plan. The care plan is made available and a care guideline is created in PreManage when indicated.

7.6.c.(2).(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).

Through the work of the MOU and ICCCs, the AAA/APD case managers provide assessment services for members in their home or residential/nursing facility who are in LTSS. They also provide case management services, which may include helping members to obtain in-home personal care services.

7.6.c.(2).(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.

CPCCO actively partners with all three county public health departments and Community Action programs. Currently, both organizations provide types of home visiting services in each county, including CaCoon and Healthy Families. In addition, CPCCO has funded each county's Community Action Team for a "Healthy Homes" program to assess the quality of the home environment. This program utilizes skilled home assessors for mold, carbon monoxide, mites, hazardous substances, leaks and other issues that could be remediated with roofing, weatherization or other home rehabilitation services. Members who are part of this program also are case managed by Community Action Team staff for a year following a home improvement intervention.

The CPCCO RCT includes Health Resilience Specialists, who are licensed clinical social workers who can provide interventions to members in the home or community as needed (Clatsop, Columbia counties); the community paramedic (Columbia County) also provides in-home services. Depending on the needs of the community and population, we may expand the team to include RNs for in-home assessments, especially as we expand our palliative care services. Some of our primary care organizations provide home visits including OHSU Scappoose. In addition, OHSU physicians staff and provide medical direction to nursing facilities in Columbia County, and see their patients there. Finally, CMHP's have established practices of utilizing nurse practitioners, PAs, and other clinical staff to provide services in home or community settings for members in need of behavioral health services.

7.6.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.

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

UM activities are tailored to address the needs of diverse populations through coordination and collaboration with community partners and care coordination between behavioral health and

physical systems. Utilization management program activities include the evaluation of appropriateness of clinical services and treatment, and encourage the highest quality care, including using care coordination to engage APS, DHS, DD, specialty mental health, and physical health providers to gather additional information about the member and supports available through those networks. Utilization management also includes a retrospective review of covered services already rendered or already incurred costs. Finally, UM uses predictive modeling to identify individuals or populations for disease management or care management programs.

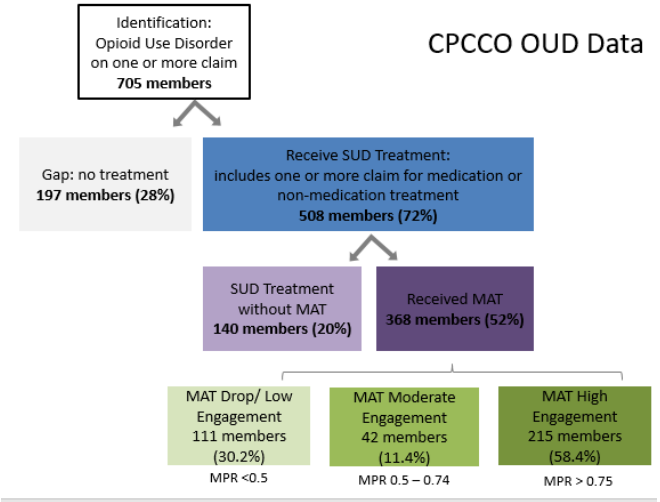
Most authorizations in the outpatient setting are seamless and flow between primary providers and specialty care without the need for an authorization. For certain types of ambulatory care, we conduct prior authorization reviews for certain high risk, high cost diagnostic procedures (such as MRI/CT scans) and certain ambulatory surgeries. For acute levels of care, if these are planned admissions, they would have been prior authorized. For those that are admitted via the emergency department, an initial utilization review is conducted the next business day using nationally accepted evidence-based criteria and concurrent review is conducted regularly on a subset of stays thereafter to ensure continuing care criteria continue to be met.

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

CPCCO monitors over- and under-utilization using a CPCCO Cost & Utilization dashboard that details, by service category, total cost and utilization over time. We follow several utilization measures (ED, primary care, specialty, mental health, etc.,) and can disaggregate this data into demographic or other groups such as members in LTSS services, members with SPMI, or foster care status. We examine cost trends to identify areas of focus indicated by increasing costs. Data are then analyzed based on provider specialty to review rates/quantity of service requests for outliers. This analysis can inform policy change, provider education, or potential fraud waste and abuse concerns.

During the prior authorization process, the prior authorization team (including Medical Directors, RNs, and line staff) identify patterns and opportunities to improve the overall process. This can include identifying services which should be reconfigured to no longer require prior authorization, services which should require prior authorization, and provider patterns which are questionable compared to their peers. The identified opportunities are reviewed by a team of Medical Directors and the Clinical Operations Manager to investigate the relevant rules and guidelines as well as most recent evidenced-based care.

We also use the quality improvement data to understand over- and under-utilization. For instance, by regularly reviewing data about the utilization of medication assisted treatment (MAT) for substance use disorder, we identified an opportunity to expand the use of MAT as an effective response to opioid use disorder. This data was used to convene partners in developing innovative approaches to reducing opioid-related harms and finding better treatment models.

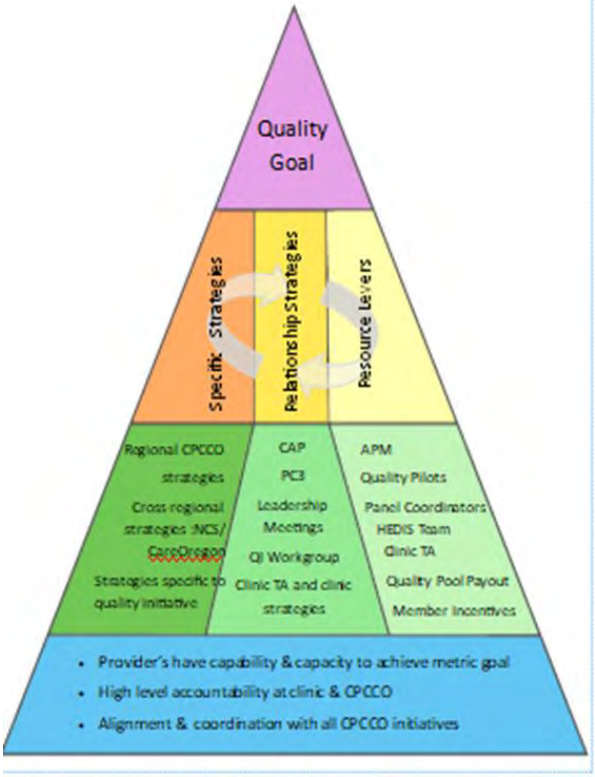


In addition, we developed an evolved approach to assess the number of people with an opioid use disorder diagnosis not in treatment and are actively developing a strategy to address undertreatment.

7.7. Accountability (recommended page limit 1½ pages)

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

CPCCO has several mechanisms for quality measurement and reporting that we will continue to utilize and improve. Our Transformation and Quality Strategy complies with all state and federal requirements. In partnership with CareOregon, we employ robust quality measurement and reporting programs including collection and reporting of performance on health quality indicators including CCO Incentive Metrics and State Quality measures, and HEDIS and CAHPS measures. Through our CAP, we continually measure and report on these quality indicators to inform the development of innovative strategies to achieve the Quadruple Aim. Collectively, we develop systems to close gaps in care, increase prevention and wellness activities, expand access to care for physical, behavioral, and dental health services, and address inappropriate utilization and improve cost-effective care.



7.7.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)?

CPCCO's parent organization, CareOregon, collects and reports HEDIS and CAHPS measures for its Medicare Advantage plan and is fully compliant with all reporting requirements. CareOregon underwent a successful CMS Program Audit in 2018.

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

The CPCCO Board oversees development and implementation of the CPCCO strategic plan and sets CCP performance expectations that include metrics for quality and transformation. These measures include but are not limited to the CCO Incentive Metrics, and address CPCCO's collective actions to improve access, impact community health, reduce cost, promote equity, integrate care, and improve health care quality. The Clinical Advisory Panel (CAP), at the direction of the Board, provides the strategic leadership and direction for clinical transformation. The CAP ensures CPCCO's clinical transformation efforts and quality priorities are strategically aligned with those of its constituent organizations, the CPCCO community advisory council as well as the CPCCO board, and that these efforts have the active support of clinical and executive champions at the highest organizational and community levels. The CAP has developed a strategic approach to quality that combines the CPCCO Board's strategic plan, the state mandated TQS components, clinical priority initiatives, and Performance Improvement Projects (PIPs) into a defined set of well-articulated goals to improve and transform the health and wellness of the CPCCO population.

To ensure that CareOregon is providing administrative services as outlined in the agreement with CareOregon, The CPCCO Board receives reports from CareOregon at least semi-annually that include but are not limited to: Appeals and Grievance analysis, Delegation Oversight status and any relevant Corrective Action Plans, outcomes of the state External Quality Review and the progress of the TQS. The CPCCO Medical Director sits on the CareOregon Quality Management Committee to provide alignment between CPCCO and CareOregon.

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

CPCCO uses the Clinical Advisory Panel as a mechanism to share organization-level and CCO-level performance, unblinded, to cross-regional clinical partners. Within that forum, providers and CPCCO can discuss areas of high and low performance and collaboratively work on areas for improvement. We share similar data with our primary care clinic leadership and to individual physicians in smaller clinics. The unblinded data-sharing is meant to inform and drive quality improvement. We further share this data in our primary care learning collaboratives with operational primary care staff within our region who are leading quality improvement efforts at their clinics.

We also disseminate performance information with externally accessible quality performance dashboards via Tableau that are available on a real-time, daily basis. These dashboards and reports range from opportunities to improve CCO metric performance and identify members with gaps in care, to opioid member lists to help organizations know which patients are at highest risk and how to focus clinical improvement efforts, to diabetes-specific member dashboards to promote effective diabetes management.

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

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

CareOregon and its wholly owned CCOs utilize multiple methods and activities to provide guidance on identifying and reporting possible or suspected FWA. These items include the CCO Ethics and Compliance Program, an extensive Code of Conduct, new hire and annual FWA training material and related reporting mechanisms. Each of these items and related activities are independently evaluated annually by State contracted External Quality Review (EQR) auditors.

CPCCO and CareOregon Board members are jointly responsible for the reasonable oversight of the Compliance Program and FWA activities. The Board members receive annual FWA training and related oversight due-diligence training to help guide them in their governance role. The CPCCO Board appointed CareOregon's Internal Audit and Compliance Officer as its Corporate Compliance Officer, who is responsible for the daily activities and overall effectiveness of the Compliance Program and related FWA activities. The Compliance Officer provides both the CPCCO and CareOregon Boards with periodically reports on compliance and FWA concerns. A significant number of internal audits are performed each year for the CareOregon Medicaid lines of business, including audits specific to CPCCO, and include evaluations of establish controls and incorporate fraud detection components. CareOregon has also established an Internal Compliance Committee (ICC), made up of various senior management, to review and discuss compliance, audit and FWA concerns to ensure a strong consistent culture of compliance. Additionally, CareOregon maintains a provider Payment Integrity Committee (PIC) to identify and monitor high-risk providers and utilization/billing outliers. The CCO provider network is monitored through a combination of the

Audit and Compliance department, Peer Review Committee and PIC. All three together holistically examine the provider network through claims monitoring, clinical oversight and overall FWA monitoring. Through these avenues, when appropriate, we will use FWA themes for quality improvement activities.

Subcontractors and delegated entities are monitored and audited by CPCCO and CareOregon personnel including department business owners who work directly with vendors to monitor delegated activities and related performance measures. Internal Audit and Compliance evaluates the effectiveness of the Delegation Oversight function and ensures delegated entities provide sufficient annual FWA training to their staff and downstream contractors, including available anonymous non-retaliation reporting mechanisms and expectations.

Regardless of how the noncompliance or FWA is identified, CareOregon on behalf of CPCCO will initiate a reasonable inquiry as quickly as possible, but no later than two weeks after the potential noncompliance or potential FWA incident was identified. When potential FWA is identified, the Compliance Officer will refer the issue to the appropriate State and Federal agencies within the stipulated time lines.

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

CareOregon monitors and audits subcontractors and delegated entities on behalf of CPCCO. Oversight may include: CareOregon functional area business owners who work directly with vendors to monitor delegated activities and related performance measures, Delegation Oversight personnel who monitor contracting and provide oversight of the CareOregon business owner and vendor relationships, and an Internal Audit and Compliance function that evaluates the effectiveness of the Delegation Oversight function and ensures delegated entities provide sufficient annual FWA training to their staff and downstream contractors to include available anonymous non-retaliation reporting mechanisms and expectations.

Additional auditing and monitoring are already conducted on an ad hoc basis, if the delegated entity becomes aware of any credible allegation of fraud, waste or abuse. The characteristics of suspicious cases that should be referred are described in the Core Contract, Exhibit B, Part 8, Section 14.c.(2)(a). Current and continued reporting requirements at a minimum are: monthly OIG/SAM checks; quarterly review, investigation and resolution of complaints and grievances related to fraud, waste or abuse; and annual submission of their fraud and abuse policies, annual compliance and program integrity training of their staff, and an annual review of their program integrity according to OHA contract requirements. CareOregon also supports FWA prevention through our provider credentialing system and those of our plan partners.

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

7.9.a. Please describe policies, processes, practices and procedures to improve Member outcomes.

CPCCO has developed a quality framework to achieve quality improvement initiatives. We utilize this framework to engage and support our network to improve quality and positively impact member outcomes. Within this framework, CPCCO uses a population health strategy to improve member outcomes. All CPCCO actions will be informed and prioritized with the evidence-based approach of using data, community input/needs assessment, current clinical evidence, and emerging practices. CPCCO's medical director leads these efforts, in partnership with the CAP. The CAP uses a strategic approach to quality combining the CPCCO Board's strategic plan, the state mandated

health care transformation and quality components, clinical priority initiatives, community and regional needs based on population data and Performance Improvement Projects (PIPs) into a set of well-articulated goals to improve and transform the health and wellness of the CPCCO population. These priorities are reviewed and executed by the CPCCO CAP and, as relevant, local CACs.

While specific clinical priorities may change over time, we consistently employ the following practices to improve member health and outcomes:

- Use clinical advisory panel to develop clinical strategy and areas of focus.
- Ensure programs and initiatives serve the entire community, including providing culturally responsive services and services in multiple languages.
- Provide regular data sharing, clearly and openly communicated with partners, for use as a continual improvement tool.
- Use claims data, cost data, and utilization data to identify opportunities for improvement.
- Solicit community feedback/input to identify and respond to emerging needs.
- Convene and facilitate collaboratives for shared learning across the region
- Provide coaching and trainings for organizations on quality improvement, using QI methods such as PDSA, value stream mapping and other LEAN tools.

7.9.b. 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.

Regional network wellness: CPCCO has a clinician and staff wellness program to respond to burnout, increase resilience, and build focus on wellness and retention. The program funds mind-body medicine programs and mindfulness programs for health care teams, and includes other activities to help support the health of the network, including a medical leadership collaborative and community of practice to address professional isolation in rural Oregon.

Member wellness: CPCCO funds health and wellness activities provided to patients, including wellness centers in all three counties helping with programs to address pain and anxiety, diabetes initiatives with nutritional supports, cooking classes and wellness activities. CPCCO's *Rx to Play* is an initiative that allows health care providers to give prescriptions to patients for wellness activities like gym memberships. CPCCO also directly provides members with gift card incentives to encourage annual wellness visits, childhood immunizations, tobacco cessation, pregnancy wellness, and more.

CPCCO staff wellness: CPCCO's parent organization has implemented a variety of wellness and health improvement activities within its benefit structure for CPCCO employees, including reimbursement for health and wellness-related expenses, an Employee Assistance Program, wellness resources within health benefits, incentives for completing wellness and prevention activities, and on-site yoga.

7.9.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.

CPCCO has extensive experience meeting regular performance targets and benchmarks. We have dedicated staff in quality improvement, analytics, primary care and behavioral health technical assistance, and provider relations to ensure performance benchmarks are achieved. We have consistently used CCO Incentive Measures and statewide PIP metrics as a baseline to assess the value of health services and have incorporated them into our value based payment methodologies. Provider organizations receive a percentage of the quality pool payout in proportion to their contribution to overall CPCCO metrics achievement, and have ownership and input into how remaining funds are used to improve health within the community. In this way -- through direct payment and a collective desire to improve the health and health services within the community -- the accountability metrics have served to effectively engage our provider network and as a pathway for shared goals to improve member care. We review metrics at multiple external meetings including our CAP, Primary Care Collaborative, and individual clinic leadership meetings to encourage quality improvement, elicit strategy feedback and ideas, and report on clinic-level and overall metric performance. CPCCO has multiple strategies and documented workplans for each metric and its Quality workgroup meets bi-monthly to operationalize quality improvement strategies to meet metric benchmarks. See 7.9.a.

7.9.d. Policies and procedures to ensure a continuity of care system for coordination of care and arrangement, tracking and documentation of Referrals and Prior Authorization.

Our policies and procedures governing coordination of care and utilization management are designed to support a continuum of care that integrates behavioral, oral and physical health services to achieve the objectives of whole person, integrated care. The CPCCO RCT team utilizes the GSI care coordination platform to collaborate among providers to assure that information for the members' care plans is available to assure continuity of care. Within the RCT, CPCCO Health Resilience Specialists track referrals and prior authorizations to collaborate with providers, and/or members, and/or member's representatives to assure that information for the members' plans of care is available to assure safe transitions across care settings and help high and rising risk patients receive the care they need. We also have ENCC nurses who coordinate care for complex patients.

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

7.10.a. Is Applicant under Enrollment and/or Marketing sanction by CMS? If so, please describe?
No

7.10.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?
Yes, CPCCO's Affiliate, CareOregon, operates a Medicare Advantage plan (CareOregon Advantage). The Service Area includes Clackamas, Jackson, Multnomah, Tillamook, and Washington counties.

7.11. Service Area and Capacity (not counted towards overall page limit)
7.11.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.

Columbia Pacific CCO Service Area Capacity

County	Maximum Enrollment	
	Physical/Behavioral	Dental
Clatsop	15,300	12,000
Columbia	18,000	14,000
Tillamook	12,000	6,500

7.11.b. Does Applicant propose a Service Area to cover less than a full County in any County? No.
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.
The above questions are N/A.

7.12. Standards Related to Provider Participation (recommended page limit 5 pages)
7.12.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.
INSTRUCTIONS: Submit the information in about each Provider or facility using the DSN Provider Report Template.
Please see DSN Provider Report.

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

CPCCO maintains direct service agreements with all provider types necessary to ensure adequate access to all Covered Services, including services required by those with special needs. CareOregon Provider Contracting staff negotiates and maintains all provider agreements. A team of Provider Relations Specialists provide education and support to all provider types.

Rural communities have significant difficulty recruiting and retaining practitioners and CPCCO's region is no different. For this reason, our network focuses on finding providers that can serve the broadest population possible. The majority of our providers are family practitioners who have skills to serve elderly, youth, children, and disabled patients. For our members with intellectual or developmental delays we have occupational, physical, and speech therapies available in all three of our counties. We also have a network of specialists in Portland for members who require different types of specialties that are not available in our counties.

We partner closely with our network to provide care coordination for the members mentioned above and those with high health care needs, substance use disorder, multiple chronic conditions, and or mental illness. We meet weekly with our major primary care providers and community mental health providers to review shared patient lists, members who have visited the ED that week, and members who have had an inpatient discharge. This partnership enables CPCCO to support our network with comprehensive care coordination. In addition, we have convened County Operational Workgroups in each of our counties to build better workflows around care coordination. In Clatsop County, for instance, we had the clinical manager who oversees specialty care identify workflows that would enable the hospital based specialists to better integrate into the counties care coordination supports.

7.12.c. Standard #3 – Publicly funded public health and Community mental health services (recommended 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
Please see Excel table provided separately.

7.12.c.(1) Describe how Applicant has involved publicly funded providers in the development of its integrated and coordinated Application.
There are multiple ways CPCCO has involved publicly funded providers, notably county public health departments and local mental health authorities, in the development of our plans and programs for the future. As described in the RFA Community Engagement Plan, as well as in 10.B.2.a, CPCCO entered into a formal LOA with these entities to share data and collaborate in decisions about health improvement priorities for the new five-year Regional Health Improvement Plan. In addition, CPCCO has worked with these entities over the past six years, co-creating solutions and strategies to address community and member needs, as the first CPCCO RHIP prioritized improvements in both behavioral health and public health issues, such as suicide prevention. This prior work is the foundation for the next five years.

Finally, public health and behavioral health organizations have had positions on the CPCCO Board of Directors and have participated in the local CACs and the regional CAP, to shape the direction and share strategies for community health and clinical innovation.

7.12.c.(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.

The public health departments in all three counties participated in and signed LOAs to create a shared 2020-2024 regional heath improvement plan. This agreement includes the intent to collaboratively share with the community at large the results of the needs assessment and the resulting community health improvement plan. The regional partnership includes hospitals and community mental health centers and will continue the work of developing collective impact models and leveraging community investment dollars across sectors.

Clatsop, Columbia and Tillamook counties have been key partners along CPCCO's developmental journey, including representation from all three community mental health programs (CMHPs) on the Board of Directors, the CAP and the CAC. CPCCO currently holds contracts with all three CMHPs for the services outlined in ORS 141.153(4). Those contracts remain in effect and CPCCO and the CMHPs continue to work closely to align services, including, but not limited to, agreed upon outcomes, key provisions related to the county's role as the local mental health authority, management of transitions to or from the Oregon State Hospital or residential care, mental health crisis services, supported employment and education, early psychosis programs, ACT, intensive case management, and home-based services for children. Together with all three counties, we work closely with the local criminal justice system to provide specialized services to reduce recidivism of individuals with mental illness in the criminal justice system. As we transition the management of the full behavioral health benefit effective June 1, 2019, we will deepen our relationships with the CMHPs in all three counties and identify ways we can invest more in shared programs and improved outcomes.

7.12.c.(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.

N/A

7.12.d. Standard #4 – Services for the American Indian/Alaska Native Population (AI/AN) (recommended limit ½ page)
7.12.d.(1) Please describe your experience and ability to provide culturally relevant Coordinated Care Services for the AI/AN population.

For several years CareOregon has been engaged in building our partnership with the Tribes of Oregon, their Tribal clinics, and the NARA Urban Indian Center to improve and expand Tribal members' ability to access providers and healthcare services. Through our programs, we are poised to provide care coordination services to our members. In service to that partnership, we have ongoing training in expanding our cultural understanding and competency, meet with Tribal clinic staff and learned about their facilities in person, and have ongoing discussion and feedback about the needs of Tribal members and their unique experience of barriers to care. Through this work we have become more culturally intelligent as well and we understand better how to partner and tap into resources with our Tribal partners who offer robust supports as well.

Further, through our care coordination and work in improving access to services, we have looked to impact the specific care Tribal members' experience. We continue to work to identify providers who can understand and respond to the cultural needs of the member. When appropriate, we provide feedback to service providers on the needs of the Tribal population. Our goal is not only to resolve the barriers of the moment, but also to find ways the reduce systemic barriers for the future.

The oversampling of Tribal members in the micro-narrative primary data collection process described earlier in this attachment will also provide guidance from Tribal members in their own voices to our development of culturally responsive services.

7.12.e. Standard #5 – Indian Health Services (IHS) and Tribal 638 facilities (recommended limit 1 page)
7.12.e.(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.
There are not IHS facilities located in the CPCCO service area. We maintain contracts with NARA, which is located within the CPCCO service area, in addition to Grande Ronde Tribal Health Center and Siletz Community Health Clinic which are located outside the service area. We maintain contracts with these two entities. Members may have access to addition facilities outside or our service area based on our CareOregon network contracts.

7.12.e.(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.
CPCCO's referral process for members seeking care in IHS or Tribal 638 facilities includes providing the greatest latitude possible for primary care provider's (PCPs) in decision making for their patients while assuring medical services rendered are consistent with the benefit and are medically appropriate. Although CPCCO strongly supports the medical home model of care and encourages members to discuss specialty service needs with their PCP, CPCCO nevertheless does allow all members to have direct access to specialists for funded services. Members may access the specialists by calling them directly to make appointments. In addition, referrals originating from an IHS or Tribal 638 facility follows the same process. If needed, CPCCO will arrange for non-network specialty care when it is determined that providers are unavailable or inadequate to meet a member's medical need.

Authorizations will be issued to those providers based on the member's benefit package, including applicable rules and policies, as previously stated. If the provider requests a "single case agreement" before the service is provided, care management staff notifies the contract manager, who then secures the agreement based on the urgency of the service need and within the authorization processing timelines.

7.12.f. Standard #6 – Pharmacy Services and Medication Management (recommended limit 5 pages)
7.12.f(1) Describe Applicant's experience and ability to provide a prescription drug benefit as a Covered Service for funded Condition/Treatment Pairs.
CPCCO has extensively integrated the use of the Prioritized List (PL) into the development of our drug formulary and prior authorization (PA) procedure. We have a robust process to evaluate PL and guideline notes changes that might have potential impact on formulary and/or PA criteria. Formulary placement decisions are made factoring in the likelihood that a medication is being used for a covered (above the line) diagnosis. Drugs that are used exclusively (or in a majority) for below the line conditions are often left off the drug formulary. During the PA process, all requests are set up with a cross-walking of the submitted ICD10s to

the prioritized list line. This produces clear internal documentation as to the applicable line(s) placement to review the request under. We also take into consideration clinical evidence, PL and applicable Guidelines Notes in developing and revising PA criteria. During the PA review process, any denial for below the line services rendered now communicates directly the line that was applied and the existing funding line. Prior to a denial being issued, all submitted diagnoses are reviewed to determine if there are any that could make the member's diagnosis coverable, i.e. the comorbid rule. In addition, CareOregon pharmacists who provide Medication Therapy Management services are cross trained on pharmacy formulary and benefits. They are part of the pharmacist team that is directly involved with making PA coverage determinations. This unique cross functional training also gives us additional opportunity to gather information outside of regular PA process to support our members' medications needs.

7.12.f.(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.
The CPCCO formulary for OHA members is a closed formulary; medications not listed on the formulary are considered non-formulary and not allowed at pharmacy point-of-service without prior authorization. These medications may be accessed by requesting a prior authorization. Alternatively, the prescriber can choose a formulary alternative that is available on the formulary.

Clinical criteria for non-formulary medications requires formulary medications have been tried and/or another specific medical issue precludes use of a formulary item. Formulary development principles include choosing multiple FDA approved drug products for each therapeutic prescription drug class when available and that are safer and more cost effective than non-formulary agents. Over-the-counter medications are available for multiple therapeutic classes.

The goal is to provide sufficient choices in drug therapy to assure the common needs of the beneficiaries are met in the context of available benefits from the program. Clinical pharmacists involved with clinical policy development for drug use also participate in applying these policies to individual cases. All clinical reviewers participate in regular case reviews via auditing or inter-rater reliability assessment to review congruence and alignment with the benefit plan requirements, quality goals, PL, and formulary associated with the Medicaid plan for beneficiaries.

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.
The CareOregon formulary is developed and maintained by a team of health care professionals as part of their P&T review process and includes both FDA approved prescription drug products and over-the-counter drugs from each of the therapeutic classes for treatment of funded conditions where applicable. Not all therapeutic classes have agents that are OTC. The goal is to assure sufficient choices in drug therapy so that the common needs of the beneficiaries are met in the context of available benefits from the program.

Development of clinically appropriate utilization controls.
Utilization management principles are applied to formulary products to promote evidence based and cost-effective medication options to improve utilization and quality in accordance with FDA approved indications and best practices for funded conditions. A key attribute is the ability to react and adapt utilization management controls as the evidence for appropriate use and/or cost change

emerges. This may mean eliminating utilization management controls such PA, ST, or QL or adding those UM controls as warranted with appropriate notification to members and prescribers. In addition, our integrated care coordination models allow us to implement robust drug use management controls and strategies with our local provider networks.

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.

CPCCO, through CareOregon, has its own Pharmacy & Therapeutics Committee. The Committee is comprised of both internal and external healthcare professionals. We also establish representation from each of the CCOs we serve. Our policies and procedures state that the Committee is to be maintained with a majority being external members. The Committee is comprised of physicians and pharmacists and meets every other month. All new FDA approved products and new clinical indications are reviewed under the authority of the Committee. Internal plan staff create summary reviews of the evidence with recommendations that are then presented to the Committee for final decision. In addition, the CareOregon Medical Management department unit reviews the treatment guidelines on an ongoing basis. Pharmacy staff coordinate with Medical Management staff to evaluate if any changes are needed based on the review of up-to-date treatment guidelines.

7.12.f.(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.

CPCCO engages in continuous evaluation of the provider network to ensure adequate pharmacy coverage for their assigned members. This evaluation includes geographically availability of pharmacies according to CMS's established network standards. A network adequacy study is available upon request. CPCCO has information available on its website which provide the PA criteria, formulary, and necessary forms to submit prior authorization requests. The CareOregon Pharmacy department utilizes internal staff to provide customer services for both provider and member calls. This allows us to provide more detailed information on using the pharmacy benefit, network access, and how to initiate a prior authorization. CareOregon also disseminates important formulary changes though our Provider Network representatives and our CCO teams who engage locally with the network on significant changes before and after implementation.

7.12.f.(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.

CPCCO uses CareOregon pharmacy benefit manager (PBM) OptumRx to provide real-time claim adjudication for pharmacy dispensed medications. We can access this information in real-time as well as having robust reporting capability on paid, rejected, and reversed claims on demand. For members identified as having secondary only coverage with the CCO, the system is set up to ensure primary insurance is billed first. Claims that are submitted to the CCO without this information are rejected and given instructions to the pharmacy to "bill primary." The system is also coded with a maximum cost so that any high cost secondary items are ensured a manual review for appropriate billing and coverage. We also have dedicated Medicaid pharmacy benefit coordinators who daily monitor the accuracy and status of the pharmacy claim adjudication system.

7.12.f.(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 prescribers or pharmacies will be able to submit Pas.

CareOregon administers a PA process that is compliant with OAR 410-141-3225 (9)(f), CFR 438.210(d)(3) and section 1927(d)(5)(A) of the Social Security Act. CPCCO manages all prior authorization requests internally (they are not delegated to the PBM or any other entity). We staff PA reviews 7 days per week in a manner that assures all requests are responded to within 24 hours after receipt. This includes weekend and holiday coverage, 365 days per year. CareOregon has established compliance standards for both Medicaid and Medicare lines of business. The performances are monitored and reported weekly at department level and monthly at organization level. PA turn-around-time is one of many key operational indicator reporting elements that are monitored and reported to all leadership levels including executives and officers.

7.12.f.(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.***

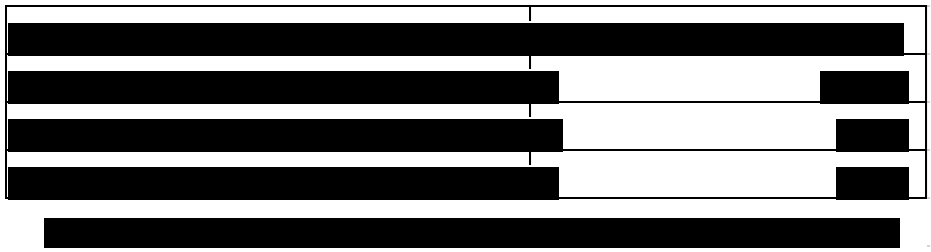
[redacted]

[redacted]	
[redacted]	[redacted]
[redacted]	[redacted]

[redacted]

[redacted]	
[redacted]	[redacted]
[redacted]	[redacted]

[redacted]



7.12.f.(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,

We have worked with our FQHCs to ensure they are reporting their 340B eligible claims correctly to the state. We have one project staff member specifically trained in 340B to connect with clinics. We have fostered clinics sharing best practices with each other in 340B and 340B structure.

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

The 340B program is the responsibility of the covered entity (such as the FQHC and hospital system) with oversight by HRSA. We believe in the original mandate of 340B provided in the Federal Register: the intent of the 340B Program is to permit covered entities "to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services." CCOs are not involved in evaluating adjunctive programs associated with the 340B program, but we are aware of examples of 340B revenue helping clinics or hospitals financially support their clinic and pharmacy teams to hire initial or more clinical pharmacists and/or expanding or starting pharmacies attached to the clinics or hospitals.

How the Applicant is evaluating the impact of these adjunctive programs whether they are generating positive outcomes.

We believe it is the requirement of the FQHC or DISH Hospital, HRSA and State or Federal process to evaluate their work and determine how 340B is helping according to the provisions required for being a qualified entity. Our achievement of CCO quality metrics performance targets in light of increasing benchmarks year over year is indicative of positive outcomes, and clinical pharmacists are particularly involved in improvement on many of the measures, particularly diabetes. CPCCO's clinical pharmacist helps our providers be much more efficient at managing their patient panels by helping with complex medication issues. All clinical pharmacists participate in monthly pharmacist collaborative meetings where we discuss and spread best practices for pharmacist prescribing and projects.

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

CPCCO partners with pharmacists in primary care to disseminate best practices in patient care, practice development, clinical pharmacy integration within the PCPCH, and align goals and initiatives with clinical pharmacy patient care activities that further support the Quadruple Aim. CareOregon enrolls clinical pharmacists as performing providers to provide covered health services in line with ORS 413.042 and the essential health benefit. Contracted clinical pharmacists receive reimbursement on a fee-for-service basis per ORS 743B.005.

CareOregon reimburses clinical pharmacy services, including medication therapy management, as well as Evaluation and Management CPT codes for post-diagnostic disease state management services.

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

CareOregon uses its Pharmacy Benefit Manager (PBM) OptumRx to facilitate and ensure E-Prescribing is available to our providers through the Electronic Medical Records (EMR) of their choice. CareOregon monitors the process regularly, and OptumRx provides reports of volume that can be monitored for unexpected changes.

Pharmacy Support for PCPCH Providers

Improving Population Health	-Develop and disseminate best practices that support the Clinical Pharmacist Practitioner integration within the PCPCH and the Regional Care Team framework. -Improve quality of Applicant's network by understanding and contributing CCO and Medicare incentive metrics that support value based alternative payment models
Reducing Cost	-Implement and refine policies that support the Clinical Pharmacist Practitioner's ability to provide interventions that reduce unnecessary health care utilization and increase access to clinical pharmacy services. -Assist CareOregon in the development and implementation of formulary cost saving strategies and initiatives.
Enhancing Patient Experience	-Identify and problem solve barriers that cause care coordination issues and reduce access to high quality health services for members -Refine and implement Care Coordination and referral processes that support the Regional Care Team framework.
Enhancing Provider Experience	-Expand clinical pharmacy reimbursement for covered health services that allow pharmacists to practice at the top of their licensure and improve provider efficiency.

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

CPCCO and CareOregon publish our formulary including PA, Step Therapy, and Quantity Limit information on our websites. Full Prior Authorization criteria are also published. This information is updated routinely (typically following the every-other month P&T Committee meetings). Additionally, a table is posted to identify the changes that occurred in the most recent updates. For large, impactful changes, CPCCO will provide more specific communication to prescribers. This may include more detailed FAQs on our website and direct patient faxes.

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

7.12.g.(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.***

When members need inpatient and outpatient hospital services, CPCCO is committed to ensuring all members have the same access within our area. On behalf of CPCCO, CareOregon's Network Clinical Services team contracts with a comprehensive list of providers, including hospitals, as listed in our DSN report, and monitors adequate access to care using Network Adequacy reports and

quality improvement processes and tools. Our CPCCO Regional Care Teams provide a single point of contact to more efficiently and effectively coordinating care within a specific county. If members need a higher level of care than available in the rural A/B hospitals, they can be transported to Portland or other surrounding areas to get the care that they need. This transportation is funded through EMS or NEMT.

Given our rural nature, local hospitals may not provide all services available in metropolitan settings. For some services our members travel to access care in Portland or other locations. CPCCO, through CareOregon, has an extensive network of contracted providers to ensure members have access to the full continuum of services. Our Regional Care Team helps members coordinate services within and outside of our service area; in addition, CPCCO is directly responsible and manages the NEMT (Non-Emergency Medical Transport) benefit through a local NEMT brokerage contract. The NEMT benefit offers an additional avenue to facilitate access and appropriate utilization to health care appointments and services for members that do not have reliable means of transportation to medical appointments. Transportation options available to members are low cost options for ride-sharing, public transit, mileage/meals/lodging reimbursements, sedan or ambulatory rides, commercial train and airlines, and volunteer driver programs. Members who have special needs limiting their physical or mental abilities to use lower cost options are screened and provided the most appropriate level of transport, these include: stretcher, wheelchair, bariatric wheelchair, secure and non-emergent ambulances for medical monitoring needs. NEMT is the needed link between locally available hospital services and the resources and oversight needed to transport members to higher level trauma centers that are primarily based in Portland. Through Network Adequacy, EMS funding, Regional Care Team coordination, and NEMT benefit administration, CPCCO closely partners with local organizations that can provide the reliable and appropriate continuum of services that are medically necessary.

Transplant services are not available in our local network and we currently have active contracts with two transplant networks, LifeTrac and Optum. Both contracts allow our members the option to access LifeTrac or Optum's network of hospitals and physicians in various states at their reduced contracted rates. If a hospital is not part of the LifeTrac or Optum's transplant network, we have the option to enter into a Single Case Agreement with the hospital to ensure members receive services.

Describe any contractual arrangements with out-of-state hospitals.

CPCCO primarily contracts on a Single Case Agreement basis with out-of-state hospitals. These agreements are negotiated collaboratively between the Medical Management and Provider Contracting departments to efficiently coordinate approval of the services, contract rate and length of time. In addition, we contract directly with Lucile Packard Children's Hospital in Palo Alto, CA for specialized children's services. This agreement allows us to pay claims at the negotiated OHA contract rates for members needing services at Lucile Packard Children's Hospital. We are also in the process of finalizing a contract with Seattle Children's Hospital.

Describe Applicant's system for monitoring equal access for Members to Referral Inpatient and outpatient Hospital services.

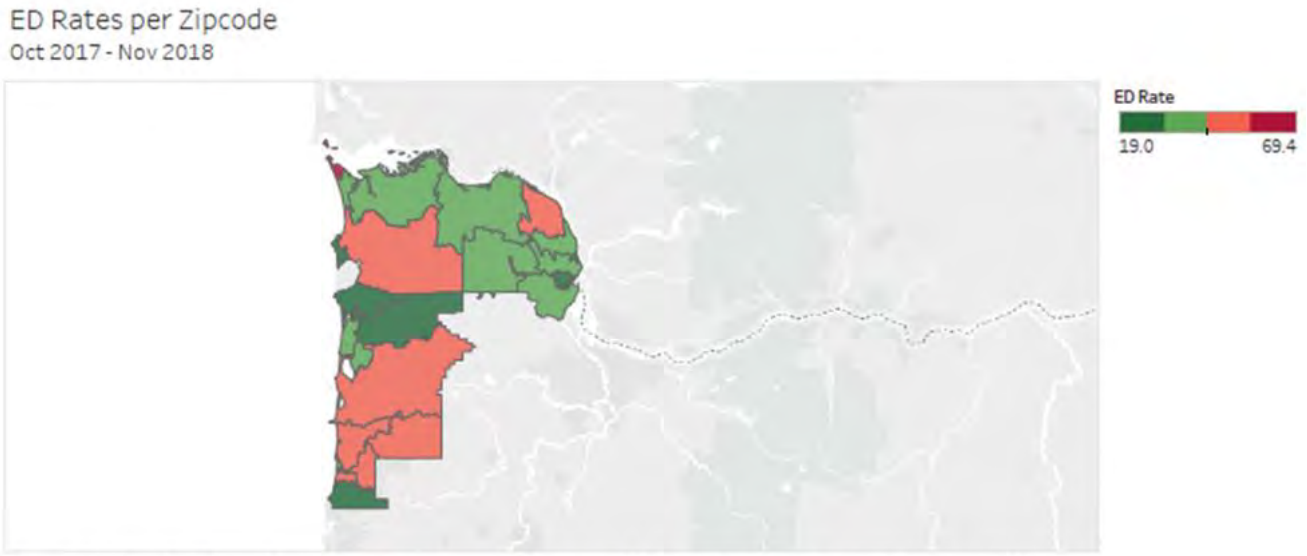
CPCCO's provider network has broad geographic distribution across its three counties. The CPCCO network offers access to the full range of inpatient and outpatient hospital services, and is monitored using network adequacy standards and access standards referenced above in Network Adequacy, Question 4. CPCCO has no gaps in the CMS time and distance standards for inpatient

and outpatient services in our service area; therefore, CPCCO members have equivalent access to services equal to other people in the service area. We conduct ongoing monitoring of access, timeliness, amount, and scope are all monitored of our network through the Network Adequacy Steering Committee.

As we integrate the behavioral health benefit from GOBHI to CareOregon on June 1, 2019, CPCCO will ensure that there are no prior authorization or concurrent review requirements that create a barrier to accessing behavioral health benefits, including inpatient and outpatient hospital services, or that is more restrictive than medical/surgical benefits. Managing the specialty behavioral health network will allow for transparency and coordination throughout the system to continue to ensure there is no conflict with parity regulations.

On behalf of CPCCO, the CareOregon Medical Management department monitors grievances related to access issues, looking for trends and addressing individual complaints one by one. Complaint thresholds are established and if they are exceeded, complaints are referred to a Peer Review committee. Peer Review can recommend corrective action or intervention by provider relations specialists to help resolve issues. The Access Complaints report is used to monitor complaints from members regarding access to care.

7.12.g.(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:
7.12.g.(2) a. 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.



CPCCO uses PreManage cohorts to track ED usage. Each RCT receives access to these cohorts to identify and address overutilization of this service. The RCT can intervene in real-time when they receive a PreManage alert about CPCCO members. In addition to this real-time tracking mechanism, CPCCO utilizes heat maps and data to assess inappropriate utilization trends and assess opportunities for improvement to address ED utilization. Combined with this data, we also look at

top diagnoses for ED visits to assess for potential inappropriate utilization and opportunities to educate members and clinicians as indicated.

CPCCO also uses a Population Segmentation analytics tool to identify members who are not accessing care in the most appropriate manner. This tool identifies cohorts of members based on their utilization behaviors, chronic conditions, substance use flags, durable medical equipment use, and many other factors. This tool allows CPCCO to understand groups of our members in more detail and differentiate when someone has never engaged in primary care and predominately uses the emergency room or when someone has stopped using primary care due to multiple chronic conditions that have led them to become overly dependent on specialists. This nuanced analysis enables us to build more specific strategies to educate members and coordinate care.

7.12.g.(2).b. Procedures for improving appropriate use of Ambulance, Emergency Rooms, and urgent care/walk-in clinics.

Top 10 Avoidable ED Visits by Total Payment

Dx Code	Visits	Payment	Description
N39.0	224	$224,182	Urinary Tract Infection Site Not Specified
J06.9	478	$208,124	Acute Upper Respiratory Infection Unspecified
R51	218	$199,338	Headache
M54.5	168	$109,881	Low Back Pain
J02.9	157	$62,420	Acute Pharyngitis Unspecified
J20.9	71	$58,021	Acute Bronchitis Unspecified
M54.9	38	$38,473	Dorsalgia Unspecified
N30.00	52	$27,391	Acute Cystitis Without Hematuria
H66.91	61	$26,048	Otitis Media Unspecified Right Ear
Z02.89	39	$24,354	Encounter For Other Administrative Examinations

Top 10 avoidable dx account for 7.0% of total Columbia Pacific ED facility payments

Ensuring that members are seeking the right care, at the right time, in the right location is one of the most important ways we can achieve the Quadruple Aim. Since its inception, CPCCO has worked across its service area with service providers of all types to co-develop ways to **(1) enable providers to work at the top of their license or certification**, (2) **help members establish care in a Patient-Centered Primary Care Home**, and (3) **provide information and service orientation** so it is easy for members to choose to go to the best care provider for their unique circumstances.

Appropriate use of Ambulance. Since 2014, CPCCO has partnered and shared learnings of the importance of transportation resources of our local communities and how the intersection of ambulance and the non-medical transportation benefit can positively impact preventing or assisting individuals to attend their necessary healthcare appointments. Many of Tillamook, Clatsop and Columbia Counties' low-income and rural communities lack the disposable income and access to working vehicles or public transit systems. The increased integration efforts between emergency and non-emergency medical transportation services assist populations and individuals find the least costly, most appropriate mode of transport for their abilities, and reducing inappropriate utilization.

In 2018 CPCCO contracted with Tillamook County Transportation District (TCTD), a local public transit agency with previous experience operating as a transportation provider under the previous NEMT Brokerage. TCTD has brought their transportation specific knowledge and their cross-collaborative work with other northwest coastal transit agency partnerships to NEMT benefit administration, the new partnership has revealed a close partnership needed to provide medically necessary transportation options in a rural community. This partnership supports CPCCO activities to improve appropriate use of EDs, ensure members are experiencing safe and reliable transportation to make their healthcare appointments, and identifying capacity issues for higher

levels of transport vehicles across the three-county area. We will be leveraging this partnership to improve care, access and cost starting in 2020.

Appropriate use of Emergency Departments (EDs) and urgent care. Improving appropriate use of Emergency Departments (EDs) has been a key area of focus for CPCCO since 2012. Because the motivations for accessing services in the ED are multi-factorial, we are taking a multi-factorial approach to continue to make improvements in ED utilization. Key strategies include:

- **Member Education.** CPCCO has developed a Member education module, "OHP & You," that educates assisters and organizations directly interfacing with Members on benefits and appropriate utilization and access to benefits. CPCCO's CAC (and other CareOregon-affiliated CACs) were engaged to provide input on content, language, and design.
- **Community-Based Grants**. Later this year, CPCCO will issue an RFP for community-based organizations to apply for grant money to address appropriate utilization opportunities. An example of what could be awarded may include ED navigators, who help educate Members on appropriate ED utilization and coordinate access to more appropriate care settings.
- **Peer Support**. Beginning in 2020, CPCCO is planning to embed recovery allies (peer support specialists) in the EDs to engage members who present in the ED with an overdose or other SUD-related concern. Recovery allies help members engage in treatment or develop safe drug use plans in an effort to reduce harm to members and connect them to community resources such as county needle exchange programs.
- **Traditional Health Workers**. In addition, as noted in the THW Integration & Utilization Plan, we have executed a plan to funding CHWs, who will provide support to CPCCO's high and rising risk populations. These roles will help members to access services that are best suited to meet their specific needs or cultural context.
- **Regional Care Teams (RCT)**. CPCCO's RCT actively works with members and partner organizations to help provide information and options to Members on appropriate utilization of services. When Members enroll into RCT, education is provided regarding the appropriate use of ambulance, emergency rooms, and urgent care/walk-in clinics.
- **Inter-agency Communications.** CPCCO staff hosts county-level operations workgroups that focus on improving inter-agency communication and systems to improve care coordination and decrease the need for unnecessary utilization. CPCCO's hypothesis is that if cross-organizational communication and systems are improved and more efficient, Members' utilization of ED services will decrease because their needs will be better met outside of the hospital.
- **Community Paramedicine.** CPCCO has supported a robust community paramedicine program in Columbia County, which has seen great success and improved outcomes for members who engage with the Community Paramedic. This is a relatively new and emerging model of care and provides a unique opportunity to serve members where they live or reside, including our homeless or transient population. In addition, the program has allowed a strong partnership between EMS and the CCO, primary care, behavioral health, and hospitals. Based on the success of the Columbia County program, we are actively planning to rollout a community paramedicine program in Clatsop County for late 2019.
- **Community Engagement Team.** CPCCO's Community Engagement Team has a health literacy tool mailer designed to educate Members who have utilized the emergency department for nonemergent needs; the mailer provides information about other immediate

care options, is in both Spanish and English languages and has visual aids. It provides contact information to local service providers more appropriate to meet immediate health needs and the CareOregon customer service line for assistance establishing a primary doctor.

- **Value-Based Payments.** As discussed in Attachment 12, question 12.G.3, CPCCO uses a VBP called the Primary Care Payment Model (PCPM). One of the measures used to calculate PCPM includes the number of Ambulatory Care Sensitive Conditions, which is tracked for the entire PCPCH's attributed population. If a PCPCH keeps those with Ambulatory Care Sensitive Conditions well-managed and out of the ED or inpatient setting, it may increase its PCPM payments. This incentivizes the primary care provider to work with patients to manage these conditions in the primary care setting.

7.12.g.(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).***

CPCCO will monitor and adjudicate claims using several standardized systems. HAC and Adverse Events are built in to our automatic claims DRG pricing system. In addition, our MicroDyn pricing product in our claims processing system, QNXT, analyzes UB claims for Adverse Event and HAC codes and passes through an altered/lowered DRG payment rate to the QNXT claims processing module without comment in the pricing edits steps. In the course of reviewing IP stays the RNs may identify a HAC or adverse event. The RN forwards via the Quality of Care process for follow-up.

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

We follow OAR regarding hospital readmissions within 30 days for related conditions and do not cover stays that do not meet the requirements of the OAR. All inpatient stays are reviewed for medical necessity. All 30 day readmissions are identified by the UM RN and verified by Medical Director OHP (OAR 410-125-0410). Hospital readmissions will be bundled into a single billing when all the following are true: 1) member is OHP; 2) Hospital is paid using DRG methodology; 3) Readmission is within 30 days of discharge; Readmission diagnosis is the same or related to the prior admission. This policy does not include readmissions for a diagnosis that may require episodic acute care hospitalizations to stabilize the medical condition such as diabetes, asthma, or chronic obstructive pulmonary disease.

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

Population Segmentation Model - This robust population segmentation model allows us to segment the entire CCO population to easily identify how our membership is utilizing the healthcare system and to identify problematic hospital utilization patterns and intervene appropriately. By understanding our entire population and by matching the appropriate intervention with the right segment, we can demonstrate a comprehensive system of preventing unnecessary hospitalization from very upstream to immediate readmission prevention.

Community Paramedicine - CPCCO has supported a robust community paramedicine program in Columbia County, which has seen great success and improved outcomes for members who engage with the Community Paramedic.

Value-Based Payments - As discussed in Attachment 12, question 12.G.3, CPCCO uses a VBP called the Primary Care Payment Model (PCPM). One of the measures used to calculate PCPM

includes the number of Ambulatory Care Sensitive Conditions, which is tracked for the entire PCPCH's attributed population. If a PCPCH keeps those with Ambulatory Care Sensitive Conditions well-managed and out of the ED or inpatient setting, it may increase its PCPM payments. This incentivizes the primary care provider to work with patients to manage these conditions in the primary care setting.

SUD population - We have found that our SUD population has one of the highest utilizations of the ED and hospitals. We are currently developing processes and procedures to proactively address the needs of people with SUD. We have recently pulled data on our OUD population, and are developing ways to outreach, in partnership with our PCP clinics, to patients with an OUD diagnosis but no treatment. In doing so, we hope to decrease ED utilization and potential overdose. In addition, we are developing a real-time overdose response plan, using PreManage and claims data, where we can wrap services around patients who have an overdose, and make sure they have services in place like MAT, naloxone, therapy etc., to decrease hospitalization, ED use and overall harm in the future. We will also be using peers to help with this in year 1-3.

7.12.g.(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.

CPCCO manages the care of about 300 CareOregon Advantage Medicare Fully Dual Eligible members assigned to providers in its service area. The majority of these members are connected with large health systems providers who are utilizing PreManage to quickly identify high risk patients with real-time notifications of utilization of hospitals, ED, and now starting to include Skilled Nursing Facilities (SNF). As described earlier in this Application, the CPCCO RCT relies heavily on PreManage to quickly identify care coordination needs and identify the gaps and barriers members perceive exist that circumvents primary care visits. Care coordination includes communication with the member, conducting a screening and assessment when applicable, and then communicating with the provider to assist the member in gaining access to treatment in the ambulatory care setting. Receiving care in the ambulatory setting provides for wellness, prevention, and treatment related services with the goal of reducing preventable conditions that lead to acute care hospitalizations.

Attachment 8 - Value-Based Payment Questionnaire

8.C. VBP Questions

8.C.1. Submit two variations of the information in the supplemental baseline RFA VBP Data Template: a detailed estimate of the percent of VBP spending that uses the Applicant's self-reported lowest Enrollment viability threshold, and a second set of detailed and historical data-driven estimate of VBP spending that uses the Applicant's self-reported highest Enrollment threshold that their network can absorb.

See Attachment 8 CPCCO RFA VBP Data Template. The versions presented within the supplemental baseline RFA VBA Data Template are intended to align with the enrollment viability thresholds utilized within the financial pro forma applicable to Attachment 12: Cost and Financial Questionnaire.

8.C.2. Provide a detailed estimate of the percent of the Applicant's PMPM LAN category 2A investments in PCPCHs and the plan to grow those investments.

Over the past five years, on behalf of CPCCO, CareOregon has invested heavily in the development of the PCPCH model to help our primary care partners further the goals of the Triple Aim and develop the capacity to successfully embrace Alternative Payment Models (APM). Our goal has been to move payments away from fee-for-service (FFS) payment and into APMs that reduce the total cost of care while improving quality. As a result, over 92% of our members are assigned to primary care providers who practice in PCPCH clinics and have migrated from LAN 2A to LAN 2C and above payment models, resulting in less than 5% of our PCPCH VBP payments falling in LAN 2A or less. The infrastructure established through the PCPCH payments will support clinics moving into higher tier status and support providers in participating in payment models in higher LAN categories.

Membership Assignment by PCPCH Tier Recognition

PCPCH	Assigned Membership	% of Membership
Tier 0	1,829	7.54%
Tier 1	0	0.00%
Tier 2	4	0.02%
Tier 3	6,656	27.46%
Tier 4	9,584	39.53%
5 STAR	6,170	25.45%
Total	24,243	

The programs outlined below represent our current Primary Care Payment Model (PCPM) and Integrated Behavioral Health (IBH), programs, both of which require PCPCH program participation. In 2019, we will be refining these models, based on external partner feedback, to ensure that the programs are well-aligned with other value-based reporting programs. To the extent possible, these programs will adopt HPQMC measures with an emphasis on metrics that fall into the domains of clinical quality, equity, behavioral health integration, oral health integration, total cost of care, and social determinants of health. Only in the event that the HPQMC menu does not include measures that are applicable to the Medicaid population in each of these domains will we include additional measures. We currently align program targets with CCO targets set by the OHA as well as Medicare Star benchmarks, where applicable, and will continue to do so in the future.

PCPM Program (LAN Category 2A and 2C)

PCPM Track 1: PCPM Track 1 is an introductory alternative payment program that aims to support PCPCHs in building capacity for population health management in order to advance team-based care and to develop infrastructure to promote a culture of data-driven improvement. Successful participation in PCPM Track 1 requires:

- Minimum PCPCH Tier 3 status.

- Continuous quality improvement processes for five (5) self-selected quality measures from the PCPM Track 1 Quality Measure Set.
- Accurate reporting of standardized quality measures on a rolling 12-month time period.
- Demonstration of improvement in measure performance across entire PCPCH population (all payers).

PCPM Track 2: PCPM Track 2 is a more advanced alternative payment program which rewards clinics that achieve high quality performance across multiple care areas. PCPM Track 2 encourages clinics to advance their data reporting capabilities and align with Medicare and State Medicaid quality and cost priorities. Successful participation in PCPM Track 2 requires:

- Minimum PCPCH Tier 3 status.
- Accurate reporting of CPCCO member-level data on measure sets and timeframes defined by PCPM Track 2.
- Demonstration of high quality care through achievement of measure benchmarks.

Integrated Behavioral Health: Currently, we operate a separate Integrated Behavioral Health (IBH) program for our primary care provider network which is described below. Beginning in 2020, the IBH program will be integrated into our PCPM program.

IBH Objectives:

- Minimum PCPCH Tier 3 status
- Support the adoption of the 2017 PCPCH integration standards
- Facilitate the practices' ability to deliver same-day access to integrated, population-based preventive behavioral health services.
- Prevention and early intervention for common behavioral health issues
- Same-day brief consultations, assessments and interventions
- Warm-hand offs between primary care team and BHC(s)
- BHC(s) participation in pre-visit planning, team meetings and huddles
- Consultations between primary care team and BHC(s)
- Care coordination and communication with entities outside the patient-centered primary care home including other behavioral health clinicians, psychiatrists, other specialist providers, hospitals, schools, etc.

Depending on the level of integration, qualifying clinics can participate in one of two tracks:

- CareOregon Integrated Behavioral Health Model Tier 1
- CareOregon Integrated Behavioral Health Model Tier 2

Plan for Growing LAN category 2A investments in PCPCH

Given that we have been working with our network to move beyond LAN category 2A, we will continue to support our PCPCH partners with data and technical assistance to enhance their capacity to serve our members and successfully transition to higher levels of VBP. We will continue to provide technical assistance in the PCPCH enrollment process and the design and development of workflows to support the PCPCH model. Our technical assistance program is nationally recognized in providing training for support and implementation of primary care medical home models. Through a partnership between CareOregon, UCSF Center for Excellence in Primary Care, and the MacColl Institute, we support the further spread of the primary care medical home model by training and supporting practice coaches who can directly support clinics in their implementation process.

CPCCO is committed to continued support of the PCPCH program as we work with our network to manage care within a sustainable rate of growth while supporting SB231 and SB934 primary care spending requirements.

8.C.2.a. Payment differential across the PCPCH tier levels, estimated annual increases to the payments

The tables below show payment differentials within the programs described above. PCPCH tier level payments will range from $1 in Tier 3 to a maximum of $18 for Tier 5 clinics demonstrating high quality performance and outcomes. As noted above, the majority of our members are seen in tier 3 and above clinics, justifying the approach to this payment structure. We will continue to evaluate the PCPCH engagement of our network and invest in new or lower tier PCPCH clinics if warranted by changes in our current PCPCH clinics or by new primary care providers entering the market. If impacted membership warrants the added operational and administrative complexity, we will add a separate PMPM payment for tier 1 or 2 clinics of $.50 - $1.00. We currently have no members assigned to tier 1 clinics and four members assigned to tier 2 clinics.

Within CPCCO's PCPM and IBH programs, we have combined LAN categories 2A and 2C.

PCPM Track 1(including IBH)					
PCPCH Tier	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5
PMPM Payment Range*	$0	$0	$1 - $8.25	$0 - $8.25	$0 - $8.25
PCPM Track 2 (including IBH)					
	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5
PMPM Payment Range*	$0	$0	$0	$0 - $16.25	$0 - $16.25
PCPCH PMPM (If Needed)					
	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5
PMPM Payment Range*	$.50	$1.00	$0	$0 -	$0
PCPCH PMPM (If Needed)					
	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5
PMPM Payment Range*	$.50	$1.00	$0	$0 -	$0

To provide ongoing support for the PCPCH program and primary care in general, we anticipate increasing primary care funding annually. A portion of this will be accomplished by shifting funding from FFS to VBP models, in alignment with best practices, OHA goals, and regulatory requirements. We anticipate that a combination of these shifts and increases will range from 5%-10% each year. Final payment levels will be dependent on risk-adjustment and quality measure performance. Current payment ranges are on a contract cycle that expires June 30, 2020. Payment ranges for contracts effective July 1, 2020 – June 30, 2021 will be finalized no later than December 31, 2019 and will follow a structure similar to that illustrated above.

8.C.2.b. Rationale for approach (including factors used to determine the rate such as Rural, Urban, or social complexity)

All program rates have been developed with the intent of engaging and rewarding clinics that have attained higher PCPCH Tier status (Tier 3 – 5). PCPCHs at the higher tier levels have

demonstrated the sophistication and capacity necessary to effectively participate in value-based payment programs and further the goals of the triple aim.

Rates are also risk adjusted for medical complexity using Chronic Illness & Disability Payment System (CDPS) and Hierarchical Condition Category (HCC) data. While social complexity data is not currently used to adjust rates, on behalf of CPCCO CareOregon is currently engaging with some pediatric clinical partners in the Portland metro area to determine if and how we could use Health Complexity data developed by the Oregon Pediatric Improvement Partnership (OPIP) and the OHA to risk-adjust payments for a pediatric population. CPCCO will evaluate CareOregon's findings and assess other options for incorporating medical and social factors into risk-adjustments for APM payments.

8.C.3. Describe in detail the Applicant's plan for mitigating any adverse effects VBPs may have on health inequities, health disparities, or any adverse health-related outcomes for any specific population (including racial, ethnic and culturally-based communities; lesbian, Gay, Bisexual, transgender and queer (LGBTQ) people; persons with disabilities; people with limited English proficiency; immigrants or refugees and Members with complex health care needs as well as populations at the intersections of these groups. Mitigation plans could include, but shall not be limited to:

On behalf of CPCCO, CareOregon is committed to developing innovative payment models that incent providers to deliver high quality care while also ensuring no adverse behavior by providers towards certain patient populations because those members may require additional or unique support. Our existing analytics platform, experience with risk adjustment, and established processes embedded within VBPs equip us for ongoing system evaluation and management. Specifically, we guard against potential unintended consequences primarily by:

- Measuring provider performance against the clinic's own historical performance
- Exploring VBPs that consider social and medical complexity in the risk-adjustment
- Monitoring grievances and patient re-assignments

a. Measuring contracted Provider performance against their own historical performance rather than national benchmarks when patient mix is more complex;

CPCCO recognizes that the composition of a provider's patient population may affect the clinic's performance metrics and that some measures are particularly sensitive to populations with greater medical and social complexity. Given this and based on feedback from our clinical network partners, we have measures that both focus on individual clinic improvement and benchmark attainment depending on the program and tier the clinic is participating in.

For example, PCPM Track 1 clinics are measured against their past performance for all metrics. Whereas, once clinics advance to Track 2, they are evaluated based on their performance against benchmarks and against their historical performance for the Cost of Care. The Cost of Care is a measure of inpatient admissions and emergency department utilization for ambulatory care sensitive conditions. This measure is particularly sensitive to populations that may have greater medical and social complexity and experience health inequities or disparities *(i.e.* specific populations).

For all physical and behavioral health providers, the quality metrics both incentivize and provide a framework for monitoring access, engagement, and health outcomes. Through routine performance monitoring, quality teams evaluate year-over-year performance changes and population changes.

With five years of existing baseline data, we have a strong platform for evaluating trends and exceptions.

b. Use of risk-adjustment models that consider social & medical complexity within VBP

Another strategy we will employ to mitigate adverse effects of VBP arrangements is risk adjustment models that consider medical and social complexity. PCPM rates are risk adjusted for medical complexity using Chronic Illness & Disability Payment System (CDPS) and Hierarchical Condition Category (HCC) data. While social complexity data is not currently used to adjust rates, on behalf of CPCCO, CareOregon is engaging with some pediatric clinical partners to determine if and how we could use Health Complexity data developed by the Oregon Pediatric Improvement Partnership (described below) and the OHA, accounting for both medical and social factors, to risk-adjust payments for our pediatric population. To be successful in this endeavor, we anticipate a need for consistent Health Complexity data and would look forward to a partnership with the OHA in achieving this goal.

OHA's Pediatric Health Complexity Model

Despite gains in pediatric primary care homes, there is a need to better support children with health complexity (combination of physical health and social risk factors). The term Health Complexity is a variable that describes the degree to which a child has both medical and social complexity. This is important, as children with high social complexity would benefit from different resources than those with medical complexity. The children with both high social and medical complexity are some of our most vulnerable children.

Several social determinants of health put our pediatric population at risk, particularly those with chronic medical conditions. OHA in conjunction with OPIP has developed a robust pediatric health complexity model. This model accounts for both:

1. Physical health (using the Pediatric Medical Complexity Algorithm = PMCA) – a tool that accounts for utilization of services, diagnoses and the number of body systems impacted over a three-year lookback. It divides children into 3 categories (complex chronic, non-complex chronic and children without chronic disease); and
2. Social complexity – The Center of Excellence on Quality of Care Measure for Children with Complex Needs (COE4CCN) has identified 18 different social complexity factors associated with worse health outcomes and increased costs. OHA was able to get data on 12 of these children and family social risk factors. Many of these factors are ACES (Adverse Childhood Experiences).

By understanding how each tool works within pediatrics, we are working to develop a payment model that is financially appropriate and supports pediatric medical homes. CPCCO also anticipates aligning with and leveraging any risk adjustment mechanisms OHA implements for CCOs based on pediatric best practices in assessing the social determinants of health for CPCCO provider VBPs. All such risk adjusters and changes in risk profiles allow for provider, regional, and statewide comparisons for patient mix complexities.

c. Monitoring Grievances and Patient Re-Assignments

CPCCO will monitor the network for signs of providers selectively choosing or dismissing members from their practice through several different mechanisms.

- **Review grievance reports**. Using this data, CPCCO can track issues with providers and identify patterns for members being dismissed from providers. We have added a grievance

type for equity issues that includes issues related to: provider bias barrier; member not treated with respect; provider's office exhibits language or cultural barriers or lack of cultural sensitivity; interpreter services not available; and member neglect. If a provider is identified as engaging in discriminatory behavior, CPCCO reaches out to the provider and conducts an investigation into the cause.

- **Review Quality of Care grievances**. This category of grievance describes the member experience and their perception of the care they are or are not receiving.
- **Monitor the number of patients reassigned** from primary care providers as well as review quality metric denominators to identify any unusual member re-assignment trends. Significant deviations from baseline data will trigger additional monitoring or investigation as indicated.

8.C.4. Describe in detail the new or expanded, as previously defined, care delivery area VBPs the Applicant will develop in year one and implement in year two. The two new VBPs must be in two of the following care delivery areas: Hospital care, maternity care, children's health care, Behavioral Health care, and oral health care; noting which payment arrangement is either with a Hospital or focuses on maternity care, as required in 2021. The description will include the VBP LAN category 2C or higher, with which the arrangement aligns; details about what quality metrics the Applicant will use; and payment information such as the size of the performance incentive, withhold, and/or risk as a share of the total projected payment.

[redacted]

Measure	Data Source	Definition/Description
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

[redacted]

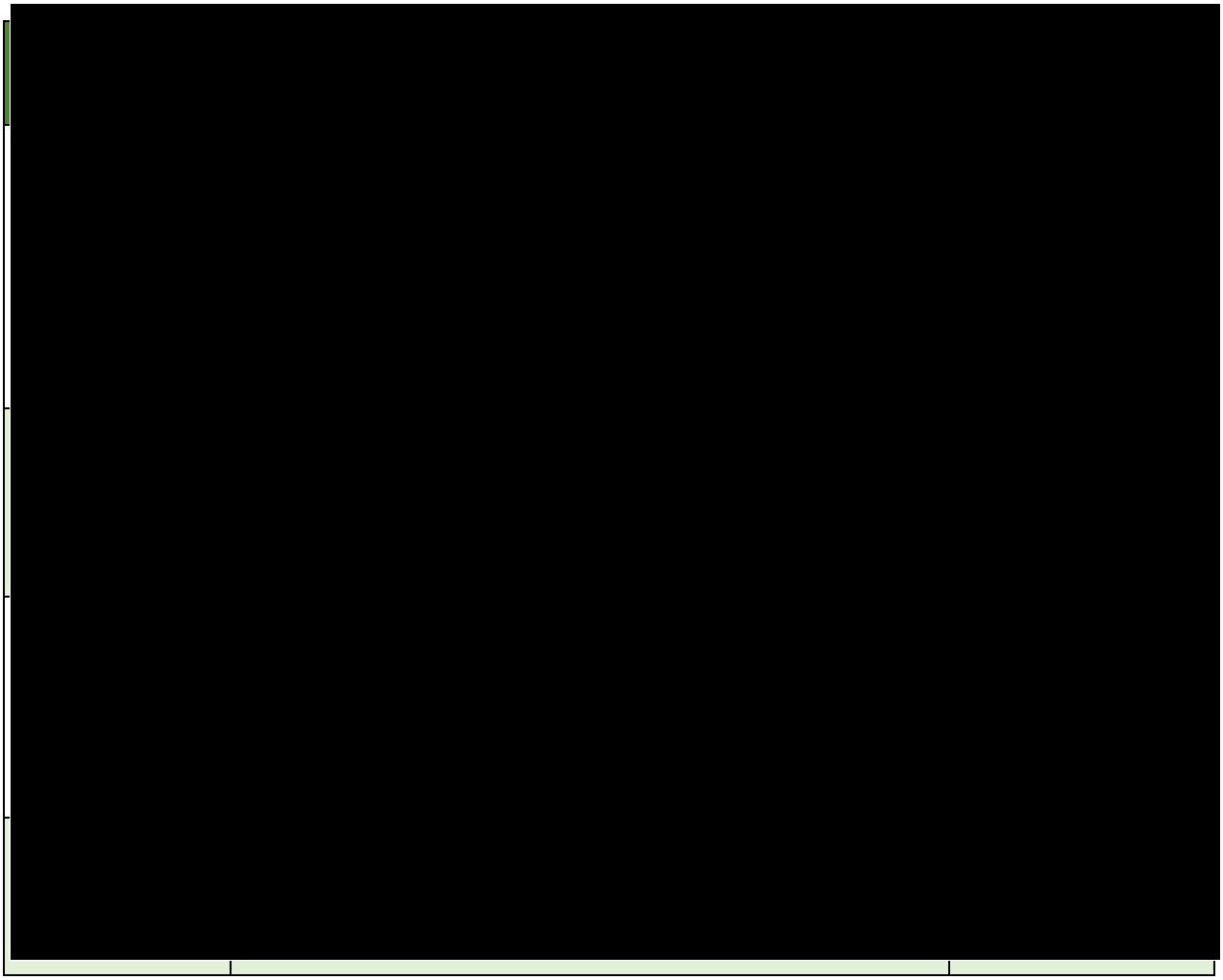
[redacted]

[redacted]

[redacted]

8.C.5. Provide a detailed plan for how the Applicant will achieve 70% VBP by the end of 2024, taking into consideration the Applicant's current VBP agreements. The plan must include at a minimum information about:
8.C.5.a. The service types where the CCO will focus their VBPs (e.g. primary care, specialty care, Hospital care, etc.)
8.C.5.b. The LAN categories the CCO will focus on for their payment arrangements (e.g. mostly pay for performance, shared savings and shared risk payments, etc.)

[redacted]



[redacted]

[redacted]

[redacted]

[redacted]

Attachment 9 - Health Information Technology

9.A. HIT Partnership

9.A.1. Informational Question

9.A.1.a. What challenges or obstacles does Applicant expect to encounter in signing the 2020

CPCCO does not expect to have any challenges or obstacles in signing the HIT Commons MOU and fulfilling its terms. CPCCO has leadership actively engaged in HITAG, HIT Commons, and other collaborative bodies to ensure active engagement with OHA.

HIT Commons

Amit Shah MD – CareOregon (as a CCO physician representative)

HITAG

Nate Corley – CareOregon (representing Jackson Care Connect and Columbia Pacific CCO)

9.B. Support for EHR Adoption

9.B.1. Evaluation Questions

For each evaluation question, include:

- ***information on Applicant's current operations,***
- ***what Applicant intends to arrange by the Contract Effective Date, and***
- ***Applicant's future plans.***
- ***When answering the evaluation questions, please include in a narrative as well as a roadmap that includes activities, milestones and timelines. (***Please note: Roadmap attached as an Excel spreadsheet)

Columbia Pacific CCO (CPCCO) shares OHA's vision of "a transformed health system where health information technology efforts ensure the care Oregonians receive is optimized by health information technology." Over the past six years, we have worked with our provider partners to promote the adoption and spread of technology to further the goals of the Quadruple Aim and drive value for members, providers, populations and CCOs.

- *Member value*: Capture patient information, including, social determinants of health (SDOH) at the point of care, we envision optimizing EHR's for more effective integrated care, reducing risk and waste.
- *Provider value*: Optimized EHR and HIE for more effective integrated care bringing information to the point of care not previously available; maximize actionable, timely, and accurate information, with analysis and reporting to drive quality outcomes for patients and populations. If done correctly, this can help decrease current provider burnout related to EHR.
- *Population value*: Manage the health of a community through improved access, quality and SDOH information with integrated clinical data to support programs to reduce population disease burden and risk.
- *Plan value*: We envision the above and additional HIT strategies will provide value to meet Quadruple Aim goals of improved health, better patient experience, lower costs and reduced provider burnout for the community we serve. With HIT we improve risk capture, assess variances in care delivery, and provide and manage value for the members and providers we partner with. We will continue to evaluate and ask the OHA and our partners to participate

in the assessment of the return on investment for HIT to assure value is added. We also recognize that HIT is expensive and creates significant change fatigue. In our plan for HIT moving forward, we hope to balance the time and resources needed with the urgency of the Quadruple Aim.

Below and in the subsequent sections of Attachment 9, we share our current and planned efforts to support, bring new value, and improve our health care system by supporting further adoption and spread of health information technology. As a smaller CCO serving rural communities, we benefit from our relationship with CareOregon, which provides us with the sophisticated HIT expertise and resources of a larger CCO that ultimately adds significant value to our members and providers.

CareOregon serves approximately 250,000 Medicaid members across the state and has developed a comprehensive technology strategy to support its partner CCOs and the major role it plays in Health Share of Oregon. Although CareOregon is the backbone for much of our infrastructure needs, our local CPCCO Board, comprised of community stakeholders, providers and members, creates the vision and defines our organizational strategies based on the health and social support needs unique to our members and communities. The CPCCO Board reviews and approves clinical recommendations that come from the CPCCO Clinical Advisory Panel. Working closely with our regional partners, CPCCO will develop a 5-Year Health Plan outlining our strategies to improve our local health care system by supporting innovation and spread of existing health information technology solutions.

Our overarching plan for deepening the impact of HIT is seen in the table below:

Year	Intervention	Impact
Year 1	Current state analysis and environmental scan Formally incorporate HIT strategies under the oversight of the Clinical Advisory Panel Prioritized list of work identified and approved by Clinical Advisory Panel	Community led process for alignment and engagement in HIT goals to bring value Continue current HIT work and maximize impact across integrated settings
Year 2	Create workplan: Bring initial priorities to pilot or next stage of spread in current efforts Align resources (APMs, technical assistance, and other resources) for HIT driven Quadruple Aim outcomes	Test new processes and maximize current successes. Begin spread of best practice Providers ready to implement new targeted and aligned HIT based solutions.
Years 3-5	Spread of best practice, deepened implementation of HIT and elimination of HIT services that do not support value Assess ROI for HIT programs; adjust resources and refine practices	Refinement of HIT based solutions to value-based outcomes for return on investment

Please be aware in the remainder of this Attachment 9 we have assumed we will find certain results in the environmental scan designated to occur in Year 1. And, thus we are planning for certain activities and outcomes. Given that much will depend on the initial environmental scan and the

newly formed stakeholder HIT work group, the prioritized list of work may change to meet the needs of our community.

9.B.1.a. How will Applicant support increased rates of EHR adoption among contracted physical health Providers?

Current EHR adoption

OHA's technical assistance support and federal and state Meaningful Use incentive programs have contributed to strong electronic health record (EHR) adoption and use throughout Oregon, including in CPCCO's service area. The majority of our physical health providers have adopted Epic through our hospital partners Providence, Adventist, Legacy and OHSU, except for Columbia Memorial Hospital which is on Cerner. Our FQHC and RHCs are primarily on Epic through their hospital systems, Yakima Valley Farmworker's Clinic (Coastal) or OCHIN (Tillamook County Health Dept, Rinehart and our school-based clinics). Some of our smaller clinics use PracticeFusion. Some small, independent practices do not use a certified EHR, however, these small clinics service approximately 2 percent of our members.

Given that such a small percent of our members are served by clinics without an EHR, we have shifted our focused from EHR adoption to providing EHR optimization support through workflow and process improvement technical assistance. The challenge is to support EHR adoption and optimization in a way that provides value to our clinicians and community providers, without creating unnecessary additional burdens or contributing to clinician burn-out.

Over the past six years, CPCCO has and will continue to encourage and support adoption and use of EHRs in a variety of ways as described below:

By encouraging clinics to participate in OHA's MU technical assistance. Over the past several years, CPCCO encouraged providers to participate in OHA's Oregon Medicaid Meaningful Use Technical Assistance Program (OMMUTAP). CPCCO worked with OCHIN, OHA's subcontractor, to develop a regional workplan that identified the clinics CPCCO thought would most benefit from the program. Our clinics received the following services:

- Tillamook County Community Health Center – Interoperability testing
- Rinehart – Interoperability Consulting, Risk and Security Training and Assessment, Enrollment and TA plan Development
- Columbia Memorial Hospital - Interoperability Consulting, MU Attestation
- Pacific Family – Interoperability Consulting, and Meaningful Use Education and Attestation Guidance
- Columbia Health Services - Meaningful Use Education and Attestation Guidance

By supporting PCPCH development and ongoing quality improvement. CPCCO supports Oregon's Patient-Centered Primary Care Home Program, which strongly encourages the adoption of an EHR for higher levels of PCPCH certification. Approximately 92% of our members receive care in a tier-3 or higher PCPCH. We use our payment models and quality payout to incentivize EHR adoption. The PCPM program has varying levels of EHR reporting expertise requirements; the more difficult the levels of reporting and health outcome achievement the higher the payment. CPCCO provides hosts collaboratives and provides direct technical assistance to advance the primary care home capabilities.

Our technical assistance program is nationally recognized in providing training for support and implementation of primary care medical home models. Through a partnership between CareOregon, UCSF Center for Excellence in Primary Care, and the MacColl Institute, we support the further spread of the primary care medical home model by training and supporting practice coaches who can directly support clinics in their implementation process, including determining how process is supported by EHR.

By supporting and incentivizing providers in population data and quality metrics achievement. Related to above, CPCCO partners with our clinical providers in achieving the OHA quality incentive metrics. Many of these metrics require EHR documentation and reporting. CPCCO works with organizations to provide clinical best practice workflows, which include EHR documentation and improved efficiencies. Increased quality pool payout is reserved for organizations that are able to pull and submit EHR data. We also provide a blended clinical dashboard for metrics such as diabetes and hypertension where we blend clinical EHR data with pharmacy claims data to develop a clinical dashboard to improve quality outcomes. We plan to expand these types of clinical dashboards moving forward. As part of the workflow redesign assistance, we help the clinics identify opportunities to more meaningfully use their EHRs to support CCO Quality Metric documentation and reporting which furthers our mutual population health and quality improvement goals.

By integrating use of EHR in our care coordination activities. CPCCO's Regional Care Team incorporates the use of provider EHRs into regular interdisciplinary care coordination and case conference meetings that include health professionals from primary, behavioral health and oral health organizations engaged in the member's care. Participants bring laptops and actively work within their agencies' EHRs to create and maintain consistent documentation across care settings. To further support care coordination, CPCCO has implemented a robust care coordination platform that delivers a care plan to our provider web portal and delivers secure messages directly to the provider's EHR. This further streamlines workflow and encourages use of EHRs.

By supporting integration between primary care and behavioral health. CPCCO supports an integrated, team-based model of behavioral health services in primary care. One payment model that CPCCO offers requires integrated behavioral health services in order to receive the enhanced alternative payments. The data aggregation and care coordination activities required to receive the enhanced rates in the APM require use of the EHR. Clinics in CPCCO that have integrated behavioral health include: Tillamook County Community Health Clinic, Coastal, Rinehart and rural health clinics associated with Columbia Memorial Hospital, Providence, OHSU, and Legacy hospital systems.

By using VBP programs. CPCCO is increasingly engaging with its providers in value-based payment arrangements like the one mentioned above. EHRs are important tools for promoting workflows and providing information necessary to achieve the desired financial and clinical results encouraged by our VBP arrangements. Our Quality Payments incentivize EHR adoption by giving additional dollars to clinics/systems that provide eCQM data. In the future, CPCCO's value-based payment models may include incentives that will require the use of EHRs, for example encouraging providers to electronically submit their CCO Incentive Measure data to OHA's Clinical Quality Metrics Registry.

Overall for the interventions listed above, CPCCO helps clinics identify opportunities to more meaningfully use their EHRs to support quality improvement and PCPCH enhancement goals. In addition, through our value based payment models and our investment grants, CPCCO provides clinics with an opportunity to secure additional funds to invest in innovation, including staffing, technology and new care models to improve patient care and clinic operations.

In addition to encouraging EHR optimization through the interventions listed above, our staff also provides technical assistance to support clinic and system transformation. In working with our clinic partners, we have helped them improve the use of their EHRs. Some of the examples include:

- Optimizing documentation of clinical quality metrics in EHRs
- Data reporting capabilities (pulling reports)
- Referral documentation, reporting and closing loops
- Dot phrases for EHR efficiencies (Adolescent well check, depression, SBIRT, one key question, ACE's).
- Medication reconciliation best practices
- Elbow support with EHR vendors for optimization

Future Plans

In the future, we will continue to encourage and support adoption and optimization of EHRs over the next five years. We will work with our Clinical Advisory Panel (CAP), the committee that develops and monitors our regional clinical strategy and quality improvement initiatives, to develop our Health Information Technology Plan. The plan will include strategies to support our EHR optimization goals.

By Contract Effective Date

By contract effective date, staff will work with members of our CAP to complete the 5-Year HIT Roadmap required by OHA to support our EHR optimization goals and define structure for carrying out activities defined in the roadmap.

We will also initiate conversations about ways to systematically incorporate EHR optimization into our clinical initiatives and quality improvement processes. Some examples might include: Working with our clinic partners to optimize preference lists for opioid prescribing (limit default quantities), developing improved "dot phrases" for clinical metrics such as depression, best practice documentation for referral pathways for follow up after SBIRT and ASQ screening, and optimizing decision making for imaging, etc.

In Year 1, CPCCO will:

- **Formalize structure to govern the HIT Plan development and monitoring activities -** Working with our Clinic Advisory Panel, we will determine the structure to lead the HIT assessment and workplan development efforts. The work may remain housed within the CAP or delegated to a newly formed workgroup.
- **Define EHR system needs -** Working with the CAP (or its designees), CPCCO will define current and anticipated future EHR capabilities (*e.g.*, data extraction, data merging, data analysis and data reporting) needed to successfully participate in the activities that further health system transformation goals generally and CPCCO Quality Improvement and CCO Incentive Metrics specifically. At a minimum, we will consider needs related to: Capturing data and reporting on existing and new metrics, accurate coding, integrating behavioral and

oral health services in the primary care setting, cross-system care coordination, screenings for preventive service, and SDOH.

- **Conduct an environmental scan and identify gaps -** We will assess current EHR capabilities, define anticipated EHR needs to support a robust medical home and conduct a gap analysis. As a part of the environmental scan, we will identify those clinics without EHRs that provide essential access for our members and evaluate their value in terms of the volume of members, quality of their metric performance and PCPCH tier. We will evaluate the benefits of providing subsidization for small clinics who indicate they would like to adopt EHRs.
- **Create a 5-Year HIT Plan -** Based on gaps and areas of opportunity identified during the assessment process, the CAP (or its designees) and staff will develop a 5-Year HIT Plan that outlines the HIT priorities for CPCCO and its partners to support adoption and optimization of HIT among its community partners. We anticipate with the high rate of EHR adoption among our contracted physical health providers, CPCCO's plans will largely focus on helping providers more meaningfully use their existing EHRs.

  Overview of CPCCO 5-Year HIT Plan: We anticipate the plan will include both "new work" and existing efforts including those initiatives listed below:
  - Strategies to optimize the value of current EHR systems, including workflow and system modifications to the EHR that are necessary in order to engage with PreManage and our GSI Care Coordination Platform. This allows for improved care coordination across physical, behavioral and oral health providers. (More on HIE strategies in section C of this attachment).
  - The need to identify tools to help facilitate referrals and track data to and from social safety net organizations that provide services related to SDOH, including those potentially identified through the HIT Commons. To support this work, we will seek input from our CAC and community providers about the best ways to collect and share information related to social determinants in a way that is sensitive to the unique nature of our rural communities.
  - Process for engaging multiple partners to support existing EHR optimization, quality improvement and clinical workflow redesign efforts.

In Year 2, CPCCO will move to implement priority areas described in the 5-Year HIT plan created in Year 1. Some examples of potential focus may include:

- Provide targeted training and technical assistance for different provider groups. We anticipate using current staff, advisory forums and learning collaboratives to provide training and technical assistance.
- In collaboration with organizations providing EHR technical assistance to our clinic partners, deliver up-to-date functionality and workflows of current EHRs to include foundational and best practice standards within the EHRs related to treatment guidelines, decision support, and best practices at the point of care.
- Explore the potential to develop and build a scribe program to support EHR optimization and efficiencies among providers. Part of the evaluation will include a readiness assessment to determine if there is organizational capacity and desire within CPCCO and our clinical partners to move forward.

In Years 3-5, CPCCO will:
Spread best practices, deepen implementation of EHR and eliminate services that do not provide ongoing value. We will continuously assess return on investment for HIT programs, adjust resources and refine practices. We anticipate we may:

- Continue to support increased meaningful use of EHRs
- Implement population management tools such as patient registries, care management platforms and workflows
- Provide member and provider accessibility across diverse platforms, computers, smartphones and digital mobile devices

Our goal is to have 100% of our contracted physical health providers on a certified EHR by the end of 2024. However, to ensure access to services, particularly in rural communities, we may still be contracting with a few independent providers who have not adopted a certified EHR by then. With significant efforts in previous years by OHA, hospital systems and CCOs to support EHR adoption through resourcing and technical assistance, the few clinics remaining on paper charts may have barriers that CPCCO cannot help them overcome. In some of our rural communities we have limited provider availability; therefore, we have to balance the desire to attain 100% EHR adoption, with the need to maintain an adequate network of high quality providers for all of our members.

9.B.1.b. How will Applicant support increased rates of EHR adoption among contracted Behavioral Health Providers?

Traditionally, behavioral health issues are an underfunded and underemphasized sector of the healthcare industry. While federal and state government agencies have made significant efforts through MU incentives to promote EHR adoption among physical health providers, behavioral health providers are not eligible for the meaningful use incentives, making it more difficult and costly for providers to adopt this technology in their practice. In addition, based on a survey of behavioral health agencies conducted by OHA in 2017, we know that while many behavioral health organizations have implemented EHRs, they are not using their systems to report access to discharge/transfer reports, emergency department alerts, medications, lab results and allergies. This implies that in addition to spreading EHR adoption among those not already using them, behavioral health providers may need assistance to more meaningfully use their systems to engage in care coordination and integration efforts among primary, behavioral and oral health providers.

Current EHR adoption

The primary behavioral health and substance abuse partners for CPCCO are Columbia Community Mental Health Center, Clatsop Behavioral Healthcare and Tillamook Family Counseling Center. Together they provide more than 90% of the outpatient behavioral health services to our members. They are all on certified EHRs. Clatsop Behavioral Healthcare and Tillamook Family Counseling Center use Care Logic and Columbia Community Mental Health uses Credible. CPCCO also contracts with a small number of behavioral health specialists which are largely not on certified EHRs and will assess their interest in adoption of certified EHRs as part of the Year 1 environmental scan.

For the past 7 years, CPCCO has delegated the mental health benefit management to the Managed Behavioral Health Organization, Greater Oregon Behavioral Health, Inc. (GHOBI). In 2019, CPCCO will assume full management of the benefit, including direct contracting with community based behavioral health, substance abuse and specialty mental health providers. This change

increases the integration between the physical and behavioral health benefit management and will allow our staff to provide more direct technical assistance to behavioral health providers in our rural communities to support EHR adoption and optimization for those on existing EHRs.

CPCCO has supported PCPCH and behavioral health integration as described above in 9.B.1.a.

Future Plans:
In addition to continuing to support EHR adoption through the efforts described above, CPCCO will work with our community behavioral health partners to assess EHR adoption needs, identify available resources to provide assistance, including those provided by OHA and the HIT Commons, and develop plans to address. CPCCO will keep abreast of grant, federal or state funding opportunities to help behavioral health providers migrate to EHRs that can support interoperability with other systems, especially as it relates to opioid use and addiction.

By Contract Effective Date
By contract effective date, we will create the HIT Workgroup described above to serve as the official advisory committee to develop recommendations and support our EHR optimization goals, including those related to behavioral health.

In Year 1, CPCCO will:

- **Determine structure for behavioral health input** – CAP (or its designees) and CPCCO staff will determine how best to structure development of 5-Year HIT Plan to ensure behavioral health perspectives are well represented. This may include the development of a subcommittee or task force. The objective is to ensure we have expertise to help identify elements of the physical medicine that need to be modified, strengthened or eliminated due to the specific requirements and concerns related to Behavioral Health and develop process to identify, share, and standardize best practices regarding EHR use and configuration.
- **Conduct an environmental scan and identify gaps** - Assess current EHR prevalence, versions and capabilities and gaps for Behavioral Health Providers in our network. Evaluate specific barriers to adoption, exchange and utilization including technical, workflow and privacy concerns (real or perceived). Identify existing and needed data exchange capabilities with Primary Care, inpatient Behavioral Health Units, and SDOH support organizations. Identify data capture capabilities and deficits as relates to capture of SDOH and equity measures, clinical quality assessment, capture and reporting, access and engagement measures. We will also analyze the volume of members, quality of their metric performance to determine variance between EHR and non-EHR Behavioral Health Providers.
- **Define behavioral health EHR needs –** Based on the input from the CAP (or its designees) and the information gained from the environmental scan, define the current and anticipated future EHR capabilities that may be in addition to those identified for physical medicine providers. This might include documentation of consent, and other issues related to handling of sensitive data.
- **Create a 5-Year HIT Plan -** based on needs and gaps identified during the assessment, staff and the CAP (or its designees) will develop a 5-Year HIT Plan that outlines the behavioral health HIT priorities for CPCCO and its partners to support adoption and optimization of HIT among its community partners. The plan will address not only the technical barriers to HIT adoption but the cultural barriers and will thus include an element of provider education addressing legal elements, patient perception and cost/benefit from a

care perspective. In the plan, we will align anticipated behavioral health EHR needs with CPCCO's organizational priorities per year. The major components of the plan may address:

- Strategies to optimize value of current behavioral health EHR systems including identifying key integration points with PreManage and our GSI Care Coordination Platform to improve care coordination among behavioral health providers, physical health providers and SDOH services.
- Develop a common set of integration points for the EHR providers (e.g., OCHIN, hospital system providers, vendors, etc.) to develop and assist in referral management and integration with Reliance, PreManage and other tools to be identified.
- Evaluate the viability of the Reliance behavioral health consent and release module due out in late 2019. Determine the value and feasibility of becoming an early adopter of this module.
- Identify the cost, feasibility and interest in expanding behavioral health EHR systems already in use in the community (*e.g.,* OCHIN and Epic via one of the health systems present) to additional behavioral health providers.
- Evaluate willingness and feasibility among behavioral health providers to consider a move from current EHRs to Epic to enhance internal and cross-organizational care coordination.
- Develop technical assistance to improve data collection, claim submission and general reporting capabilities through improved workflows and EHR coding and documentation.

- **Support spread of current efforts**
  - We will also continue to support work underway in the community to improve data sharing and referral processes between the CMHP's and the primary care providers. Behavioral health providers appreciate access to clinical information to enhance their understanding of their clients' needs. Incorporating that information into their EHRs encourages further adoption and use of their health information technology.
  - We are in the process of developing a new incentive payment for our mental health and substance abuse treatment providers tied to reporting on outcomes-based care (feedback informed treatment). We will work with our partners to improve their workflows to support their ability to document and retrieve information from their EHRs (more information about value-based payment in Attachment 8).

In Year 2, CPCCO will begin to implement the plan developed and will:

- Continue to convene the group identified by the CAP in Year 1 to monitor the progress of the plan and identify new opportunities or required modifications to the plan.
- Implement best practices regarding behavioral health EHR use and configuration and monitor progress and impact.
- Engage with State, HIT Commons, PreManage, HIE service providers, and others in developing additional tools to assist in IT-enhanced patient care for the Behavioral Health Population. These may include but are not limited to:
  - Direct Prescription Drug Monitoring Program to EHR integration
  - Record Release Consent automation
  - Population Health Analytics
  - Other future capabilities identified in the plan or subsequent to the plan

- Begin design and development of EHR interoperability solutions, PreManage and GSI Care Coordination platform where deemed effective and feasible.

In Years 3-5, CPCCO will:

- Evaluate and re-assess the program to-date; identify program elements are working well, need to be strengthened or modified and those that need to be eliminated. A significant consideration will be the desire to simplify the overall technical environment and, more importantly, the end-user workflow by reducing the number of systems each clinic is required to use.
- Continue to monitor and where necessary re-educate around best practices regarding EHR use and configuration.
- Continue to monitor progress made by the State, HIT Commons, PreManage, Reliance, behavioral health vendors and others in developing additional tools to assist in I.T.-enhanced patient care for the Behavioral Health Population.
- Identify and address problems in capture and reporting of clinical measures.

As it ties into our HIE strategies, we will work with our behavioral health providers to identify the physical/dental health information they find relevant for their practices. As we determine suitable HIE methods for this data, we also will identify if and how the behavioral health EHR systems are able to receive, incorporate, and present this data to providers.

9.B.1.c. How will Applicant support increased rates of EHR adoption among contracted oral health Providers?

Current EHR Adoption

Currently CareOregon's dental team leads our oral health strategy and manages the delegation of dental service delivery to our partner dental plans. CPCCO currently contracts with Advantage Dental, Capitol Dental, ODS Community Dental and Willamette Dental to manage the dental benefit and deliver clinical services, provide care coordination and outreach to members. CPCCO is working collaboratively with the dental plan partners to ensure the tracking and monitoring of existing electronic dental record systems within the networks as well as encouraging their engagement with network providers to promote and increase rates of electronic record adoption.

In addition to electronic dental records systems in provider offices, all dental plan partners are live on PreManage and using a cohort that specifically identifies members who present for non-traumatic dental needs in the emergency department. Care coordination efforts can then be deployed at either the provider level (for those members with an existing dental provider) or at the dental plan level where a dental provider can be appropriately matched so that the patient can engage in needed oral health care.

Future Plans

We will continue to work with OHA, dental plan leadership and dental providers to identify how best to advance their use of electronic record systems within oral health. We will encourage the DCOs to support dental offices and provide technical assistance on meaningful use or other financial support opportunities. Given that dental partners often work with multiple CCOs, we will also work to collaborate with other CCOs and dental plan partners to encourage EHR adoption

among selected dental providers and aligning EHR-related requirements to minimize administrative burdens.

Other future enhancements over the contract period include financial incentives and/or alternative payment design with dental delegates and/or dental providers to promote the adoption and implementation of electronic dental records. Priority goals are leveraging electronic dental records to implement more closed loop referrals both in the dental specialty and primary dental settings as well as between the physical, oral and behavioral health.

Electronic record adoption in the dental setting will

- Allow for better integration and more sophisticated cross-disciplinary care coordination, particularly for populations with specialized health needs.
- Leverage our work in population segmentation to develop oral health specific cohorts for members likely to experience overall health benefits from receiving comprehensive oral health care
- Support increased data sharing in serving oral health specific cohorts and others benefitting from cross-disciplinary care coordination.

In addition, future enhancements include oral health risk assessment and caries and periodontal scoring that will enhance our ability to design programs and interventions that specifically target the oral health needs of the membership.

By Contract Effective Date

By the contract effective date, CPCCO will have clearly identified the electronic dental record status for all contracted providers, regardless of delegation status.

In Year 1, CPCCO will:

- **Determine structure for oral health input** –With input from our CAP, DCOs and CPCCO staff, CPCCO will determine how best to develop our 5-Year HIT Plan to ensure the oral health perspectives are well represented. This may include the development of a subcommittee or task force. The objective is to ensure we have expertise to address the elements below:
    - Adapt successful strategies from physical medicine and behavioral health workplans that can be adapted to oral health scenarios as applicable and needed.
    - Incorporate findings of the HIT Survey of Dental Care Organizations (DCOs).
    - Identify best practices regarding Electronic Dental Record (EDR) use and configuration and develop a process to share, extend, and standardize these best practices.
    - Assess current referral processes including use of GSI care coordination system, PreManage, HIE services and CPCCO's portal. Develop a road map to standardize and/or integrate referral processes between physical medicine and oral medicine practices and the emergency departments.
- **Develop a plan -** Based on the work of the CAP, DCOs and staff, the HIT Survey of DCOs, the assessment of referral processes, CPCCO staff and its oral health partners will develop a 5-Year HIT Plan that outlines the oral health HIT priorities to support adoption and optimization of HIT among CPCCO's community partners.

In Year 2, CPCCO will begin to implement the Oral Health HIT Plan and based on progress in Year 1 may:

- Continue to convene the group charged with developing the oral health elements of the 5-Year HIT plan to monitor the progress of the plan and identify new opportunities or required modifications to the plan.
- Implement best practices regarding Oral Health EDR use and configuration and monitor progress and impact.
- Implement strategies identified during the plan development to increase EDR adoption
- Engage with State, HIT Commons, PreManage, Reliance and others in developing additional tools to assist in IT-enhanced patient care for the Oral Health Population. These may include, but not be limited to:
    - Direct PDMP to EDR integration
    - Population Health Analytics
    - Other future capabilities identified in the plan or subsequent to the plan
- Begin design and development of EDR interoperability solutions with HIE services (e.g. Reliance), PreManage and the GSI care coordination system where deemed effective and feasible.

In Years 3-5, CPCCO will:

- Evaluate and re-assess the program to-date; identify program elements that are working well, need to be strengthened or modified and those that need to be eliminated. A significant consideration will be the desire to simplify the overall technical environment and, more importantly, the end-user workflow by reducing the number of systems each clinic is required to use.
- Require the DCOs to capture and exchange population-level and member-level information from their providers' EDRs for quality measurements.
- Work with the DCOs to integrate closed loop electronic referrals and/or preauthorization's within their providers' EDR workflows.
- Work with DCOs on incorporating EDR-enabled VBP methodologies with their contracted oral health providers.
- Identify opportunities for how EDR systems in oral health settings can be augmented to better support care coordination with and information sharing the primary care providers.
- Continue to monitor and where necessary re-educate around best practices regarding EDR use and configuration.

9.B.1.d. What barriers does Applicant expect that physical health Providers will have to overcome to adopt EHRs? How do you plan to help address these barriers?

Numerous barriers to adoption have been noted in the literature, including the investment to transition to an EHR, the cost, technical support required, keeping up with the new technology, clinicians' attitudes toward technology, disruption in workflow, concerns about patient security and privacy, communication among users, disruption in communication between patients and physicians, reliability, speed and issues with data integrity, and appropriate data exchange.

However, as mentioned above, most of the physical health providers in our region are affiliated with FQHC clinic systems or large hospital delivery systems which provide upgrades and training support to further EHR adoption. For the smaller clinics (private, 1-2 provider practices) that have not adopted EHRs, the primary barriers are provider or staff resistance, startup costs, and limited staff capacity and expertise to lead a change management process. This is particularly true in rural communities. Despite these barriers, our regional hospitals and FQHC systems share our vision for maximizing EHR use, have provided technical expertise and have brought in new technologies to support data acquisition, analysis and reporting. The reality is if clinics did not adopt EHR when there were Meaningful Use incentives and free technical assistance through OMMUTAP, the current barriers may be prohibitive to adoption and further resourcing may be ineffective. To help address these barriers, CPCCO will develop a strategy to incorporate EHR adoption and optimization into clinical improvement work and consider incentive options, like those included in our value-based payment programs. Strategies for overcoming these and other barriers identified during our environmental scan will flushed out in our HIT workplan.

9.B.1.e. What barriers does Applicant expect that Behavioral Health Providers will have to overcome to adopt EHRs? How do you plan to help address these barriers?

As mentioned above, all of the primary behavioral health providers have adopted certified EHRs. They are using PreManage to coordinate emergency care and have begun to utilize Arcadia to share data electronically at the plan level. The challenges to continually optimizing EHR performance are limited staff time and resources, particularly in our rural communities.

In the past, clinics that have co-located primary care and behavioral health staff have had challenges with effectively using their EHR's to: 1) document and track relevant behavioral health and physical health information, 2) support communication and coordination of care among integrated teams and 3) exchange information with tablet devices and other EHRs. Practices developed workarounds in response to these challenges such as duplicate data entry, scanning and use of freestanding tracking systems. As practices have gained experience with integration, they have begun to move beyond workarounds to more permanent HIT solutions ranging in complexity from customized EHR templates, more sophisticated EHRs and unified multi-disciplinary EHRs. For clinics on OCHIN's Epic, they have developed behavioral health navigation screens that allows behavioral health providers to document their services in an integrated record within Epic.[1]

Privacy regulations, specifically 42 CFR Part 2 create barriers for sharing important data between behavioral health providers and others. We would like to better integrate SUD information to the extent possible within existing regulations. One of the main limitations reported by behavioral health providers is concern and lack of knowledge around compliance and records exchange. We will stay abreast of the issue and communicate any changes to 42 CFR Part 2 that improve the ability for behavioral health professionals to optimally use their EHRs to engage in information exchange.

Through its involvement in HITAG and HIT Commons state committees, CPCCO and CareOregon will work with regional stakeholders, vendors and clinicians to advocate for EHR solutions that support integrated care delivery functions, such as: Documentation and reporting to support tracking patients with emotional and behavioral health problems, integrated teams working from shared care plans, template-driven documentation for common behavioral health conditions such as depression, and improved registry functionality and interoperability. CPCCO will also work

[1] J Am Board Fam Med 2015;28:S63-S72

with OHA to evaluate the OARs and promote streamlining the documentation requirements for integrated settings.

9.B.1.f. What barriers does Applicant expect that oral health Providers will have to overcome to adopt EHRs? How do you plan to help address these barriers?

Dental providers will have varying barriers to adopting electronic dental records. Many larger clinic systems have already adopted electronic dental records and digital imaging. However, not all will be certified due to the lack of certified options and specialized functionality. A significant part of the dental provider community is in solo or very small group or associate practices. These offices experience additional barriers when considering transitioning to an electronic system.

Some barriers we expect to encounter include:

- Cost to implement EHRs, including significant additional costs to implement digital imaging capabilities in the dental setting.
- Lack of proven interoperability between medical and dental EHRs.
- Lack of financial incentive to invest in EHR technology. Meaningful use incentives have not been favorable for dentists.
- Lack of training on oral health IT in pre-doctoral and residency programs.

Given that the expense of converting from paper charts and conventional x-rays to an electronic platform with digital imaging can be excessive, some providers in small offices may opt for a simple EHR that is not certified even when they transition away from paper charts. Additionally, dental providers who do adopt electronic dental records are unlikely to adopt a fully integrated health record unless the practice is part of a co-located system. Currently, the dental functionality within fully integrated health records lags far behind the capabilities and features of other available dental electronic record systems, making these systems unattractive to practices outside co-located systems.

Larger group practices with electronic records will eventually need to evaluate HIE and other mechanisms for information sharing. This will require the EHR vendors' willingness and ability to push or pull data from dental specific systems to create integrated platforms as well as the willingness and ability for other systems to accept and integrate their data. CPCCO will support its dental plan partners and providers in adopting certified EHRs as described in the oral health section above.

CPCCO will help address barriers through outlined above by working with dental providers and partners to understand their needs and use cases and provide technical assistance and evaluation of the current available systems within the clinically appropriate context. Opportunities to connect via HIE and other shared data platforms can be leveraged to create whole person metrics and analytics that include oral health. We can explore opportunities to understand current and future capabilities of extracting key elements from dental electronic records systems that would add to whole person, coordinated and integrated care delivery. It will be critical to understand from our medical and behavioral health counterparts the types of data and information that will be usable and important. Conversely, oral health care providers have a high level of need for information that can be gleaned from medical and appropriate behavioral health data. This HIE functionality is addressed elsewhere and will be a critical key to successful clinical integration. We remain committed to partnering with other CCOs and dental organizations to ease administrative burdens and would be interested in

partnering to leverage future EDR and HIE opportunities at the system level and across multiple regions and provider, plan or CCO partners.

9.B.2. Informational Questions

9.B.2.a. What assistance you would like from OHA in collecting and reporting EHR use and setting targets for increased use?

- OHA could play a valuable role in bringing DCO and CCO leadership together around EHR adoption approaches and target rates to help set common expectations and identify opportunities to combine efforts and standardize/simplify requirements.
- OHA could drive the creation of a 'Behavioral Health OMMUTAP', possibly using funding for addressing the opioid crisis. OHA could evaluate funding for technical assistance at the state level to promote best practices for behavioral health EHR, HIE adoption and use.
- The state could create vendor guidance and prioritization for metrics and population health statewide, thus vendors would have clear priorities, and the individual clinic and health systems would have less burden advocating for individual versions/needs.

9.B.2.b. Please describe your initial plans for collecting data on EHR use, and setting targets for increased use by contracted physical health Providers. Include data sources or data collection methods.

CPCCO has close relationships with all of our partner organizations. Team members who interface regularly with them are able to collect data by working directly with the clinics. We also regularly collect information from providers about their EHRs during our contracting and contract update process. We will augment this data with information collected through the environmental scan outlined above. As part of the scan, we will work with OHA/OCHIN to understand what information they have through the OMMUTAP program about the history and success of providing EHR adoption and Meaningful Use support to clinics in our region, and if useful, conduct a survey. Elements of the environmental scan will be incorporated into an annual survey we plan to conduct to evaluate EHR adoption and optimization and identify ongoing needs. Based on the outcome of these activities, we will set a realistic target for EHR adoption.

CPCCO plans to utilize our Clinical Advisory Panel as the committee who will oversee and advise on EHR adoption and optimization. This panel, as noted above, will work with staff to create our HIT plan and contribute to the development of ongoing strategies, including technical assistance, to improve clinical outcomes and data integrity through improved use of EHR.

9.B.2.c. Please describe your initial plans for collecting data on EHR use, and setting targets for increased use by contracted Behavioral Health Providers. Include data sources or data collection methods.

CPCCO has close relationships with all our partner organizations, and team members who interface regularly with them are able to collect data by working directly with the clinics. As mentioned earlier, we have a high EHR adoption rate among contracted behavioral health providers and have begun collecting this information as a part of our initial contracting and provider information update processes. As part of our overall EHR assessment in Year 1, we will be conducting a survey about EHR needs and capabilities. Elements of this information will be incorporated into an annual survey to evaluate improvements and identify ongoing needs. Based on the outcome of these activities, we will set realistic targets for EHR adoption.

9.B.2.d. Please describe your initial plans for collecting data on EHR use, and setting targets for increased use by contracted oral health Providers. Include data sources or data collection methods.

CPCCO will have clearly identified the electronic dental record status for all contracted providers, regardless of delegation status prior to contracting. That survey is currently in process in partnership with our current dental partners. The DSN will serve as our framework for the collection of needed information. Based on those results, an appropriate goal for increasing EDR adoption can be set at the CCO and individual delegate level. A CCO-wide plan that outlines the strategies and targets will be in place. Additionally, we will collectively explore and grade barriers to determine leverage points to improve EDR adoption across the network. System barriers can be addressed collectively while other barriers may require more targeted financial incentives or technical assistance. There may also be scenarios, based on informed and conscious decision making, where there is not an adequate cost-benefit ratio (*i.e.*, some narrow specialty providers) to support use of electronic records systems. However, that would not preclude the development and implementation of HIE or other mechanisms for closed loop referrals or other means of transmitting relevant information even when electronic records systems are not feasible or practical.

9.C.1.a. How will Applicant support increased access to HIE for Care Coordination among contracted physical health Providers? Please describe your strategy, including any focus on use cases or types of Providers, any HIE tool(s) or HIE methods included, and the actions you plan to take.

- ***For each evaluation question, include information on Applicant's current operations, what Applicant intends to arrange by the Contract Effective Date, and Applicant's future plans. When answering the evaluation questions, please include a narrative as well as a roadmap that includes activities, milestones and timelines.*** (Please note: Roadmap attached as an Excel spreadsheet)

CPCCO and our clinic partners have participated in a wide variety of health information exchanges, and other HIT platforms that support foundational work of population health, care coordination and management of over-utilization. Below we list multiple platforms currently supported by CPCCO and in use by us and our network.

PreManage - CPCCO has been a leader in the implementation and spread of PreManage, owned by Collective Medical Technologies (CMT), in our region. PreManage is an HIE tool that allows hospital event information (emergency department and Inpatient admissions and discharges) to be sent in real time to CCOs and provider groups for specified member or patient populations. PreManage has several unique functionalities that allow users to create targeted groups, cohorts, and reports that directly align with strategic initiatives and inform clinical workflows, such as primary care review and follow up after an emergency department visit. The tool supports care coordination among providers and between providers and CPCCO, through real-time event communication as well as a shared care plan. The shared use of PreManage between primary care, EDs and CMHPs is intended to bring attention and coordinated intervention to those members who present in emergency service and hospital settings.

CPCCO helped remove barriers to adoption for some of our local providers by paying for PreManage licenses and partnering with CMT to help our clinics design workflows that leverage the tool. Providers using PreManage today within CPCCO include, primary care, CMHPs, and Aging for Persons with Disabilities (APD) with reading privileges only, and all the DCOs (reading privileges only). We have coordinated with the emergency department Medical Directors at the hospitals to develop best practice standards for Care Recommendations and workflows to enhance cross-system care coordination. To further support successful adoption and use of PreManage, we have covered the costs for provider partners to attend statewide collaboratives to share with their peers and learn about best practices.

CPCCO uses PreManage in a collaborative manner with our regional partners in the following ways:

> Pre-Manage: Support cross system care coordination among our community partners - Several of our clinics, including behavioral health providers, use PreManage to proactively identify when their high-risk patients visit the hospital, and subsequently initiate an outreach plan, coordinate with hospital staff, and use peers to meet with the patient in real time in the emergency department when possible.
>
> Pre-Manage: Support care coordination between CPCCO and regional providers – Referrals to our regional care team come from providers and from the CPCCO triage coordinator, who utilizes targeted cohorts in PreManage to identify members who would benefit from a collaborative, multi-disciplinary care plan and subsequent outreach and wrap around services in an effort to prevent future inappropriate costly emergency department visits and inpatient stays. As a CCO we are able to monitor the volume of care recommendations developed by each organization and offer technical assistance to each system in order to tailor the support to meet their specific needs, from workflow development to IT support to advance their adoption of the tool.
>
> Pre-Manage: Support health equity – CPCCO has also adopted the use of the OHA-Collective sponsored disparity group and cohort which captures members who have a serious persistent mental illness and present to the emergency department for physical health reasons. CPCCO actively uses this cohort to ensure members needs are being meet and directly aligns with the work of CMHPs, as described above, with the ultimate collaborative goal of reducing disparities those with mental illness experience.

In addition to PreManage, CPCCO and our provider partners use a variety of other tools to enhance the exchange of timely clinical information to improve patient care across the continuum and further the goals of the Quadruple Aim. These include:

Epic's Care Everywhere - The majority of contracted physical health providers in our service area are on Epic, including the hospital systems, FQHCs, rural health clinics and our school-based health centers. This allows providers in our community to communicate directly through Epic or through "look in" functionality through Epic's Care Everywhere, which provides clinical data for providers who use Epic and other affiliated electronic health systems. The outlier is Columbia Memorial Hospital and its provider clinics which are on Cerner.

EDIE - All hospitals in our service area have adopted EDIE, which is an HIT tool that provides real time alerts to emergency departments, identifying patients who are frequent utilizers of the emergency department or have had an inpatient admission in a 12-month period. EDIE allows for additional flexibility in setting up proactive identification of high-risk patients, such as those with rare diseases or unique care plans that require strict adherence for the safety of the patient. The EDIE functionality allows real time notification for such cases and proactively pushes this information to emergency department care teams, which reduces the chance for patient harm or inappropriate care.

All hospitals in Oregon have adopted the use of EDIE and are actively contributing real time utilization data through the Admits Discharge and Transfers (ADT) database, which is securely

transmitted to a centralized data warehouse, managed by Collective Medical, and informs the complementary HIT tool, PreManage. Emergency department providers have reported finding significant value in receiving these notifications, which in addition to providing information about utilization, often includes information about providers and care managers involved in the care of the patient, relevant patient background, brief care recommendations, and historical information on security threats related to patient behavior or presentation in prior hospital visits.

Additionally, the HIT Commons has been working to bring PDMP information to Emergency Departments through integration of the Oregon PDMP registry with the EDIE platform. Such integration allows an automatic search of the Oregon PDMP registry for any patient that triggers an EDIE summary to be generated. This allows the emergency department care team to proactively identify potentially risky prescribing patterns, address poly-pharmacy concerns, conduct comprehensive medication reconciliation, and provide education to patients on proper medication management and address any risky behaviors related to prescription drugs they are receiving. Currently, in CPCCO, the Providence Seaside emergency department is actively using this tool, and CPCCO plans to support adoption of PDMP EDIE integration among remaining regional hospitals.

CPCCO Provider Portal - The CPCCO provider portal supports referrals among primary care and DCOs. Through our provider portal, physical health providers can request dental service in the same online portal where our providers submit prior authorization requests. CPCCO has provided technical assistance to physical health providers and their teams to integrate the workflow into their clinic's care coordination processes.

CPCCO is currently in the process of expanding this functionality to create an electronic mechanism for tri-directional referrals in which providers from physical, behavioral or oral health can request service navigation and care coordination services from our care coordination team. Future iterations will explore the ability to transition to a closed loop referral mechanism from our care coordination platform, GSI. In our next phase of development, we will create the functionality to allow our oral health or behavioral health providers to request care coordination and navigation support, with a longer-term goal of supporting a closed loop referral process. This will create a tri-directional navigation and referral system that can support or augment future and more robust HIE development and implementation.

GSI - Care Coordination Platform - CPCCO has implemented a robust Care Coordination Platform that has dramatically increased our efficiency. The platform provides greater access to comprehensive assessments, uses standardized workflows to improve efficiency and avoid errors, and allows the RCT to work from a common care plan, dramatically reducing duplication of services or wasted time reassessing needs. The platform delivers a care plan to the provider portal so the provider is aware of what is happening for the member, and we are able to deliver secure messages directly to EHRs (when authorized). For those providers without secure messaging, CPCCO uses the provider portal to communicate the care plan and we will generate a care plan via Premanage for members with acute needs.

E-consults through RubiconMD - RubiconMD is an e-consult platform that providers can use to consult with a national network of board certified specialists for guidance on diagnosis workups, and treatment advice options. To expand our provider capabilities for specialty referral and consultation, CPCCO has negotiated licenses for providers to access this service without charge. We hope this allows every patient to get the care they deserve regardless of affiliation with CPCCO. In addition,

Rubicon now provides up to 20 hours of CME for completed consults, 0.5 hours of continuing medical education (CME)per consult. We view this as an upskilling tool for our providers to effectively manage patient needs, while simultaneously using technology to expand the services patients can receive.

Project Echo - CPCCO currently supports and has funded providers to participate in Project ECHO as a peer-based learning platform that has shown significant effectiveness in upskilling providers on complex medical and behavioral health topics. CPCCO staff are currently faculty in an ECHO teaching MAT implementation in primary care.

Telehealth - CPCCO supports telemedicine to give members a wider access to quality care and eliminate distance barriers to improve access to services in conjunction to guidelines set by the Division of Medical Assistance Program (DMAP) and Centers of Medicare and Medicare Services (CMS). Our partners use telehealth technology in the behavioral health setting to access adult and child psychiatry support and coordinate care with providers outside of our service area. We will explore additional uses for telehealth telemedicine to improve access for specialty and primary care services..

MyChart - Each FQHC and hospital system has their own version of Epic and associated MyChart patient portal to connect patients with their providers to enhance continuity of care. CPCCO has worked with organizations to encourage increased adoption of patient portals.

Secure Messaging - In addition to PreManage, our CPCCO Regional Care Team communicate with providers using Secure messaging through their email and directly from our Care Coordination platform.

In the future, we plan to continue and expand on the work outlined above, as well as engage with our providers in the following ways:

Support and expand existing technology solutions that provide timely patient information to providers and care coordinators

- Supporting further adoption of EDIE/PreManage, as indicated in the HIT prioritized work plan
- Supporting further use of Epic/CareEverywhere, as indicated in the HIT prioritized work plan to fill gaps and promote efficiencies.

Enhance coordination between physical, behavioral, oral and SDOH organizations.

- Expanding functionality of closed loop referrals via our portal
- Expanding of closed loop referrals via CPCCO's provider portal HIEs
- Researching and implementing a tool that allows us to capture and share SDOH (*e.g.*, Unite Us, Bertha, Clara)
- Expanding use of GSI for care coordination
- Expanding use of PreManage for care coordination

Support new solutions to exchange information between EHRs and other organizations, including CPCCO, OHA, research, etc.

- Encouraging our provider partners to participate with OHA's HIE Onboarding technical assistance program.
- Evaluating tools that promote national standards for sharing information among different EHRs (e.g, Carequality, CommonWell, etc.)
- Supporting electronic data exchange between EHRs and OHA and CPCCO
- Actively participating in state multi-payer data aggregation activities
- Researching bulk electronic communication between EHRs, CPCCO/CareOregon, and OHA. We are actively improving our capability to both ingest and produce data sets for clinical and community partners. We will include production and distribution of claims data sets on a clinic-by-clinic basis to assist partners better understand their patients' utilization, risk profiles and referral patterns and use the information inform their patient-specific outreach and care coordination activities.

Support solutions that expand access to specialty care, particularly in rural communities

- Promoting further expansion of e-consults through RubiconMD
- Supporting the expansion of telemedicine through possible payment strategies, policy support, and targeted grants, etc.
- Supporting Behavioral Health tele-psychiatry
- Promoting Project Echo to support critical training needs locally, for example related to Hepatitis C, psychiatry and MAT.

Support solutions that allows members to communicate with providers and CPCCO so they can better participate in their own care

- Enhancing member portal and evaluating benefits of mobile applications
- Encouraging utilization of MyChart patient portal and CBCCO Patient Portal and associated mobile apps if available.

Engage with State Committees

To ensure we stay abreast of and inform OHA's HIT priorities, members of our team actively engage in several state workgroups, including:

- Clinical Quality Metrics Registry, Subject Matter Expert Workgroup – helps define rules and technical assistance for providers to electronically submit data to CQMR in 2020.
- Oregon Health Leadership Council - EDIE Steering Committee
- HIT Commons Workgroup
- Metrics & Scoring Committee

By participating in these groups, CPCCO is able to learn best practices and bring these into our clinical strategy development pertaining to HIE within our region. Participation in these groups allows CPCCO to inform OHA's Health Information Technology priorities by providing input and feedback to ensure the community and clinical voice is informing strategic direction and priorities.

<u>Future Plans</u>

By Contract Effective Date

By the contract effective date, CPCCO will define relationship and execute on engagement with state-sponsored partner (*i.e.*, Reliance) to ensure CPCCO providers have the opportunity to participate in the OHA HIE Onboarding Program and continue to support the technology solutions identified above in 9.C.1.a.

In Year 1, CPCCO will:

Assess the current state. Assessment activities may include:

- Meet with the HIE vendors operating in CPCCO's service area (*e.g*, CMT, Reliance) to gain insight into:
  - Current level of adoption by HIE module
  - Practices discussing or planning implementations
  - Practices that have implemented, but are under utilizing the available technology
  - Future features and functions in development and timeline for availability
  - How CPCCO will be informed about advances in HIE utilization
  - HIE vendors' input about how CPCCO can increase HIE utilization
- Meet with members of the State's Office of Health Information Technology, HIT Commons and our staff engaged in state HIT committees to:
  - Better understand current statewide initiatives
  - Better understand planned and possible future initiatives
  - Opportunities for better coordination of efforts
- Develop and distribute a survey tool to providers currently using as well as to those not currently using HIE technology to determine:
  - Real and perceived barriers to adoption
  - Modules, features, and functions that would increase value to Providers
  - Technical barriers to adoption
  - Financial barriers to adoption (technology costs and labor costs)
  - Opportunities and hopes for HIE technology utilization

Develop the Plan

In partnership with the Clinical Advisory Panel and using the information gathered from the assessment described above, CPCCO will develop a 5-Year plan that may include the following components:

- Educating providers and provider staff on existing HIE capabilities and benefits
- Developing a regional workplan called for by the HIE Onboarding Program
- Identify opportunities in care transition
- Increased and streamlined referral automated workflows
- Optimizing the use of the HIEs functionality
- Promoting interoperability of HIEs to simplify end-user environment
- Monitoring mechanisms to ensure continued improvement in HIE utilization and resulting patient care coordination

Expand Existing Solutions

In addition to assessing and planning, the first year will focus on expanding the functionality and utilization of current HIE systems among existing and new connections.

- PreManage
- CPCCO will leverage the Accountable Health Communities (AHC) screening initiative to identify members with SDOH barriers and connect them to a navigator and to needed services for up to 12 months in Year 1.

In Year 2, CPCCO will begin to implement the plan and will:

- Continue to monitor HIE utilization and work with HIE vendors to achieve optimal adoption.
- Compare quality and performance metrics of providers utilizing HIE technology to those providers that have not adopted HIE technology. Use this analysis to determine the value of CPCCO HIE adoption efforts.
- Begin to evaluate, design and develop HIE interoperability solutions with Reliance, if relevant, EDIE/PreManage, Epic CareEverywhere and GSI Care Coordination platform where deemed effective and feasible.
- Continue to engage with State entities to ensure CPCCO efforts align with other initiatives.
- Evaluate Reliance's, if relevant, referral module and potential value to improve communication and coordination among CPCCO and its
- Evaluate Reliance, if relevant, and EDIE/PreManage analytics modules to determine ROI and appropriateness of each solution
- In conjunction with State efforts, evaluate mechanisms to incorporate SDOH service providers into referral and care coordination workflows.

In Years 3-5, CPCCO will:

- Continue to engage and track HIE vendor plans and enhancements to ensure CPCCO gains optimal value from HIE technology.
- Deploy, monitor and optimize HIE interoperability solutions designed in Year 2 and approved for deployment.
- If approved, deploy, monitor, and optimize Reliance referral module for CPCCO Care Coordinators
- Deploy analytics solution based on evaluation in Year 2.
- Focus on solutions for incorporating SDOH service providers into care coordination and referral workflows.

We will develop robust systems for the integration of claim and EHR data in order to share insights about members to improve outcomes. This exchange will add patient detail which may not be present in either system alone.

9.C.1.b. How will Applicant support increased access to HIE for Care Coordination among contracted Behavioral Health Providers? Please describe your strategy, including any focus on use cases or types of Providers, any HIE tool(s) or HIE methods included, and the actions you plan to take.

We understand how health information sharing is critical to ensuring effective care management across physical health and behavioral health and to supporting behavioral health integration efforts. The behavioral health organizations within CPCCO vary in their capacity to develop the necessary infrastructure and workflows to support health information exchange.

The current platforms that support HIE with behavioral health providers include:

PreManage - Currently, all of our community mental health partners (CMHPs) are enrolled with PreManage and utilizing the tool at varied levels. As described above, PreManage is a complementary product to EDIE that allows hospital event information (emergency department and Inpatient admissions and discharges) to be sent real time to health plans, CCOs and provider groups on a real-time basis for specified member or patient populations. CMHPs in our region have reported tremendous benefit from the use of PreManage and are able to conduct proactive outreach for members who may present to the emergency department with behavioral health concerns or in crisis. As able, the CMHPs peer supports meet with the patient while they are in the emergency department and coordinate with the emergency department staff as appropriate. The literature shows that this type of warm hand-off in real time results in a greater likelihood that a patient will engage with services after the emergency department visit. CPCCO has adopted the use of the OHA-Collective sponsored disparity group and cohort which identifies members who have a serious persistent mental illness and present to the emergency department for physical health reasons. CPCCO actively uses this cohort to ensure members' needs are being met; it also directly aligns with the work of CMHPs, as described above, with the ultimate collaborative goal of reducing disparities experienced by individuals with mental illness.

Telehealth - In order to allow members to access services not otherwise available in the community, our CMHP partners use telehealth technology in the Behavioral Health setting to access adult and child psychiatry services outside of our region. We will explore additional uses for telehealth to address reduced access for specialty services as they arise.

CPCCO's Provider Portal - As mentioned above**,** one of our greatest immediate needs is the ability to refer from primary care into behavioral health and vice versa. To address this, CPCCO is currently designing an electronic mechanism for tri-directional referrals in which providers from physical, behavioral or oral health can request service navigation and care coordination services from our care coordination team as described above under question C.1.a of this attachment).

In addition, all CMHPs are getting ready to onboard an ancillary EHR and telemedicine platform that uses very little bandwidth, so it can be accessed via a cell phone. This is an important benefit for improving care coordination, particularly in remote locations as the member only needs a smart phone to have a live session.

Future Plans

As we identify strategies to support further HIE use with behavioral health providers, CPCCO will be particularly interested in a solution that builds on the current EHR and HIE capabilities in the region. We will assess with our providers the value and feasibility of sharing information (including through Epic Community Connect programs, Reliance, etc.). In the future we will evaluate updates to Epic and other EHRs as they move into the behavioral health market, with a focus on feasibility of employing appropriate standards-based exchange methods that integrate with the behavioral health EHRs used by our behavioral health providers.

As mentioned earlier, 42 CFR creates current barriers for sharing important data between behavioral health providers and others. We would like to better integrate SUD information to the extent possible within existing regulations. One of the main limitations reported by behavioral health providers is concern and lack of knowledge around compliance and records exchange. We will stay

abreast of the issue and communicate any changes to 42 CFR Part 2 that improve the ability for behavioral health professionals to engage in HIE.

By Contract Effective Date
By the contract effective date, CPCCO will define relationship and execute on engagement with state-sponsored partner (*i.e.*, Reliance) to ensure CPCCO behavioral health providers have the opportunity to participate in the OHA HIE Onboarding Program. We will also formalize the role of the HIT Workgroup and task forces specific to behavioral health.

In Year 1, CPCCO will:

Assess the current state:

- Review and leverage the assessment work defined in 9.C.1.a.
- Assess provider interest and determine best way to support their engagement with HOP.
- Meet with the HIE vendors providing service in our rural communities (Reliance and CMT)
- Meet with members of the State's Office of Health Information Technology, CQMR SME workgroup representative and with a representative from HIT Commons
- Survey providers currently using and not currently using HIE technology
- Identify elements that need to be modified, eliminated or added due to special Behavioral Health requirements

Develop the Plan
Building upon the plan developed for Physical Health, CPCCO's CAP will identify a group to focus specifically on behavioral health workflows and privacy issues. This group will participate in:

- Ensure behavioral health Providers are a priority in the CPCCO regional HIE Onboarding Program (HOP) including small Providers use of HIE portals.
- Evaluating the Reliance Consent module and other HIE workflows, if relevant.

Expand Existing Solutions
In addition to assessing and planning, the first year will focus on expanding utilization of current HIE systems to clinics that have EHRs, but have not adopted HIE technology. CPCCO staff will continue to provide workflow redesign support to further adoption and use of PreManage, specifically related to increasing the number of members who have care plans generated after presenting at emergency department and being flagged by PreManage. Based on the results of the survey, CPCCO will determine if the barriers to HIE adoption for behavioral health providers differ significantly from those of the physical health providers. If so, CPCCO will develop a separate HIE adoption strategy.

In Year 2, CPCCO will begin to implement the plan and will:

- Implement the same strategies and initiatives identified for Physical Health and adapt as necessary for the special circumstances of behavioral health.
- If deemed appropriate in Year 1, implement Reliance Behavioral Health Consent Module.

- Continue to engage with State entities to ensure CPCCO efforts align with behavioral health-specific initiatives.
- Other specific activities may include:
    - Work with the HIT Commons to evaluate expanded use of EDIE to inpatient behavioral health facilities
    - Evaluate opportunities to extend telemedicine technology for members, including mobile applications that support member's ability to communicate with their care team via mobile technology. Explore ways to reduce implementation costs, including by subsidizing purchase and maintenance costs for providers and providing technical assistance and training in appropriate use of app.

In Years 3-5, CPCCO will:

- Adapting for behavioral health Providers as necessary, implement the elements identified in the Physical Health plan – section 9.C.1.a.
- Focus on solutions for connecting behavioral health Providers to SDOH service providers for care coordination.
- Support data sharing and exchange through CareOregon's data aggregation, reporting and distribution tools

9.C.1.c. How will Applicant support increased access to HIE for Care Coordination among contracted oral health Providers? Please describe your strategy, including any focus on use cases or types of Providers, any HIE tool(s) or HIE methods included, and the actions you plan to take.

Our dental partners work directly with their contracted providers to identify opportunities to engage in HIE and share information across the continuum of health care providers.

PreManage - All of CPCCO's delegated dental plan partners have implemented and receive notifications for their members going to the emergency department for non-traumatic dental issues. They have also implemented a care coordination process whereby each member who goes to emergency department for dental issues receives outreach, care coordination and support in scheduling a visit. CPCCO is working with dental care partners to increase the percentage of members completing a dental visit within 30 days of an emergency department visit for non-traumatic dental issues.

Provider Portal - CPCCO, through CareOregon, has also invested in tools to support enhanced communication between our primary care, oral health and other providers. As discussed above, we have created a dental request within the provider portal that allows primary care providers to submit a request for dental navigation and coordination by our dental care coordinators. On our provider portal, Primary Care Clinics have access to an online form where they can input basic patient information (name, member ID, DOB, phone, clinic referring, provider name, phone number of clinic) and the dental care team will send the information to each respective dental plan for outreach and care coordination. More complex members may also be connected to other care coordination services if needed. Additionally, our care coordination platform includes the ability to document relevant unmet oral health needs and has the associated workflows to connect members to dental care.

Future Plans

In the future, we will work with work with our oral health partners to implement the following activities:

In Year 1, CPCCO will:

Assess the Current State

- Conduct assessment as described in Section B above with EHR.
- We will work with CCOs, DCOs and HIE vendors to explore an oral health information exchange. This group will examine the existing dental HIEs and explore strategies to expand and connect to other HIEs and platforms (*e.g,* Reliance, Epic). The group will also identify the types of information that will be useful to exchange. While there are many dental workflow opportunities to use physical health data clearly dental providers do not need or want all the available physical health data. Our assessment of this area will focus on data needed to fuel workflows, the abilities of Electronic Dental Records (EDRs) to hold and display that data, and the HIE methods supported by vendor systems.
- We will evaluate the efficacy of the dental request referral process described above by crosswalking claims data with those members who had a request through the portal to follow up with members and analyze "connection" success rates

Develop the Plan

- Building on the plan developed for physical health and information generated through the assessment phase, CPCCO, through its partner CareOregon, will develop the oral health content of its 5-Year HIT plan.

Expand Existing Solutions

- Encourage further utilization of the one-way electronic referrals to CareOregon or DCO portals for improved care coordination

- In Year 2, CPCCO will begin to implement the plan and will:
- Promote further use of EDIE for emergency department and urgent care event notifications for oral health related diagnosis
- Explore expansion of current pilots within DCOs using PreManage for high risk oral health conditions and/or members
- Expand existing electronic dental referral process with physical and oral health providers
- Working with OHA and HIT Commons, explore ways to integrate PDMP information into HIE services and downstream to Electronic Dental Record systems
- Continue to engage with State entities to ensure CPCCO efforts align with oral health-specific initiatives

In Years 3-5, CPCCO will:

- Support efforts identified in years 1 and 2 to further HIE between oral health and others
- We will continue to expand explore ways to improve electronic communication between oral health and other types of providers through our provider portal (*e.g.,* support bi- or tri-directional communication by allowing any kind of provider to request services and care

coordination from any other health discipline. This tri-directional ability will alleviate some of the system complexity from the various provider groups to assure a provider friendly mechanism to connect a patient to care.)

- Work with the DCOs to integrate closed-loop electronic referrals and/or preauthorization's within their providers' EDR workflows

9.C.1.d. How will Applicant ensure access to timely Hospital event notifications for contracted physical health Providers? Please describe your strategy, including any focus on use cases or types of Providers, which HIE tool(s), and the actions you plan to take.

CPCCO will continue to encourage the use and spread of EDIE/PreManage to alert providers and their care coordination staff about a member's emergency room visit or inpatient hospital event. Many clinical care teams use (EDIE/PreManage) to receive and act upon alerts on members who have accessed care in an emergency department outside of their primary delivery system. Those on PreManage exchange clinical information with various organizations, including hospitals, doctor's offices, public health authorities, pharmacies and other health plans. (See additional information in question 9.B.2.d. of this attachment).

PreManage support is often a topic at our recurrent coaching-led Patient & Population Centered Primary Care Learning Collaboratives (PC3), behavioral health peer-to-peer meetings, Clinical Advisory Panel, risk-share community partner convenings, and clinic-based one-on-one coaching and technical assistance support. These venues are specifically designed to facilitate, disseminate, and share best practices, workflows, and staffing models that support providers in caring for the population they serve. This support includes education of and how to operationalize HIT tools and data to address and improve care.

In Year 1 CPCCO will:

- Incorporate hospital event notification access into environmental scan activities discussed earlier
- Include hospital event notification access in CPCCO's HIT workplan
- Continue PreManage license coverage for CPCCO's member population
- Identify and prioritize organizations that are not currently using PreManage
- Begin engaging organizations not currently using PreManage to address functionality or deployment issues

In Year 2

- Continue working with organizations to spread use of PreManage
- Work to address funding model for PreManage based on state support plans

In Years 3-5

- Continue working with organizations to address issues and spread use of PreManage

9.C.1.e. How will Applicant ensure access to timely Hospital event notifications for contracted Behavioral Health Providers? Please describe your strategy, including any focus on use cases or types of Providers, which HIE tool(s), and the actions you plan to take.

CPCCO will expand the use of PreManage with contracted behavioral health providers to coordinate care for patients with complex needs. Specific actions will include:

- Educate BH providers on the benefits, utilization within the community and appropriate use of PreManage.
- Identify needs per clinic for technical and/or financial assistance and provide assistance as able and appropriate.
- Monitor utilization to ensure clinic adoption and utilization is hard-wired into workflows.

In Year 1 CPCCO will:

- Incorporate hospital event notification access into environmental scan activities discussed earlier
- Include hospital event notification access for behavioral health providers in CPCCO's HIT workplan
- Continue PreManage license coverage for CPCCO's member population
- Identify and prioritize high-value behavioral health use cases

In Year 2, CPCCO will:

- Identify and prioritize behavioral health organizations that are not currently using PreManage
- Begin engaging organizations not currently using PreManage to address functionality or deployment issues
- Work to address funding model for PreManage based on state support plans

In Years 3-5, CPCCO will:

- Continue working with behavioral health organizations to address issues and spread use of PreManage

9.C.1.f. How will Applicant ensure access to timely Hospital event notifications for contracted oral health Providers? Please describe your strategy, including any focus on use cases or types of Providers, which HIE tool(s), and the actions you plan to take.

CareOregon was one of the first organizations to build an oral health cohort within PreManage and has been receiving notifications specific to oral health for several years. This allows for follow up with members to ensure they are aware of their dental benefits, select a provider and arrange for a follow up dental appointment. We have seen a reduction in the number of members who present to the emergency department multiple times for oral health needs since implementation. We also monitor, report and calculate the percentage of members who have follow up dental visits within 30 days of their emergency department visit and have annual improvement targets in this area. In situations in which we have dental plan partners, the notification information was originally transmitted from the CCO to the dental plan for follow up with the member. We have supported each of our dental plan partners with their own implementation of PreManage and most are using the cohort developed by CareOregon. They now receive their own notification and conduct their own follow up and outreach while the CCO continues to monitor repeat emergency department visits by the same member as well as dental visit follow up within 30 days.

Moving forward, we would like to transition to notifications at the provider level and support the dental provider networks to become more involved in the management of urgent care needs and follow up of their patients. This also removes a layer of intervention between the need for the patient and dental provider to resolve issues that had resulted in the initial emergency department

visit. As care becomes more integrated, oral health providers will also find value in other types of notifications related to their patient populations. We look forward to partnering with dental providers to better understand and identify additional cohorts that would be beneficial to their dental care, such as diabetes and cardiovascular information.

In Year 1 CPCCO will:

- Incorporate hospital event notification access into environmental scan activities discussed earlier
- Include hospital event notification access for oral health providers in CPCCO's HIT workplan
- Continue PreManage license coverage for CPCCO's member population
- Identify and prioritize high-value oral health use cases

In Year 2

- Identify and prioritize oral health organizations that are not currently using PreManage
- Engage organizations not currently using PreManage to address functionality or deployment issues
- Work to address funding model for PreManage based on state support plans

In Years 3-5

- Continue working with oral health organizations to address issues and spread use of PreManage

9.C.1.g. How will Applicant access and use timely Hospital event notifications within your organization? Please describe your strategy, including any focus areas and methods for use, which HIE tool(s), and any actions you plan.

As discussed extensively throughout this attachment, CPCCO actively engages providers across our BH, physical health, and oral health networks, both electronically and in person, to promote the value of EDIE/PreManage content. We do this through education and by embedding clinically relevant information within PreManage, completing care guidelines, and creating access for our members.

We are using PreManage within our organization to:

- Trigger Care Coordination outreach to members currently enrolled in care coordination programs. Our care coordination staff review the notification and based on the patient's acuity and needs, develop their outreach strategy. Care coordinators provide assistance with care transitions, filling prescriptions, making follow-up appointments or connecting patients to organizations to help address their SDOH needs (see Attachment 7 for more on care coordination).
- Stratify members into risk segments and generate reports based on utilization to prioritize the members we would like to engage in care coordination. We share this information with our community partners who use PreManage and help them use to tool to prioritize their outreach and engagement activities.
- Retrieve daily reports that identify our members with inpatient admissions and/or discharges and enroll them into Care Coordination to provide transitional support.

- Identify gaps in care which can manifest as emergency department or inpatient admissions. We will address those gaps via partnerships between our Care Coordination team and network partners.
- Align care needs to the proper facilities. As members arrive in emergency department or inpatient facilities for non-critical care, we redirect those encounters to occur in dental, behavioral health, or outpatient physical care facilities.
- Distribute real time information to our internal utilization management, meds management, pharmacy, member Service and Care Coordinators involved in real-time interactions with members.

Additionally, data extracts from the CMT platform can provide enhanced and timely information to perform analytics on key populations and to provide a vehicle for more aligned cohort definition and management in real time. In the near future, we plan to expand not only the use of messaging from PreManage, but also develop feeds from CMT of the data that it contains about our members, their care teams, and their inpatient experience. We intend to apply our data analytics tools and improve our assessment of member risk and emergency department utilization.

9.C.2. Informational Questions

9.C.2.a. What assistance you would like from OHA in collecting and reporting on HIE use and setting targets for increased use?

CPCCO requests assistance from OHA related to HIE use and setting targets for increased use of HIE in several ways:

- We would like to understand what information may already exist about HIE utilization within state systems, including how it collected, and at what cadence.
- CPCCO service area shares a border with Washington, and many of our members utilize PeaceHealth in Longview for services. We would like OHA to work with Washington on interstate HIE integration (single sign-on) and help to encourage interstate care coordination.
- We would OHA to establish data standards and common definitions for key SDOH activities in order t to further the exchange of this information to support improved member and population health. We remain committed to partnering with current (i.e., Health InSight) and future community organizations who are vested in continuing improvement of health outcomes for Oregonians.
- We would like to partner with OHA to set meaningful targets for increasing use of HIE. We recommend that OHA differentiate between region(s) and provider types when setting targets to differentiate challenges around the state and focus resources on areas of greatest potential impact.
- We would like to work with OHA to define opportunities for the HIE onboarding program, beyond the currently defined 'Phase 1' (i.e. long-term care services, social services, other providers).
- We would like OHA, through the HIT Commons, to evaluate the benefits of Reliance integrating with OneHealthPort.
- There may be a role for OHA to support and leverage EDR and EHR vendors to allow for the type of data and information integration necessary to accomplish broader integration goals.

- We would like OHA to develop common approaches to oral health within HIEs and convene clinical and operational interests to establish the types of clinical information that would be most valuable across different provider types. The administrative simplification that could be realized by accomplishing some of this work at the state level has the potential to benefit all CCOs and their dental partners and providers and leverage system level decision making rather than promoting multiple iterations.

9.C.2.b. Please describe your initial plans for collecting data on HIE use, and setting targets for increased use by contracted physical health Providers. Include data sources or data collection methods.

CPCCO will:

- Working with our provider partners, we will gather data through our regular communications with our clinics to better understand how clinicians are using HIE at or near the point of care.
- Collect HIE utilization data from PreManage on a quarterly adoption and level of use information from CMT to prioritize outreach and technical assistance to drive improved utilization and optimization.
- Establish prioritized list of clinic sites not utilizing HIE and establish a plan to provide technical assistance.
- Actively promote onboarding on the eHealth Exchange to increase communications sent via Direct Messaging versus fax.

9.C.2.c. Please describe your initial plans for collecting data on HIE use, and setting targets for increased use by contracted Behavioral Health Providers. Include data sources or data collection methods.

Our plans for behavioral health will be similar to those outlined above for physical health. We will determine HIE capabilities during our environmental EHR and HIE inventories that will be performed in Year 1.

As described previously, we successfully use CMT EDIE and PreManage for many HIE key use cases. We intend to work directly with CMT to better measure this activity, determine our providers current usage state, identify gaps relative to key workflows, and have this inform our choice of suitable targets.

9.C.2.d. Please describe your initial plans for collecting data on HIE use, and setting targets for increased use by contracted oral health Providers. Include data sources or data collection methods.

CPCCO will obtain current HIE information from our 4 DCOs and oral health providers along with electronic health record information. Targets for oral health providers will be set collectively by our CPCCO dental team in partnership with DCOs and providers based on determined functionality of HIE and strategic decisions on what information is most valuable to exchange within and between clinical disciplines.

In addition, we currently receive oral health referrals from primary care via electronic request within our CPCCO provider portal, providing secure care coordination and follow up for members in need of oral health services. We track the percentage of members who successfully complete a follow up dental visit by matching member requests and dental claims history. We will continue to assess our referral platforms and workflows which will provide additional opportunities for target setting to encourage HIE adoption.

Other targets can be set based on the future goals and functionality available to oral health providers (*e.g.,* electronic dental record adoption, PreManage, integrated care coordination platforms and data aggregation at the member level).

9.D. Health IT For VBP and Population Health Management.

9.D.1. Informational Questions:

9.D.1.a. If Applicant will need technical assistance or guidance from OHA on HIT for VBP, please describe what is needed and when.

Columbia Pacific CCO (CPCCO) would benefit from technical assistance from OHA on a number of fronts.

Specifically the CCO would like to see increased best practice sharing across CCOs related to:

- population health management to meet the needs of Medicaid Members,
- VBP Reporting,
- HIE implementation, and
- integration of non-health-related information (social determinants and community level data).

CPCCO would like assistance through continued data sharing agreements of OHA/state data sources to increase perspectives and actionability of social risk information. Standardization of SDOH, Race and Ethnicity codes will be essential to ensure integration and portability of information and OHA needs to play a key role. This will help guide smart investments in system integration, health equity, social determinants, and prevention.

Another area which could benefit from OHA's leadership is the continuation of efforts to support the standardization of value-based payment models and measures to increase comparability of data and metrics. CPCCO and CareOregon have been active participants and contributors to the work being done by the PCPCRC and the Oregon CPC+ payor group around VBP alignment and reporting. Continued engagement and support by OHA in these efforts is vital.

9.D.1.b. What plans do you have for collecting and aggregate data on SDOH&HE, that may be self-reported or come from providers rather than be found in claims? Can you match demographic and SDOH&HE- related data with claims data?

Collecting and aggregating Social Determinants of Health data is critical to shifting both interventions and investments within the CCO model. While availability of these data elements is improving through claims, it is vital to supplement data collection through alternate methods. Expansion of capabilities through alignment within the CCO will be major area of focus over the next five years. Collection and integration of these data elements will be facilitated in various ways such as client and provider surveys and questionnaires, Health Risk Assessments, provider data uploads (SFTP transfers) and Electronic Health Record information. CPCCO is committed to enhancing system-wide data with more of this information as it becomes available.

First, CPCCO intends to partner with delivery systems to leverage capabilities of medical record platforms to capture data from these systems. As an example, in the Epic medical record platform, 2018 enhancements related to Social Determinants were aimed at tracking ten specific domains: alcohol use, tobacco use, financial resource strain, depression, stress, food insecurity, transportation, physical activity, violence, and social connection. These data points are captured through patient

visit interactions and patient self-reported questionnaires. CPCCO has partnered with OCHIN to gain access to the OCHIN Acuere population health management platform. This access allows CPCCO to retrieve member-level EHR information for all CPCCO members receiving care at one of our partner clinics using OCHIN's Epic. Many of the aforementioned social determinant data fields are available in this data set; however, these fields are not used often in practice. Moving forward, CPCCO will be exploring how we can support the adoption of workflows to better capture this information and how we could integrate and use this data to inform interventions and strategic initiatives. Alongside this work, CPCCO will partner with our entire network to encourage broader use and collection of Z-codes (specifically within the Z59.xx group) which identify and track needs related to social determinants of health and health equity. There is strong interest and alignment around increasing the use of these codes to track more closely member needs and the correlation between need and outcomes.

Second, through a partnership with DHS, OHA and the Oregon Pediatric Improvement Partnership (OPIP), CPCCO receiveed SDOH data for our pediatric membership that reports health complexity based on a combined medical and social complexity score. Social complexity factors include poverty (received TANF), foster care, parental incarceration, substance abuse, child abuse or neglect, parental disability, limited English proficiency, mental health services, and parental death. CPCCO, in partnership with CareOregon, has convened a Pediatric Complexity Steering Committee to determine how to best utilize the health complexity data to align with internal strategies that address identified population risk, needs, and disparities. Current committee objectives include identifying areas of health disparities for resource allocation, completing an environmental scan, and providing recommendations for a Pediatric APM model. We will also work with our CAP for advisement on how to utilize this data within provider clinics and the community.

Lastly, CPCCO, in partnership with CareOregon and the Oregon Primary Care Association, has offered annual in-person training opportunities to FQHCs, RHCs, and non-CHC primary care providers that focus on improving coding practices aimed at capturing accurate patient complexity, inclusive of SDOH. Coding data is a powerful tool in assessing patient needs and structuring clinical services to address care of an individual and population alike. These trainings are hosted by OPCA and a contracted coding organization with deep experience in supporting safety net providers. Content for each training is informed by provider network identified interests and areas of upskilling highlighted through claims analysis. For example, the 2019 training is focusing on coding for behavioral health and SUD.

For any data sources that are not directly aligned with Medicaid reporting and the use of unique patient identifiers, CPCCO will have the capability to perform patient matching within CareOregon's enterprise data warehouse. This data can then be shared across partners through routine data-sharing mechanisms, including monthly data feeds, SFTP, etc.

9.D.1.c. What are some key insights for population management that you can currently produce from your data and analysis?

CPCCO uses data and analytics to support a number of population management strategies and outreach programs. Although the approaches differ based on populations served, common themes are present and there has been considerable momentum and increased sophistication in the past five years. Specifically, the themes focus on (1) identifying members who warrant additional outreach based on gaps in needed services or underutilization, (2) identifying individuals who have frequent visits to emergency departments or multiple hospital admits or readmissions, and (3) early

identification of members who have a rising risk profile and may warrant additional outreach and engagement. These analyses enable our delivery system partners and our care coordination team to address key Quadruple aim objectives within the scope of their networks and provider relationships.,

In addition to these key network and population management insights, CPCCO leverages our sophisticated analytics capacity to address more complex population health issues through machine learning-enabled population segmentation and other techniques. These analyses often highlight issues that may not meet an intervention threshold within any particular delivery system but, when viewed system-wide, do represent significant challenges and costs for the region's Medicaid system, and as a result warrant collective intervention. We believe our use of analytics in this area has been innovative and groundbreaking, as best practices such as these are only beginning to emerge in the literature.

Our Population Segmentation model combines claims data and risk scores from the Johns Hopkins ACG model and applies a clustering algorithm to stratify population into segments from Healthy to Chronic. This model allows our RCTs to identify key population segments such as those with 'rising risk' and apply appropriate strategies to engage them in necessary care and care coordination, helping to achieve the triple aim.

CPCCO is also leveraging analytic tools to integrate information from various data sources to inform population health management activities. For example, access to Acuere, OCHIN's population health management platform, has allowed us to combine EHR data such as lab values, tobacco use, and disease screening results with pharmacy and medical claims data for a better understanding of the utilization patterns of our population with chronic diseases. This enables us to create targeted interventions for outreach and engagement or create recommendations for improved pharmaceutical options.

9.D.2. Evaluation Questions

(Please note: Roadmap for evaluations questions is attached as an Excel spreadsheet)

9.D.2.a. Describe how Applicant will use HIT to administer VBP arrangements (for example, to calculate metrics and make payments consistent with its VBP models). Include in your description how Applicant will implement HIT to administer its initial VBP arrangements and how Applicant will ensure that it has the necessary HIT as it scales its VBP arrangements rapidly over the course of 5 years and spreads VBP arrangements to different care settings. Include in your description, plans for enhancing or changing HIT if enhancements or changes are needed to administer VBP arrangements over the 5-year contract, including activities, milestones, and timelines.

CPCCO currently has implemented VBP arrangements with a number of providers and is committed to increasing VBP over the next five years. Our arrangements incentivize and hold partners accountable for performance on Oregon's CCO incentive metrics as well as other measures of clinical quality. While the measures for these arrangements are currently aligned with OHA priorities, future governance decisions and VBP needs could expand these measures of accountability to include engagement with high-priority populations, elimination of health disparities, or other measures related to quickly emerging VBP arrangements.

To that end, we are well positioned to operationalize these evolving arrangements through our software platform that supports VBP administration. This new VBP tool, a leading third-party software, currently allows us to administer payments, collect performance metrics, adjust performance-based payments, and integrate VBP and claims data. This functionality is critical to our

ability to report on payment arrangements by LAN category, as required. In early 2018 we began to use to this software to manage payments for our PCPM, CPC+ and IBH programs (described in Attachment 8). The evolution of work in this area may seem intuitive, however, administration of non-claims-based payments in a health system that was built on a FFS system has required a significant amount of operational overhaul. Moving from manually processing checks to integrating this work into our claims processing system, including records of performance has greatly improved efficiency. We will continue working to refine the system to incorporate additional functionality for metric calculation; however, current functionality allows us to administer and record performance and associated payment in one location.

The functionality above is implemented only for our primary care VBPs. In year one 2020, we plan to expand use of this tool to include our risk agreements, capitation payments and other VBPs. In year two (2021), all VBPs agreement payments will be managed using this software.

CPCCO is committed to further enhancing analytics capabilities to better model, negotiate, administer, and monitor value-based payments by stronger integration of data between financial systems, contracting systems, clinical systems, and claims systems. Integration will allow us to better track the percentage of VBP payments in relation to claims payments. During Year 1, we will explore integration options, feasibility of integration of these systems, and develop concrete roadmaps based on findings. During Years 2 and 3, we expect to implement identified roadmap items and make them fully operational in Years 4 and 5.

CPCCO's HIT infrastructure, which is powered by Care Oregon's analytics platform and resources, will play key role in monitoring both CCO performance and accountability of its partners. Our analytics platform is the result of considerable investments to ensure that validated and reliable metrics are available. Data and measures will be regularly shared with partners to identify opportunities and drive performance.

Our platform is capable of attributing members to particular clinics (PCPCH assignment) and can also track members as they move from one delivery network to another. It also manages attributions for dental relationships. Maintenance of provider attribution information has required considerable effort and will be an area of continuous improvement to ensure that performance is tracked accurately in an increasingly risk-bearing environment for physical, dental and behavioral health.

A successful VBP oversight and support program will require: metric tracking; individual risk stratification approaches; use of current analytical structures, tracking validated quality and outcomes measures, and communication and coordination with partners. While many of these functions are well-supported with our existing capabilities, all functions are not integrated for external reporting purposes. We are currently working on integrating these elements into one provider report which should be complete before Year 1. In Year 1 and beyond, we will continue working with our provider partners to ensure they have data that facilitates success in our VBP programs.

9.D.2.b. Describe how Applicant will support contracted Providers with VBP arrangements with actionable data, attribution, and information on performance. Include in your description, plans for start of Year 1 as well as plans over the 5-year contract, including activities, milestones, and timelines. Include an explanation of how, by the start of Year 1, the Applicant will provide contracted Providers with VBP arrangements with each of the following:

CPCCO will support contracted providers with VBP arrangements by providing timely, actionable data, attribution, and information on performance. Our existing capabilities support contracted providers by providing data and information via online tools such as interactive dashboards, scorecards, reports, and actionable lists using Tableau software. We are currently working on refining these reports as mentioned previously to optimize success in our VBP programs, by enabling providers to view data specific to their performance in the VBP program, as opposed to their performance as a clinic on the broader CCO metrics generally. We have a team of data analysts and practice coach staff that regularly monitor CCO and clinic performance to identify areas of opportunity. These staff are available to clinics that need assistance in report interpretation, analysis, and quality improvement activity implementation. We also support additional ways of providing necessary data as needed, such as secure file transfers, data feeds, etc.

During Year 1, we will be launching enhanced capabilities which include access to expanded interactive dashboards and scorecards as well as ability to receive provider scorecards via email. These will be tailored to a clinic's VBP program participation and population needs. Our data aggregation and analytics capabilities will continue to evolve over Years 1 to 5 to support deeper integration of data between financial, clinical, contracting, and claims systems. As the richness of information grows with elements such as SDOH discussed previously, it will open further opportunities for partnering with our providers to drive improved performance and care. For detailed information on how these report development and implementation activities are aligned with the VBP roadmap, please see the Value Based Payment 5-Year roadmap in Attachment 8.

In addition to supporting performance analytic capabilities, during Year 1 we will also make access to care coordination information available to our provider partners and explore expansion of claims data sharing which will further support care activities and analysis needed to succeed in a VBP environment.

9.D.2.b.(1). Timely (e.g., at least quarterly) information on measures used in the VBP arrangement(s) applicable to the Providers;

CPCCO regularly shares data, at least quarterly, with its providers. As mentioned previously, we are currently expanding this capability to ensure that data provided to clinics is specific to VBP arrangements in which they participate. Our existing analytics infrastructure and software tools allow us to deliver Oregon's CCO incentive metrics and select HEDIS–NCQA measures to providers on a regular basis as previously described. Enhancements planned in Years 1 through 5 will expand our ability to deliver additional measures and metrics, as appropriate based on VBP arrangement participation, to providers on a regular and automated basis. Providers will be able to view a broad menu of measures, as well as those applicable only to their payment arrangements. Scorecards include both aggregate (clinic-level) and member-level information, making data more actionable for intervention.

9.D.2.b.(2). Accurate and consistent information on patient attribution; and

Our reporting platform includes data on patient assignment and utilization. For purposes of VBP arrangements, we calculate performance on an "assigned" basis. In instances where members are inappropriately assigned, we have staff that work to quickly reconcile and reassign as appropriate. Information on patient assignment is available both through our data reporting platform as well as our provider portal. Transparency of this information allows for productive conversations around population health management expectations under our VBP arrangements.

9.D.2.b.(3). Identification of specific patients who need intervention through the year, so the Providers can take action before the year end.

We use a multi-prong approach to facilitate comprehensive identification of patients who need interventions, so providers can take action. As previously mentioned, we make data inclusive of clinical quality measure performance and health system utilization available to providers continuously through an online platform. These member-level reports make it easy to identify which members have not had recommended services or intervention. In addition, reports are currently being enhanced to include several markers of risk, including health care condition recapture data. These reports are the foundation for discussion of clinical quality improvement best practices held at our network-wide learning collaboratives and one-on-one technical assistance meetings discussed previously in this application.

In addition to external provider reporting, CPCCO has internal staff that directly support identification and coordination of members in need of services. We have a team of panel coordination staff who are out-stationed directly in our provider's offices and act directly as a part of the clinic care team. This team uses the reports previously described, as well as data obtained directly through chart reviews to prepare providers for member office visits. They currently focus primarily on needed services identified by a gap in a CCO incentive or CMS Star measure or lack of engagement with their primary care provider. During Year 1 they will enhance their use of PreManage to outreach to unengaged members seeking care through the Emergency Department and use our GSI care coordination platform to coordinate services for members with complex chronic health problems or psychosocial issues. The team is also working to identify a member caseload for each panel coordinator based on risk criteria and will be responsible for ensuring that each member has meaningful contact, gaps in care addressed, and are engaged with their primary care provider.

In addition to above report, on quarterly basis, we also use the Johns Hopkins ACG model to generate risk scores for our population. We stratify our population using advanced clustering and machine learning to identify populations which may benefit from interventions. Our Regional Care Teams (RCT) will use information from these tools to guide their work in the GSI care coordination platform.

CPCCO also provides reports showing opioid prescribing rates, and is starting to look at OUD diagnoses across organizations. Both of these are accompanied with member lists so that CPCCO care coordination staff as well as primary care teams can use these data and lists for outreach and action.

9.D.2.c. Describe other ways the Applicant plans to provide actionable data to your Provider Network. Include information on what you currently do, what you plan to do by the start of the Contract (Jan. 1, 2020), and what you intend to do in the future. Please include a narrative as well as a roadmap that includes activities, milestones and timelines.

As described in 9.D.2.b, CPCCO currently provides performance tracking for many clinical quality performance and utilization measures. These include actionable patient lists, dashboards, and score cards. Also, as previously described, we are enhancing our reporting capabilities to include additional measures, inclusive of SDOH and risk. Other ways in which we support provision of actionable data to the provider network include our work around HIE discussed previously in Attachment 9. As we continue to foster relationships between physical, behavioral, and oral health partners, we will continue to enhance data sharing capabilities between these provider types to the extent allowable

under federal regulation. Please refer to section C of this attachment for a description of data sharing activities and plans.

9.D.2.d. Describe how you will help educate and train Providers on how to use the HIT tools and data that they will receive from the CCOs.

CPCCO will educate and train providers on using tools and data by facilitating webinars (virtual training), hands-on in-person training and technical assistance, and learning collaborative forums. We currently provide coaching and continuous community-level learning opportunities through our recurrent coaching-led Patient & Population Centered Primary Care Learning Collaboratives (PC3), behavioral health peer-to-peer meetings, Clinical Advisory Panel, risk-share community partner convenings, and clinic-based one-on-one coaching and technical assistance support. These venues are specifically designed to facilitate, disseminate, and share best practices, workflows, and staffing models that support providers in caring for the populations they serve. This support includes education of and how to operationalize HIT tools and data to address and improve care. These community venues and one-on-one coaching support also intentionally incorporate action planning and accountability through quality improvement monitoring and data transparency that directly motivates and equips our provider partners to use these HIT tools to care for their patient population.

9.D.2.e. Describe the Applicant's plans for use of HIT for population health management, including supporting Providers with VBP arrangements. Include in the response any plans for start of Year 1 as well as plans over the 5-year contract, including activities, milestones, and timelines. Describe how Applicant will do the following:

CPCCO's comprehensive approach to population health management will leverage HIT heavily to create insights and to enable providers to manage care. Our technology allows segmenting populations into appropriate strata based on available information through claims, risk models such as John Hopkins ACG, and demographic information. As described in 9.D.1.c, our model for segmenting population will enable us and our partners to drive appropriate interventions. Our care coordination platform will allow our care team to manage care for complex and rising risk populations by collaborating effectively with providers.

During Year 1, we will provide access to care coordination information for our provider partners through our provider portal. Our care coordination platform will provide insights into care plans as well as population segmentation information. We will also provide VBP and other utilization data to our provider network as described in 9.D.2.b.

During Years 2 through 5, we will explore further integration opportunities between claims data, financial data, and clinical data to facilitate modeling, administrating, and monitoring VBP agreements. Some of this work will include exploring additional opportunities through Acuere and use of pediatric health complexity data.

9.D.2.e.(1). Use HIT to risk stratify and identify and report upon Member characteristics, including but not limited to past diagnoses and services, that can inform the targeting of interventions to improve outcomes? Please include the tools and data sources that will be used (e.g., claims), and how often Applicant will re-stratify the population.

We currently have several risk models in place, each used for different purposes. For purposes of population segmentation as described in 9.D.1.c, we employ the John Hopkins ACG model. This model is used for internal care coordination and will be shared with providers as a means of coordinating care across cohorts of members with similar clinical profiles. We aim to stratify

populations using this model once every quarter using automated process to improve consistency and timeliness of available information.

For purposes of VBP risk adjustment, we use a combination of CDPS-Rx and Hierarchical Condition Category (HCC) data received from the OHA and CMS. This data will be shared with providers in our enhanced VBP reports and will include information on past diagnoses and services, to the extent that it is available. The goal of sharing this information is to ensure providers have complete information on the member's clinical history, regardless of where care was previously received.

During Year 1 and 2, we will explore expanding these models to include additional SDOH categories through incorporation of Z-codes and health complexity data, as previously mentioned.

9.D.2.f. What are your plans to provide risk stratification and Member characteristics to your contracted Providers with VBP arrangements for the population(s) included in those arrangement(s)?

For purposes of VBP risk adjustment, we use a combination of CDPS-Rx and Hierarchical Condition Category (HCC) data received from the OHA and CMS. This data will be shared with providers in our enhanced VBP reports, described in 9.D.2.b, and will include information on past diagnoses and services, to the extent that it is available. We will have the ability to include data on a subset of a provider's population if the VBP arrangement is not inclusive of the entire population. Population segmentation data will also be shared in a similar manner.

9.D.2.g. Please describe any other ways that the Applicant will gather information on, and measure population health status and outcomes (e.g., claims, clinical metrics, etc.). Describe Applicant's HIT capabilities for the purposes of supporting VBP and population management. Again, please provide plans for start of Year 1 as well as plans over the 5- year contract, including activities, milestones, and timelines. Include information about the following items:

CPCCO will gather information on and measure population health status and outcomes through various approaches, such as claims and clinical metrics as discussed earlier in this section. During Year 1, we will expand our abilities to further gather and integrate data from Health Risk Screenings and explore EHR integration with provider partners. During Years 2 and 3, we will explore and enhance QRDA I and III exchange capabilities to increase our ability to gather population health status outcomes. Our comprehensive analytics infrastructure consisting of an enterprise data aggregation and analytics platform, data marts, and third party analytic tools will allow us to analyze, draw conclusions, and drive appropriate actions to improve health status and outcomes for our members.

9.D.2.g.(1) Data sources: What data sources do you draw on – for example, if you incorporate clinical quality metrics, what data do you collect and how? How often do you update the data? How are new data sources added? How do you address data quality?

CPCCO uses wide range of data sources and will continue to add more sources over the contracted period. Physical, dental and behavioral health claims processed in-house by our claims system form the backbone of our data assets. This data is further enriched by integrating pharmacy claims, APAC formatted claims, and enrollment and risk data received from other entities. Additional data sources that augment our administrative data include: PreManage, ALERT data received from OHA, lab values from select vendors, EHR data obtained through chart review, EHR data obtained through Acuere, and Clinical Quality Measure (CQM) data received from CQM-reporting providers. Data is

updated on varying schedules, no less than quarterly, dependent on frequency of receipt from each source.

During Year 1 of contract we will explore collaboration opportunities with Reliance for additional EHR data acquisition as well as the Oregon Primary Care Association for patient experience survey data.

A data governance framework and process is used for governance and quality assurance. Our Data Governance committee is chartered by our executive leadership team and is attended by senior management to ensure organization-wide ownership, accountability, and consistency around data governance policies and procedures.

During Year 1, we will further improve our data governance processes by chartering subgroups focused on member and provider data. We will deploy processes and tools for managing and maintaining business glossary and a data dictionary to promote consistent use and interpretation of data.

During Year 2, we will improve our data governance processes by convening subgroups focused on claims and reference data.

9.D.2.g.(2). Data storage: Where do you store data (e.g., enterprise data warehouse)?
CPCCO has comprehensive data storage infrastructure comprising an enterprise data warehouse which contains critical subject areas such as Claims and Pharmacy, and subject area data marts such as Finance.

During Years 1 and 2, we will extend our enterprise data warehouse to increase data integration across subject areas and data sources. We intend to augment our current enterprise data warehouse to incorporate a patient-centric view of data in addition to our existing claim-centric view. We will increase our data warehouse's ability to store EHR and other clinical data. We will also leverage modern cloud capabilities to further store and handle unstructured data and to support integration of future data sources such patient-centric home devices.

9.D.2.g.(3). Tools:
9.D.2.g.(3).(a).What HIT tool(s) do you use to manage the data and assess performance?
We use industry standard tools, processes, and practices for managing data and for assessing performance. Our tool set includes comprehensive EDW and data marts as data repositories. Our data repositories are primarily SQL Server Enterprise running on robust infrastructure. We use SSIS as our tool of choice for moving data between systems and databases. We use third party software platforms such as Arcadia and Cotivity to assist with clinical quality measure calculation.

9.D.2.g.(3).(b). What analytics tool(s) do you use? What types of reports do you generate routinely (e.g., daily, weekly, monthly, quarterly)?
CPCCO uses variety of industry-leading tools to drive analytics. Tableau is used for generating and distributing robust, meaningful, and easy-to-understand analysis dashboards and scorecards. Our Tableau infrastructure will deliver these dashboards within our CCO and to our clinic partners. These dashboards are refreshed between weekly and quarterly depending on business needs.

We use SQL Server Reporting Services to deliver transactional and detailed reports to users on regular basis. Frequency of these reports varies from real-time to quarterly depending on business needs.

Excel is used as reporting tool where it is appropriate, i.e. Finance. CPCCO uses SAS auto jobs and other tools to generate these files on regular basis. Frequency of refresh for these files varies from weekly to quarterly depending on business needs.

Tools such as R, SAS, SPSS, and Python are used for statistical and predictive modeling to answer advanced analytics questions such as identifying populations at risk of adverse health related events.

Tools such as the Johns Hopkins ACG are used for risk assessments and stratification of population, and other third-party tools are used to distribute reports via email. We use our care Coordination platform to provide up-to-date information on care coordination activities.

9.D.2.g.(4). Workforce: Do you have staff (in-house, contractors or a combination) who can write and run reports and who can help other staff understand the data? What is your staffing model, including contracted staffing?
CPCCO has robust data and reporting teams. We have 30 permanent data and analytics staff members who manage our HIT and databases, assure data quality, develop reports, conduct statistical analyses, develop predictive models, and perform other data/analytics functions across the enterprise. We can also subcontract to outside vendors if additional specialized skills are needed. Our team includes software developers, data architects, database administrators, business analysts and healthcare analysts; these skill sets cover the entire spectrum of activities and skills needed to deliver high quality analytics.

In addition, CPCCO has dedicated quality improvement and technical assistance staff to offer support for data/report translation and implementation activities both internally and externally. Our quality improvement staff are skilled in explaining data to internal staff and external provider partners on the level that meets the need. Our staff have dedicated time over the past year to honing data visualization skills in order to better communicate complex analyses to wider audiences.

Our innovation specialist team offers technical assistance directly to providers and can help with report reading and translation as necessary. This team also assists providers with using data in meaningful ways for quality improvement purposes. CPCCO's panel coordinators, working full-time directly in the provider's offices, are also available to assist clinic staff in understanding data and reports.

9.D.2.g.(5). Dissemination: After reports are run, how do you disseminate analysis to Providers or Care Coordinators in your network? How do you disseminate analysis within your organization?
CPCCO disseminates reports to our provider partners, care coordinators, and internal users through variety of ways. Reports are delivered via web-based solutions such as Tableau, via email, and by using Excel. Our flexible approach ensures we can meet the needs of our providers and care coordinators and reduce barriers to access information. While access to the web-based reports is continuously available, reports are also disseminated are reviewed at key stakeholder meetings both internally and externally such as our Clinical Advisory Panels, Quality Improvement Committees, Learning Collaboratives, and Board Meetings.

Internal performance is reviewed regularly through team huddles as well as our Quality Governance and Executive Management structures. Detailed member-level profiles are reviewed on a regular basis for the purposes of care coordination through our Regional Care Teams.

During Year 1, we will expand our capabilities to enable single sign-on to key reporting systems, automate the broadcast of templatized score cards to clinical partners, and launch a new Analytics portal.

9.D.2.g.(6). Effectiveness: How will you monitor progress on your roadmap and the effectiveness of the HIT supports implemented or to be implemented?

Robust internal monitoring processes and structures are in place to track progress, remove barriers, and adjust as necessary.

Analytics capabilities are a key part of CPCCO and CareOregon's strategic plans thus ensuring organizational and executive buy-in for project activities. It also creates high degree of visibility at the executive leadership and Board of Directors levels, ensuring planned progress is made on roadmap and that any necessary adjustments are made with broad organizational goals in mind.

Project Management Office (PMO) is responsible for planning, executing, and reporting progress on roadmap and project activities. PMO has adapted industry standard processes for planning, monitoring and reporting progress on projects; this ensures consistent tracking and reporting is in place.

A steering committee consisting of members of our leadership team guides ongoing program development, implementation plans, addresses barriers, and provides direction on bi-weekly basis to key analytics programs.

We use a *Voice of Customer Forum* along with other processes to ensure that we consider the perspective of analytics and reporting customers when planning and delivering various roadmap items related to analytics.

9.D.2.g.(7). Addressing challenges: What challenges do you anticipate related to HIT to support VBP arrangements with contracted Providers, including provider-side challenges? How do you plan to mitigate these challenges? Do you have any planned projects or IT upgrades or transitions that would affect your ability to have the appropriate HIT for VBP?

From our vantage point, there are several key challenges we need to overcome to successfully support VBP arrangements by using HIT:

- Portability and standardization of data across partners and across subject areas is a first essential step to ensure cost-effective analytical solutions can be built. Key areas where standardization will enable us to better analyze data include race and ethnicity codes, and SDOH-HE data elements. CPCCO will continue working with OHA and other CCOs through HITAG to establish and/or refine needed data standards.
- Standardization of performance measures for VBP is another important challenge. Lack of alignment increases difficulty in successfully engaging providers in this work. CPCCO will provide actionable population and member-level information to providers to succeed in

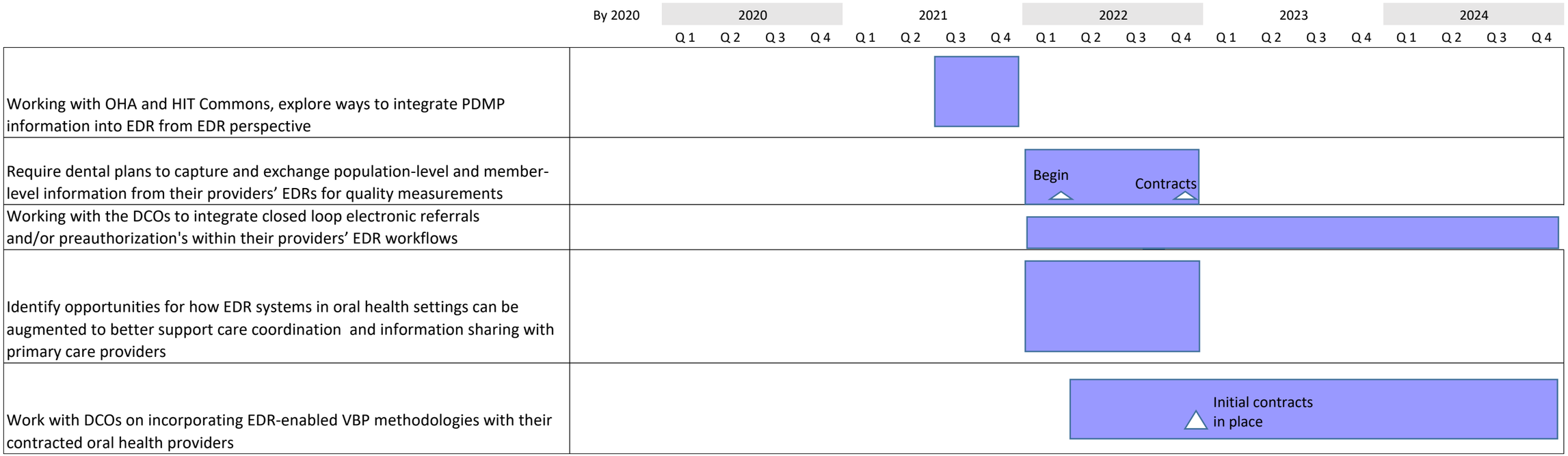
- Integration of clinical data to successfully administer VBP arrangements may present challenges. Initiatives such as HOP and HIE solutions will help respond to this challenge. Also, CPCCO will explore opportunities to integrate clinical data into our data aggregation and analytics platform that provides actionable information to both CPCCO and providers.
- Standardizing provider attribution and claims reporting is critical to ensuring appropriate VBP data is reported. Lack of systematic billing practices by providers and health systems creates barriers to consistent attribution and VBP implementation.

We are mitigating the above challenges to the extent possible with internal system development. However, where alignment and standardization is key to overcoming barriers, the OHA could play a key role in leading this work.

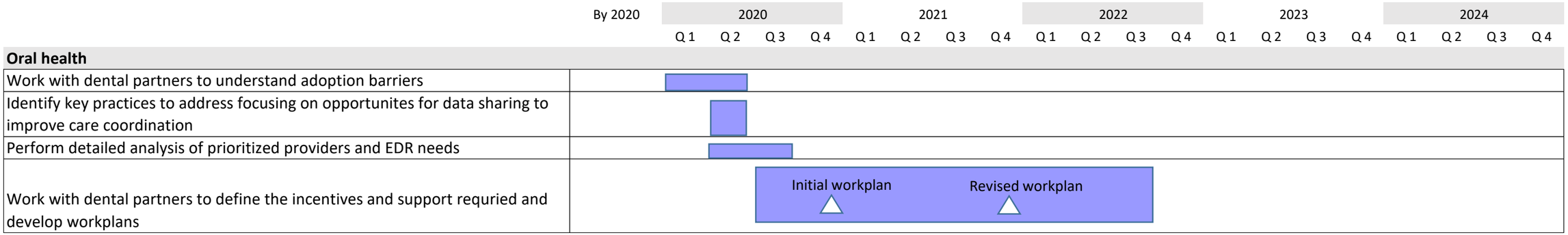
Support for EHR Adoption

	By 2020	2020				2021				2022				2023				2024			
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4
Multidisiplinary																					
Create HIT Workgroup																					
Physical Health																					
Establish CPCCO Clinical Advisory Panel (CAP)																					
Assess capacity and opportunities for EHR optimization and identification of initial strategies																					
Define EHR system needs																					
Develop workplan																					
Targeted traning and technical assistance									Engagements Begin												
Explore development of a scribe program to support improved EHR use among providers									Program defined												
Additional patient registries and workflows																					
Extend access to additional platforms (e.g. mobile devices)																					
Behavioral Health																					
Determine structure for behavioral health input																					
Conduct an environmental scan and identify gaps																					
Define behavioral health EHR needs																					
Create workplan																					
Support data sharing and electronic outcomes reporting									Incentive model for e-reporting												
Electronic Behavioral Health Referrals									Pilot	Rollout begins											
Implement best practices for BH EHR use and configuration																					
Develop additional tools (e.g. PDMP integration, ROI automation, analytics)																					

	By 2020	2020				2021				2022				2023				2024			
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4
EHR interoperability solutions with HIE and care coordination platforms						Design		Development													
Evaluate and (re)assess programs to date																					
Monitor and re-educate to maintain and improve best practices for EHR use and configuration																					
Identify and address problems in capture and reporting of clinical measures																					
Oral health																					
Build out the five-year roadmap with Dental Care Organization partners																					
Assess current provider use and determine future needs, including assessing their capacity to document and report physical health information within their Electronic Dental Records (EDR)																					
Partner with dental plan leadership to conduct a gap analysis for selected practices																					
Create a workplan																					
Bring initial priorities to pilot or next stage						Design		Implementations begin													
Identify priority Electronic Dental Record (EDR) systems and enhance their systems to integrate key clinical data from other providers, including physical health (e.g., problem lists, med lists, allergy)																					
Support further integration of physical and oral health:																					
Exploring ways to further improve and spread functionality for dentists working in integrated primary care home (e.g, Epic's Wisdom)																					
Improving ability for dentists and other clinics providing oral health services to document in physical health EHR																					
Work with DCO partners to learn about pilots within their system and identify opportunities for spread in a standardized way across DCOs																					

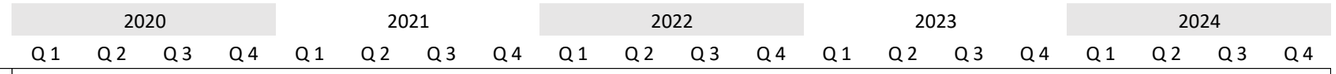


Barriers and plans to address
Physical Health
Develop EHR optimization plan (same as in EHR Adoption roadmap)
Identify key practices to address
Perform detailed analysis of prioritized providers and EHR needs
Work with partners to define the incentives and support requried and develop workplans
Behavioral Health
Conduct envionmental scan (integrated with EHR adoption/optimization analysis)
Incorporate activites to address barriers in behavioral health needs in the HIT workplan
Advocate for and promote EHR solutions at support integrated care delivery
Work with OHA to evaluate the OARs and promote streamlining the documentation requirements for integrated setting


By 2020
2020
2021
2022
2023
2024
Q 1 Q 2 Q 3 Q 4 Q 1 Q 2 Q 3 Q 4 Q 1 Q 2 Q 3 Q 4 Q 1 Q 2 Q 3 Q 4 Q 1 Q 2 Q 3 Q 4
Oral health
Work with dental partners to understand adoption barriers
Identify key practices to address focusing on opportunites for data sharing to improve care coordination
Perform detailed analysis of prioritized providers and EDR needs
Work with dental partners to define the incentives and support requried and develop workplans
Initial workplan
Revised workplan

HIE

	2020				2021				2022				2023				2024			
	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4
Physical Health																				
Assess current state and develop plan																				
Meet with the HIE vendors operating in CPCCO's service area																				
Meet with members of the State's Office of Health Information Technology, CQMR SME workgroup																				
Develop and distribute a survey tool for Providers currently using and not currently using HIE technology																				
Deveop workplan																				
Expand the functionality and utilization of current HIE systems among existing and new connections																				
Continue to monitor HIE utilization and work with HIE vendors to achieve optimal adoption																				
Compare quality and performance metrics of providers utilizing HIE technology to those providers that have not adopted HIE technology																				
Develop Solutions																				
Evaluate, design and develop HIE interoperability solutions with Reliance, PreManage, Epic CareEverywhere and CareOregon's GSI Care Coordination platform where deemed effective and feasible																				
Continue to engage with State entities to ensure CPCCO efforts align with other initiatives.																				
Evaluate Reliance referral module for referrals to CPCCO Care Coordinators																				
Evaluate Reliance and PreManage analytics modules to determine ROI and appropriateness of each solution,																				



In conjunction with State efforts, evaluate mechanisms to incorporate SDoH service providers into referral and care coordination workflows.	
Continue to engage and track HIE vendor plans and enhancements to ensure CPCCO gains optimal value from HIE technology.	

Implement Solutions

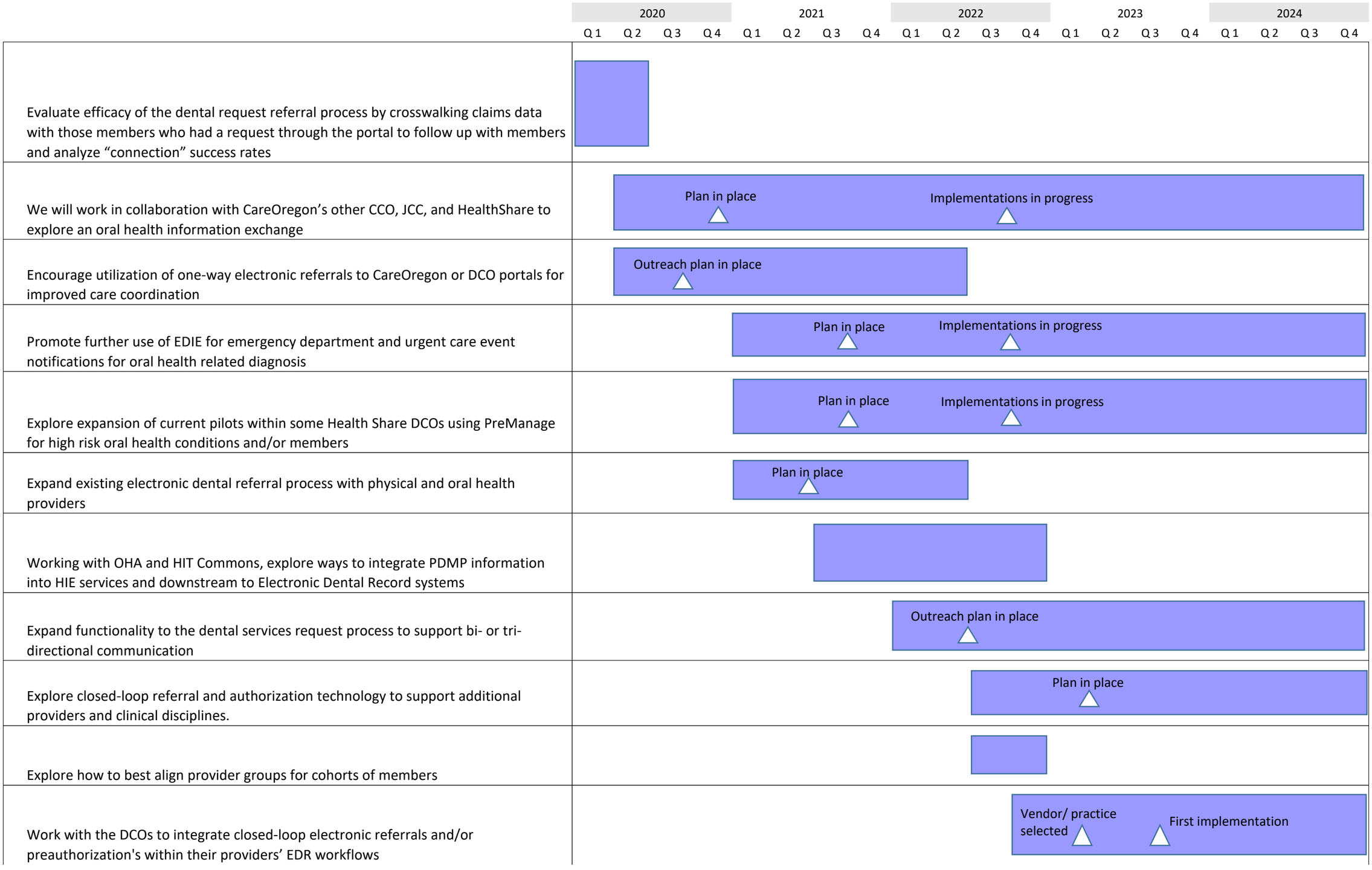
Deploy, monitor and optimize HIE interoperability solutions designed in Year 2 and approved for deployment.	Inital deployment plan △ △ Deployments begin
If approved, deploy, monitor, and optimize Reliance referral module	Care Coordinators △ △ Provider rollout begins
Deploy analytics solution based on evaluation in Year 2.	Design and pilot solution △ △ Rollout begins
Focus on solutions for incorporating SDoH service providers into care coordination and referral workflows.	Design and pilot solution △ △ Rollout begins

Behavioral Health

Assess current state and develop plan

Leverage HIE survey tool for behavioral health provdiers using and not currently using HIE technology	
Identify elements that need to be modified, eliminated or added due to special Behavioral Health requirements	
Assess provider interest and determine best ways to support their engagements with HOP	
Meet with the HIE vendors providing service in our rural communities (Reliance and CMT)	
Meet with members of the State's Office of Health Information Technology, CQMR SME workgroup representative and with a representative from HIT Commons	
Form workgroup to focus on behavoral health and privacy issues and build workplan	

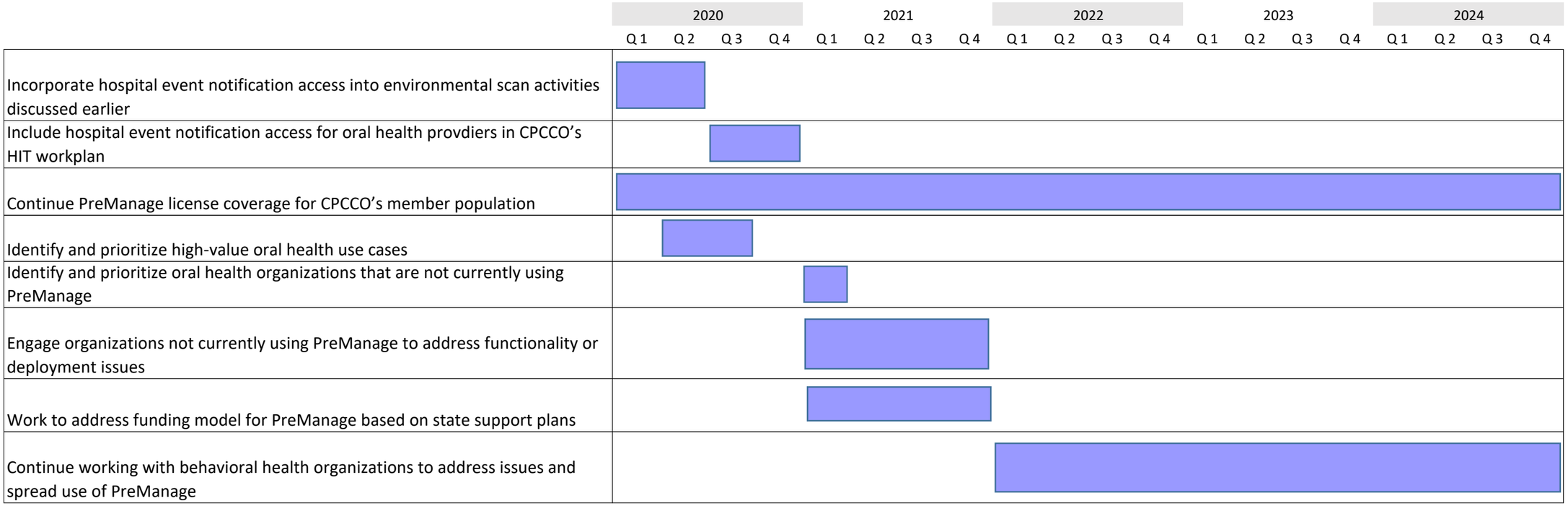
	2020				2021				2022				2023				2024			
	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4
Evaluate Reliance Behavorial Health Consent Module																				
Develop and Expand Solutions																				
Continue to engage with State entities to ensure CPCCO efforts align with behavioral health-specific initiatives.																				
Provide workflow redesign support to further adoption and use of PreManage, specifically related to increasing the number of members who have care plans generated after presenting at emergency department and being flagged by PreManage																				
Adapt physical health strategies as necessary for behavioral health																				
Implement Reliance Behavorial Health Consent Module																				
Work with the HIT Commons to expand use of EDIE to inpatient behavioral health facilities																				
Implement Solutions																				
Implement HIE interoperability solutions with Reliance, PreManage, Epic CareEverywhere and CareOregon's GSI Care Coordination platform where deemed effective and feasible																				
Evaluate and implement solutions for connecting behavioral health Providers to SDoH service providers for care coordination																				
Support data sharing and exchange through CareOregon’s data aggregation, reporting and distribution tools																				
Oral Health																				
Conduct assessment as described in Section B above with EHR																				


2020
2021
2022
2023
2024
Q 1 Q 2 Q 3 Q 4 Q 1 Q 2 Q 3 Q 4 Q 1 Q 2 Q 3 Q 4 Q 1 Q 2 Q 3 Q 4 Q 1 Q 2 Q 3 Q 4
Evaluate efficacy of the dental request referral process by crosswalking claims data with those members who had a request through the portal to follow up with members and analyze “connection” success rates
We will work in collaboration with CareOregon’s other CCO, JCC, and HealthShare to explore an oral health information exchange
Plan in place
Implementations in progress
Encourage utilization of one-way electronic referrals to CareOregon or DCO portals for improved care coordination
Outreach plan in place
Promote further use of EDIE for emergency department and urgent care event notifications for oral health related diagnosis
Plan in place
Implementations in progress
Explore expansion of current pilots within some Health Share DCOs using PreManage for high risk oral health conditions and/or members
Plan in place
Implementations in progress
Expand existing electronic dental referral process with physical and oral health providers
Plan in place
Working with OHA and HIT Commons, explore ways to integrate PDMP information into HIE services and downstream to Electronic Dental Record systems
Expand functionality to the dental services request process to support bi- or tri-directional communication
Outreach plan in place
Explore closed-loop referral and authorization technology to support additional providers and clinical disciplines.
Plan in place
Explore how to best align provider groups for cohorts of members
Work with the DCOs to integrate closed-loop electronic referrals and/or preauthorization's within their providers’ EDR workflows
Vendor/ practice selected
First implementation

	2020				2021				2022				2023				2024			
	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4
Evaluate existing dental HIEs and explore strategies to expand and connect to other HIEs and platforms (e.g, Reliance, Epic)												Plan in place								

Hospital Notifications

	2020				2021				2022				2023				2024			
	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4
Physical Health																				
Incorporate hospital event notification access into environmental scan activities discussed earlier																				
Include hospital event notification access in CPCCO's HIT workplan																				
Continue PreManage license coverage for CPCCO's member population																				
Identify and prioritize organizations that are not currently using PreManage																				
Continue working with organizations to spread use of PreManage																				
Work to address funding model for PreManage based on state support plans																				
Continue working with organizations to address issues and spread use of PreManage																				
Behavioral Health																				
Incorporate hospital event notification access into environmental scan activities discussed earlier																				
Include hospital event notification access for behavioral health provdiers in CPCCO's HIT workplan																				
Continue PreManage license coverage for CPCCO's member population																				
Identify and prioritize high-value behavioral health use cases																				
Identify and prioritize behavioral health organizations that are not currently using PreManage																				
Continue working with organizations to spread use of PreManage																				
Work to address funding model for PreManage based on state support plans																				
Continue working with behavioral health organizations to address issues and spread use of PreManage																				
Oral Health																				


2020
2021
2022
2023
2024
Q 1 Q 2 Q 3 Q 4 Q 1 Q 2 Q 3 Q 4 Q 1 Q 2 Q 3 Q 4 Q 1 Q 2 Q 3 Q 4 Q 1 Q 2 Q 3 Q 4
Incorporate hospital event notification access into environmental scan activities discussed earlier
Include hospital event notification access for oral health provdiers in CPCCO's HIT workplan
Continue PreManage license coverage for CPCCO's member population
Identify and prioritize high-value oral health use cases
Identify and prioritize oral health organizations that are not currently using PreManage
Engage organizations not currently using PreManage to address functionality or deployment issues
Work to address funding model for PreManage based on state support plans
Continue working with behavioral health organizations to address issues and spread use of PreManage

VBP

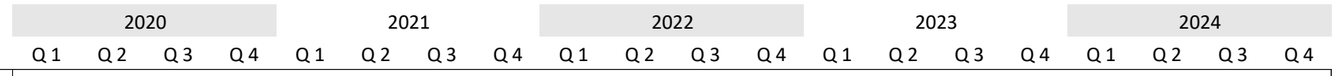
HIT to Administer VBP Arrangements

	2020 Q1	Q2	Q3	Q4	2021 Q1	Q2	Q3	Q4	2022 Q1	Q2	Q3	Q4	2023 Q1	Q2	Q3	Q4	2024 Q1	Q2	Q3	Q4
Expand use of VBP administration system already in use	addional VBP models ▲																			
Explore integration options (financial, contracting, clincal, and claims systems), feasibility, and develop roadmaps based on findings	Roadmap in place ▲																			
Implement identified roadmap items																				
Operationalize and identified roadmap items																				
External reporting data integration and distribution improvements	Integrated reporting production ▲								Assessment and adjustments ▲								Assessment and adjustments ▲			

Enhancing analytics platform and services -- aligned with VBP strategy

	2020 Q1	Q2	Q3	Q4	2021 Q1	Q2	Q3	Q4	2022 Q1	Q2	Q3	Q4	2023 Q1	Q2	Q3	Q4	2024 Q1	Q2	Q3	Q4
Sustaining NEMT (4B)																				
Work with Primary Care to sustain 2C																				
Support expansion of 3B for Primary Care	Tools and data in place ▲												Adjustments evaluated ▲				Adjustments in place ▲			
Support and expand PCPM T1&2 for Pediatrics (2C)	Tools and data in place ▲				Adjustments evaluated ▲				Adjustments in place ▲				Adjustments evaluated ▲				Adjustments in place ▲			
Expand 2B-C for Hospital quality metrics and Bundled Payment (3B)	Tools and data in place ▲				Adjustments evaluated ▲				Adjustments in place ▲				Adjustments evaluated ▲				Adjustments in place ▲			
Expand 3B for Provider/Health System Shared Risk	Tools and data in place ▲				Adjustments evaluated ▲				Adjustments in place ▲				Adjustments evaluated ▲				Adjustments in place ▲			
Expand and sustain Maternity care Global Payment Model for SUD (2C, 4B)	Tools and data in place (2C) ▲				Develop tools (4B) ▲				Tools and data in place (4B) ▲											
Behavioral Health Care					Develop tools (2C) ▲				Tools and data in place (3A) ▲											
Oral Health Care									Develop tools (2C) ▲				Tools and data in place (2C) ▲							

	2020				2021				2022				2023				2024			
	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4
Pharmacy																	Develop tools (2C) ▲			
Supporting contracted providers with VBP arrangements																				
Deliver quarterly reports and dashboards (see Enhancing analytics platform….section above for miletones)				▲ Launch access to expanded dashboards and scorecards																
Explore expansion of claims data sharing																				
Deliver quarterly member rosters and attribution reports																				
Provide on-line member-level portal access and reports for quality measures and risk																				
Generate refreshed risk scores each quarter																				
Other ways of providing actionable data																				
Enhance reporting capabilities to include additional measures, inclusive of SDoH-HE and risk																				
Incorporate VBP considerations in HIE analysis and solution design																				
Investigate data from HIE platform and data reporting solutions																				
HIT data for population health management																				
Provide real-time access to CPCCO's care coordination system - acces care plans and population segmentation information																				
Monthly or quarterly risk stratification and population segmentation refreshes																				
Explore further integration opportunities between claims data, financial data, and clinical data to facilitate modeling, administrating, and monitoring VBP agreements																				



Explore additional opportunities through Acuere health data aggregation platform) and use of pediatric health complexity data	
Explore expanding these models to include additional SDoH categories through incorporation of Z-codes and health complexity data	

Other ways to gather and measure population health status and outcomes

Expand our abilities to further gather and Integrate data from Health Risk Screenings	
Explore EHR integration with provider partners with our data aggregation and analytics platform	
Explore and enhance QRDA I and III exchange capabilities to increase our ability to gather population health status outcomes	

Data Sources

Explore collaboration opportunities with Reliance, and Oregon Primary Care Association	
Further improve our data governance processes by chartering subgroups focused on Member and provider data	
Deploy processes and tools for managing and maintaining business glossary and a data dictionary to promote consistent use and interpretation of data	
Improve our data governance processes by chartering subgroups focused on claims and reference data	

Dissemination of analysis

Expand our capabilities to enable single sign-on to key reporting systems, automate the broadcast of templatized score cards to clinical partners, and launch a new Analytics portal	

Effectiveness of HIT supports

Maintain governance and customer feedback forums	

Addressing Challenges

	2020				2021				2022				2023				2024			
	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4
Continue working with OHA and other CCOs through HITAG to establish and/or refine needed data standards																				
Provide actionable population and member-level information to providers to succeed in these arrangements																				
Explore opportunities to integrate clinical data into our data aggregation and analytics platform that provides actionable information to both CPCCO and providers																				

First cohort live

Attachment 10 - Social Determinants of Health and Health Equity

10.A. Community Engagement

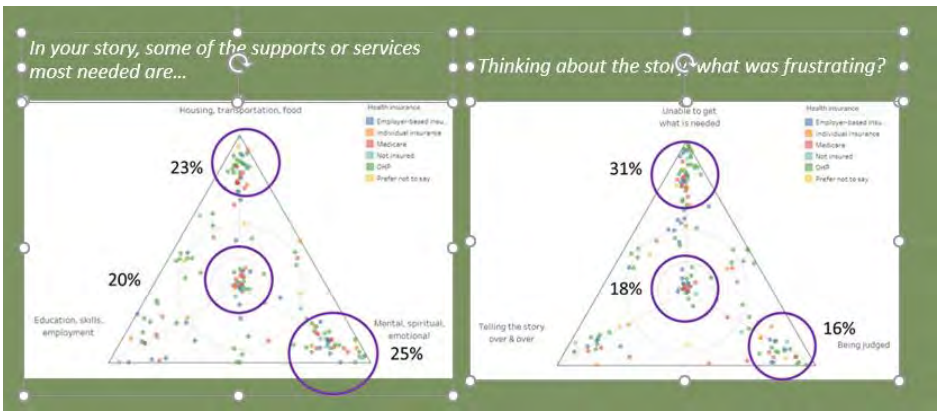
10.A.1. Evaluation Questions

10.A.1.a. Did Applicant obtain Community involvement in the development of the Application?

The strategies developed and implemented by CPCCO since 2012 have all been informed by our community and clinical partners and are also reflected in the content of this application for our work over the next five years. Most, if not all, of the strategies developed and implemented by CPCCO are informed by our collaborative dialogues with our community-led Board of Directors and local partners; through our community needs assessment and improvement planning via our Community Advisory Councils (CACs); and through the development of our annual quality, access and equity goals via our Clinical Advisory Panel (CAP). Therefore, the plans reflected in this application for our next five years have been directly informed and formed by the non-clinical and clinical communities in which we work.

We are currently engaged in assessing regional health needs as part of our five-year community health improvement plan. For the assessment, CPCCO completed a participatory primary data collection survey with key community stakeholders from the health care and social safety net sectors, CCO members, and other community residents. Through use of a software platform, the process combines quantitative and qualitative data from micro-narratives on health and well-being by OHP members and the general public in the communities we serve. The teller of the micro-narrative 'story' self-signifies the importance and meaning of the story, thereby allowing us both to hear the experiences of community members in their own voices and to develop a framework for addressing our OHP members' health care needs and the social determinants of health and health equity (SDOH-HE). Throughout, CPCCO intentionally sought to collect and amplify voices and perspectives of all CCO members, but with an oversampling of Latino and Tribal communities.

These narratives confirmed participants' difficulties in getting their health care needs met in rural communities based on access and availability, but participants also voiced that ***social determinants of health*** contributed most significantly to barriers to care. Transportation emerged as the most often cited barrier; participants often identified basic needs such as housing and food along with mental, spiritual, and emotional supports. The narratives also highlighted respondents' need to be heard and for the flexibility and predictability that comes from integrating a trauma-informed perspective, as well as frustration with the complexity of health insurance and coverage rules. The collection of these narratives has been a key driver of how CPCCO and its community partners invest both time and financial resources to address SDOH-HE through our 2020-2024 regional community health improvement plan RHIP).



In addition to the extensive community involvement in the development of the RHIP, our work is also informed by the CAP, whereby care providers and clinical leaders provide input regarding regional needs, advise on clinical strategies to best address local gaps, and advise on clinical strategies to advance equity initiatives and address disparities in health.

10.A.1.b. Applicant will submit a plan via the RFA Community Engagement Plan for engaging key stakeholders, including OHP consumers, Community-based organizations that address disparities and the social determinants of health, providers, local public health authorities, Tribes, and others, in its work.
10.A.2. Requested Documents: Completed RFA Community Engagement Plan, including all required elements as described in RFA Community Engagement Plan Requirement Components and attaching required Tables in RFA Community Engagement Plan Required Tables

10.B. Social Determinants of Health and Health Equity (SDOH-HE) Spending, Priorities, and Partnership
10.B.1.a. Does Applicant currently hold any agreements or MOUs with entities that meet the definition of SDOH-HE partners, including housing partners? If yes, please describe the agreement.
Since 2013, CPCCO has held multiple Letters of Agreement (LOA) with entities that meet the definition of SDOH-HE partners. Currently, we have six LOAs in the domain of Neighborhood and Built Environment, thirteen LOAs in Social and Community Health, three in Education, and two in Economic Stability. Each LOA has milestones specific to the project; milestones are reported and reviewed quarterly, semi-annually or annually. These current investments represent $1.7 million of CPCCO funds to support community safety-net SDOH-HE organizations. Please see 10.B.1.b. below for details of key LOAs.

10.B.1.b. Does Applicant currently have performance milestones and/or metrics in place related to SDOH-HE? These milestones/metrics may be at the plan level or Provider level. If yes, please describe.

Project	Brief Description	Metrics
Tillamook School Family Resource Center	Ensure academic success by addressing non-academic needs of at-risk students and families	# referrals, services accessed, disciplinary reductions, matriculation rates
Tillamook and Clatsop Helping Hands Re-Entry	Enhance in-house case management for homeless individuals/families	# unique individuals served, reductions in recidivism, community connections made, stable housing
NW Regional Early Learning Pathways to Services for At-Risk Children	Asset map of community and educational resources and referral pathways from screening to services for children with black/gray ASQ screens	# children receiving mental health or EI/ECSE services
Columbia Public Health Tobacco Retail Licensure	Ensure local jurisdictions implement tobacco licensing requirements related to youth purchase	Reduction in youth tobacco use
Clatsop Mobile Crisis Law Enforcement	Replicate successful program to include certified mental health specialist with law enforcement response to divert from ED or jail	# unique individuals served, placements
Clatsop Public Health Harm Reduction	Purchase pre-owned van for county-wide needle exchange	reductions in ED visits and blood-borne disease transmission
Columbia Suicide Prevention Training	Implement evidence-based Sources of Strength trainings	# individuals trained, number of organizations adopting protocol, number of school districts implemented

Clatsop Family Finding for Foster Youth	Implement evidence-based program of family/kith finding for youth transitioning out of foster care	# unique youth served
Tillamook Exercise Rx	Provider prescriptions and YMCA membership fees for year-round purposeful exercise	# participants
Tillamook Food Roots Farm to School	Expand garden and nutrition lessons in Tillamook schools	# students trained
Columbia Amani Center Medical Examiner	Expand local services for child abuse assessments	reduction in out-of-county assessments
Power Clean Astoria	Promote physical and mental health for those recovering from addictions through Cross Fit	# participants
Community Education on Substance Misuse	Train to change community narrative on dangers to youth of opioid/addictions	# community engagement meetings/attendees
Clatsop and Tillamook Obesity Reduction/Healthy Foods	Food vouchers/exercise passes, group classes and education/counseling for obese individuals	# unique individuals served, white, Hispanic
Clatsop Kids Go	Mindfulness strategies to increase self-regulation for middle school students	# kids served
Clatsop and Columbia Childhood Trauma Informed Networks	Implement self-sustaining community network to address ACEs and resilience, for educational, healthcare, child welfare, criminal justice, business and community sectors	# trauma-informed practices/agencies, infrastructure built

10.B.1.c. Does Applicant have a current policy in place defining the role of the CAC in tracking, reviewing and determining how SDOH-HE spending occurs? If yes, please attach current policy. If no, please describe how Applicant intends to define the role of the CAC in directing, tracking, and reviewing SDOH-HE spending.

CPCCO's Regional CAC charter defines the role of the CACs in SDOH-HE spending. The charter outlines the process put in place to amplify the voice of our OHP members and the communities we serve in the SDOH-HE investment decision-making process. These processes create a well-informed CAC that can make decisions for investments through our Community Wellness Investment Fund grant program, including review of the results and evaluation of the funded projects. The CPCCO Community Wellness Investment Fund opportunity occurs annually and volunteers from the local CACs review and rate applications we receive from local organizations. Results are reviewed and discussed by the regional advisory council which make final decisions for funding. Grantees make annual reports of each project status and results which are shared with local advisory councils.

The CPCCO Board of Directors designates dedicated funds to support these CAC recommended projects, aimed specifically at addressing community improvement priorities in the CPCCO RHIP.

10.B.1.d. Please describe how Applicant intends to award funding for SDOH-HE projects

CPCCO will award funding through our two existing programs, described below, in which community safety net organizations, public health, behavioral health, primary care clinics and other local non-profits apply for CPCCO funds. The process for reviewing and awarding grant funds will be the same for both, although the review committee for each may have different representatives.

(1) Regional Community Wellness Investment Fund (CWIF) grants. CPCCO's three local CACs (one in each of Clatsop, Columbia and Tillamook counties) and Regional CAC (R-CAC) will

be responsible for requesting, reviewing and recommending funding for proposals from local SDOH-HE organizations focused on priority health improvements included in the CPCCO RHIP. Currently, each CAC reviews proposals once annually, in the spring and fall. Eight of the proposals included in the above table were reviewed and recommended by one of the three local CACs and approved for funding by the R-CAC. The CACs have been given a total of $1,000,000 since 2012 to invest in SDOH organizations, replenished as needed by the CPCCO Board.

(2) Open Process grants. CPCCO runs an open process whereby safety net community organizations, clinics, public health, school districts, child welfare entities, and others can apply for program development or operational funding to address community health, prevention and health promotion, service integration or clinical innovation. The grants in this second program are solicited twice per year, reviewed by a CCO committee and approved for funding by the CPCCO Board of Directors. Grants may be for 1-3 years, up to the total amount requested by each proposal, varying from $50,000 to $320,000 in grants funded to date.

Both grant programs are funded by Quality Pool incentive dollars or CPCCO retained earnings and limited only by the total amount of funds available.

10.B.1.d.(1). How Applicant will guard against potential conflicts of interest;

CPCCO will strive to avoid conflict of interest in the review and rewarding of CCO investments in SDOH-HE projects, acknowledging that we operate in rural coastal communities where local leaders all know one another and have intertwined professional and personal lives. All members of the CPCCO Board of Directors are required to complete a Conflict of Interest policy statement annually. They, and members of the CACs who review local grant proposals, declare potential conflicts at the time a proposal for funding is discussed and recuse themselves from voting. Because CAC meetings are open to the public, as are Board meetings where funding decisions are made, we believe we guard against and can withstand public scrutiny of potential bias or conflict of interest.

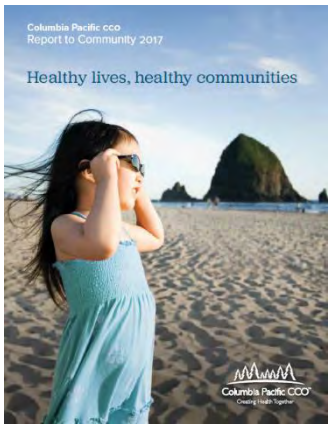
10.B.1.d.(2). How Applicant will ensure a transparent and equitable process;

CPCCO will ensure transparency and equity throughout the funding process. This starts by widely announcing funding opportunities via email lists, social media, press releases, our website and announcements at community meetings. To further increase transparency and equity in funding, funds awarded to SDOH-HE projects through the CWIF grants will decided upon by the CACs which holds meetings that are open to the public. As the name implies, open process grants are available through an open process and decided on at open meetings of the CPCCO Board. To support equitable decision making, the grant review process will evaluate each proposal based only on information that we have received directly from applicants.

10.B.1.d.(3). How Applicant will demonstrate the outcome of funded projects to Members, SDOH-HE partners, and other key stakeholders in the Community.

The R-CAC will continue to provide semi-annual reports to the Board of Directors regarding SDOH-HE proposals that have been approved for funding. We also publish a biennial report to the community with details about grants made, publicize grant awards in local newspapers and on our

website, , and will use the Community Engagement Plan commitments as an opportunity for regular, formal, updates on outcomes achieved by the CPCCO investments in SDOH-HE and clinical programs.



10.B.1.e. For the statewide housing priority only: please provide proposed metrics for assessing the impact of investments in this area.

CPCCO will continue to support initiatives and programs that provide stability, affordability, quality and safety for low-income individuals who have housing needs through investments that support or create tenancy sustaining services, provide supportive housing, or support the remediation of unsafe or inadequate housing conditions. CPCCO currently provides financial support and technical assistance to four local housing programs through Helping Hands, a non-profit helping individuals and families re-enter from homelessness in Clatsop and Tillamook counties, and the three Community Action organizations, one in each county. We will develop supports and services for the social determinants of health with Northwest Oregon Housing Authority and our contracted providers of behavioral health services. See more detail in the CPCCO Community Engagement Plan.

Based on the specific needs of each county in the CPCCO service area, proposed metrics for the 2020-2024 contract will focus on housing, health, and their interconnection, through coordinated entry models where individuals can access services, regardless of where or how they present for assistance. The proposed metrics include:

1) Increased primary care visit referrals from housing providers
2) Decreased emergency department visits by members receiving transitional housing supports
3) Increase of evidence based, best practice, transitional support services from higher to lower levels of care
4) Increase of tenancy-sustaining services (early identification, education, coaching, coordination)
5) Increased utilization of barrier removal (e.g. air purification equipment, moving costs, furnishings, utilities)
6) Increase in medical setting screening for housing support needs and resulting referral to community-based services and/or traditional health workers
7) Increase in housing supports as a part of crisis intervention, stabilization and/or transitioning from sub- acute or acute care settings.

In addition, CPCCO will explore ways in which we can proactively collect data on SDOH, beginning with data on housing instability and homelessness. We will explore the use of ICD-10 Z-codes that capture various SDOH, specifically Z59, which captures housing instability and homelessness. We plan to work with clinical partners who use Epic OCHIN EMR first, to leverage existing resources and work that OCHIN has already done integrating a validated screening tool for SDOH called PRAPARE. Housing is one of the main PRAPARE domains. Additionally, the Oregon Primary Care Association has developed and collected a suite of resources and materials on SDOH screening, identification, referral, and follow up. OPCA has also begun the Advancing Health Equity and Data (AHEAD) learning collaborative focused on providing support to community health centers in their capacity to collect and analyze SDOH data.

CPCCO will explore the use of SDOH data in the following capacities:

1. Run internal Z-code reports to assess level of need for different SDOH domains in each county, determine baseline rates for each domain, and set targets for improvement and areas for immediate intervention/prioritization
2. Integrate Z-code data into our internal population segmentation tool to elevate our risk adjustment to capture social risk

CPCCO proposes to pilot SDOH data collection with specific clinics in each county by integrating two questions on housing stability into general rooming processes and vital measurement collection performed by the MA rooming the patient. If the patient screens positive, the MA will document this in the patient chart and ensure the patient is connected to housing resources and support. CPCCO will explore the use of a community health worker (CHW) embedded in the clinic in which the MA can do a warm handoff to for those who screen positive. The CHW will initiate follow up processes and stay connected with the member until the referral is closed, documenting case result and closure in the patient record. CPCCO will work closely with the following community based organizations to address housing concerns:

1. Helping Hands - supports homeless and transitional housing in Clatsop and Tillamook counties
2. Community Action –supports homeless and housing instability through various programs in Clatsop, Columbia, and Tillamook counties

10.B.2. Evaluation Questions

10.B.2.a. Please describe the criteria Applicant will apply when selecting SDOH-HE partners.

CPCCO recognizes that many of our investments in small, rural communities address underlying gaps in services or programs that affect all residents, not just OHP enrollees. CPCCO also recognizes the importance of meeting immediate community needs while simultaneously working for changes in policies, systems, and institutional practices to address SDOH-HE. This kind of change requires more than a single year's effort or a single organization's work. Therefore, collective impact proposals, requiring partner organizations with aligned goals and efforts over multiple years are most likely to be funded. Collaboration between non-profit organizations, those they serve, and other key local partners and stakeholders are essential to systemic change. Current criteria used by CPCCO to award grants for SDOH programs include:

- Financial sustainability of the program upon cessation of CCO funding
- Measures of success or outcomes to be achieved
- Evidence or data supporting the program's likelihood of success
- Collective impact across multiple organizations or sectors
- Specific Return(s) on Investment
- Systemic or population impact
- Formal agreements to collaborate with other organizations
- Degree of need for the program

As part of CPCCO's 2019 Community Health Needs Assessment and Community Health Improvement Plan, we have developed a formal Letter of Agreement between CPCCO, all three county Public Health Departments, two Local Mental Health Authorities and the two hospitals in Clatsop County. This formal process will result both in a shared improvement plan and in collective impact to address the social determinants of health in all three counties. Criteria and funding priorities may change slightly over time as a result of this shared process and LOA, but we don't anticipate major shifts.

CPCCO supports proposals that elevate both clinical and non-clinical community-based knowledge, local assets, and the voices of the populations being served. There are currently three categories for CPCCO investments in SDOH partners: 1) proposals that **integrate services**, especially between clinical and community settings, 2) **community health improvements**, especially those identified by the CACs or included in the CPCCO RHIP, community trainings, community strategies to address screening and treatment for substance abuse, tobacco cessation, or Adverse Childhood Events (ACEs), and 3) investments in **prevention and health promotion**, including alignment of efforts with local Public Health departments and/or Early Learning Hubs, community education/awareness campaigns, suicide prevention, or programs to increase member health literacy, healthy behaviors and/or care self-management. The 2019 CPCCO Regional Health Improvement Plan will inform the categories for CPCCO investments in SDOH.

CPCCO selects partner organizations who:
Are known ***CONTRIBUTORS*** *to local community health and well-being;*
Have effective ***LEADERSHIP*** *that engages a base of community support;*
Are committed to addressing ***EQUITY*** *and health* ***DISPARITIES;***
Demonstrate the ***ADMINISTRATIVE CAPACITY, FINANCIAL PLAN, AND MULTI-ORGANIZATIONAL COMMITMENT*** *to achieve stated goals;*
Believe in formal ***EVALUATION*** *of their work and programs;*
Value ***INNOVATIVE*** *and* ***SYSTEMIC*** *approaches;*
INCLUDE IMPACTED INDIVIDUALS *in defining the problem and proposed solutions;*
Include ***DATA AND EVIDENCE****, where available, and demonstrate planning; and*
LEVERAGE *additional financial and in-kind resources.*

Only non-profit and/or government (*i.e.,* DHS) entities in the CPCCO service area are funded.

10.B.2.b. Please describe how Applicant will broadly communicate the following information to the public and through its network of partners: its SDOH-HE spending priorities, the availability of funding for projects, how interested parties can apply for consideration, and the project selection process.

CPCCO partners with organizations in the service area that offer effective solutions to address SDOH-HE. Annually, CPCCO makes investment priorities known through broad information distribution to the CPCCO Board, CAP members, CACs, community organizations in local health collaboratives that we participate in, organizations in our network, social safety net organizations and partner organizations such as the Early Learning Hub, and via word of mouth. The information includes how to apply, application deadlines, and the decision criteria that will be used to award investments. CPCCO has a multidisciplinary committee of providers, staff, and Board representatives to review, rate and recommend funding for approval by the CPCCO Board.

10.B.2.c. Please describe how Applicant will track and report SDOH-HE expenses and outcomes, including technological capacity and process for sharing and collecting data, financial systems, and methods for data collection.

All community or clinical partners that receive funding from CPCCO are notified via a formal award process for each grant recipient, including a Letter of Agreement that details funding amounts and timing of awards, required reports, and metrics to be tracked and achieved. Based on the amount of time it takes to impact outcomes related to SDOH-HE, CPCCO generally uses process measures to evaluate the success of each program. We will adjust these as needed based on the work of the OHA SDOH-HE Measurement Workgroup.

Each SDOH-HE program or project that receives CPCCO funding is assigned a unique project number, against which all expenses are recorded and reported. We record these in the accounting and financial programs used by the CareOregon Finance Department on behalf of CPCCO. Based

on the length of the project, six-month or annual project reports are reviewed prior to sending the next payment to the grant recipient. This allows for oversight of the program or project before all grant funds are expended. This project-level tracking and reporting process is replicated for Health-Related Services (HRS) CBI grants, as well. For larger SDOH-HE and HRS investments, annual financial reporting captures criteria such as costs, rationale and evidence-based practices, measurable outcomes, target populations reached and, when possible, return on investment. HRS Flex Services are tracked and reported in the care coordination system, GSIHealthIntegrated, on an individual member basis. See Attachment 11 for more detail on GSI.

In the future, CPCCO will align any new SDOH-HE reporting criteria implemented by OHA, including activities related to implementing SDOH-HE risk adjustment factors.

As noted in 10.B.i.e, specific to housing investments, CPCCO is planning to implement the use of Z codes and documentation in the clinic EHR, allowing us to quantify and monitor the primary barriers and needs of our populations. CPCCO also proposes to pilot SDOH data collection with specific clinics in each county by integrating two questions on housing stability into general rooming processes and vital measurement collection performed by the MA rooming the patient.

CPCCO will use the SDOH data, specifically housing data, combined with narrative survey data and other qualitative data to provide a comprehensive overview of the housing crisis on the Northwest Coast using a mixed methods approach. CPCCO will use such data to advocate for housing policy that increases affordable/Section 8 housing, mixed use housing developments, transitional housing, and recovery housing supportive of those on abstinence only and medication assisted recovery pathways for opioid addiction. Lastly, CPCCO will also advocate for housing policies that limit the amount of housing that can be designated for tourism or house-share programs that adversely impacts housing access and affordability, which disproportionately affects the Medicaid population.

10.B.2.d. Applicant will submit a plan for selecting Community SDOH-HE spending priorities in line with existing CHP priorities and the statewide priority on Housing-Related Services and Supports via the RFA Community Engagement Plan, as referenced in section A.

10.C. Health-Related Services (HRS)
10.C.1. Informational Questions.
10.C.1.a. Please describe how HRS Community benefit investment decisions will be made, including the types of entities eligible for funding, how entities may apply, the process for how funding will be awarded, the role of the CAC (and Tribes/tribal advisory committee if applicable) in determining how investment decisions are made, and how HRS spending will align with CHP priorities.

CPCCO anticipates investing an average of $2 to 4 million annually in HRS and SDOH-HE for clinics and community-based organizations. CPCCO supports proposals that elevate both clinical and non-clinical community-based knowledge, local assets, and the voices of the populations being served. Investments by CPCCO in HRS Community Benefit Investments (CBI) will be consistent with the definition in OAR 410-141-3150 and complement the investments CPCCO makes in partner organizations that address SDOH-HE. The bulk of CBI investments will be made to clinical partners in the CPCCO service area for proposals that **integrate services**, especially between clinical and community settings, and for **clinical capacity-building** to reduce health disparities and access barriers, improve quality and member outcomes, and address provider recruitment and retention challenges. As described in 10.B.1.a, CPCCO's CACs are involved in reviewing and

funding proposals that address HRS programs aligned with the CPCCO Regional Health Improvement Plan.

On an annual basis, CPCCO will award approximately $2 million in additional funds beyond the grants described in 10.B, for primary care and behavioral health capacity building across our network for continuous quality improvement and metrics achievement, development of new workflows, staffing and multidisciplinary team building for population health management including Traditional Health Workers, access improvements to assure timely engagement of CPCCO members with integrated care teams, and bi-directional co-location of behavioral health and primary care staff to allow for warm hand-offs and one-stop shopping for members.

As noted in 10.B.2.c, CPCCO has a grant program that will allow community safety net organizations, public health, behavioral health, and primary care clinics to apply for CPCCO investments. The process for reviewing and awarding investment grants will be the same for both SDOH-HE and HRS. (See also Attachment 10, B.2.)

In addition to the above investment process, CPCCO has developed a five-year county-level collaborative gain and risk share model that incentivizes each county to work across health systems to decrease cost and improve quality for the members served. Participation in the model is voluntary, but in general the participants are primary care clinics, CMHPs, and hospitals. Through this model, just under $1.3 million was shared in 2016 for investment in 2017-18 with the three counties, resulting in a community paramedicine program to facilitate effective care transitions, and a complex care multidisciplinary team to assure appropriate care and case management for high complexity members. Approximately $700,000 is anticipated to be available for community partners in 2019 for investment in 2020 and beyond. (See Attachments 11.A.2 and 12, A.3 for detail.)

Finally, CPCCO staff will also recommend and implement investments in additional programs and services to enable better access and to more effectively integrate care and services across clinical and non-clinical settings. For instance, CPCCO funds OHA Oral Health Programs that provide data on school-based sealant programs back to CPCCO; CPCCO then uses this data to increase coverage by community-based and provider partners. Similarly, CPCCO funds a mobile dental office parked weekly on the site of a primary care partner to co-locate dental services for easier access by CPCCO members.

10.D. Community Advisory Council membership and role

10.D.1.a. Data source(s) for defining the demographic composition of Medicaid Members in the Applicants Service Area.

CPCCO will use the 834 enrollment file received daily from the OHA to define demographic composition. The file contains information about our member population including demographics, eligibility, rate codes, and related data. Data from this file is processed in QNXT, the CareOregon claims processing and provider contract platform, and this becomes our source for member demographic information. As the process stands currently, CPCCO uses the standard HIPAA compliant fields from this file as the source for demographic information such as age, sex, language, race/ethnicity, etc. This is currently the only source of this data that covers our entire population. In 2019, CPCCO is expanding our analytic processes to get to a more granular level which separates race and ethnicity and thus will allow us to better differentiate population groups.

CPCCO will merge the 834 member enrollment data with claims data. This will allow us to understand utilization trends for our populations (*e.g.,* inpatient, outpatient, emergency department, pharmacy utilization, etc.) and detect patterns of over- or underutilization or disparities in utilization which could indicate access barriers. A population segmentation tool developed by CareOregon for use by its CCOs will be used to analyze claims data to categorize our population into risk categories (healthy, low risk, rising risk, and high risk) based on a member's chronic conditions and past utilization. We will use this data to cross-tabulate utilization patterns with race, ethnicity and other demographic data to build better points of access to care.

Finally, the Health Complexity data from OHA will be used to analyze the interplay of medical and social factors that add layers of complexity for our population. We will continue to use the member level detail in that report to analyze disparities in our CCO Incentive Metric performance by level of health complexity, and plan to use the aggregate information as part of a CPCCO Maternal Child Health focused initiative led by clinical staff.

10.D.2. Evaluation Questions

10.D.2.a. Applicant will submit a plan via the RFA Community Engagement Plan, as referenced in Section A.

Please see Community Engagement Plan.

10.E. Health Equity Assessment and Health Equity Plan

10.E.1.a. Please briefly describe the Applicant's current organizational capacity to develop, administer, and monitor completion of training material to organizational staff and contractors, including whether the Applicant currently requires its Providers or Subcontractors to complete training topics on health and Health Equity.

CPCCO is committed to ensuring our staff, providers and contractors are trained to recognize and address health disparities in a culturally responsive manner. CPCCO requires health equity trainings for staff, Board members, providers and other subcontractors. This requirement will be written into relevant documents, such as Board policies, provider contracts and vendor agreements.

Our comprehensive Equity Plan provides CPCCO-wide direction regarding: culturally responsive programs; trainings for staff, the Board, and providers; a Language Access Plan and workgroup to improve on-site interpretation at all clinics; development of a Board Statement on Commitment to Equity and relevant CCO policies; geo-maps of Spanish speaking populations across the CPCCO service area (Spanish is the predominant non-English language spoken); a primary data collection process for its 2020-24 community health needs assessment and health improvement process that includes micro-narratives from residents on supports and barriers to health and well-being; and data extracts and reports to review health disparities for key quality measures based on race, ethnicity and language. This Plan is currently in force and will be augmented by 2020 with the adoption of new Board-specific strategies related to equity, including a new Board Committee on Equity, Inclusion and Diversity, and requirements for the CPCCO CAP and CACs to include trainings for culturally responsive programs and workforce recruitment strategies into their respective work plans.

CPCCO currently has capacity to provide the following trainings: best practice trainings for interpretation services in a clinic setting and course offerings through a national consultant on equity practices on such topics as overcoming unconscious bias, disability awareness, cross-cultural care in mental health, and quality interactions with diverse populations (clinical and non-clinical staff). We will require attendance at a minimum of one training annually by clinical staff (CME credits) and non-provider clinic staff.

10.E.1.b. Please describe Applicant's capacity to collect and analyze REAL+D data.

CPCCO will use the 834 enrollment file received daily from the OHA to define demographic composition, eligibility, rate codes, and related data. This data is processed in QNXT and becomes our source for member demographic information. As the process stands currently, CPCCO uses the standard, HIPAA compliant fields from this file as the source for demographic information such as age, sex, language, race/ethnicity, etc. This is currently the only source of this data that covers our entire population. In 2019, CPCCO is expanding our analytic processes to get to a more granular level which separates race and ethnicity and thus will allow us to better differentiate population groups.

CPCCO will also use the Community Health Assessment primary data and social determinants data collected through the Accountable Health Communities (AHC) project. The AHC screening will provide member level data on five social determinants of health; housing, utilities, food insecurity, domestic violence, and transportation. As this data is available, CPCCO plans to analyze with member risk scores, claims and population segmentation to compare what these various data sets are capturing that connect social and medical complexity. In, addition, to analyze the interplay of medical and social factors that add complexity to our members' health, CPCCO will use the health complexity data from OHA, and the member level detail in that report to analyze disparities in our CCO Incentive Metric performance by level of health complexity. We plan to use the aggregate information as part of the Maternal Child Health effort led by clinical staff.

Finally, CPCCO will use publicly available data provided by the OHA to understand the demographics of the entire service area. This will complement our other sources of information by allowing insights into the entire population or entire Medicaid population of the service area beyond those assigned to CPCCO. These data will better allow CPCCO to respond to the needs of the whole community.

10.E.2. Evaluation Questions (Health Equity Assessment)

10.E.2.A. Please provide a general description of the Applicant's organizational practices, related to the provision of culturally and linguistically appropriate services. Include description of data collection procedures and how data informs the provision of such services, if applicable

See 10.E.1.a response for an overview of our organizational practices and requirements related to the provision of culturally and linguistically appropriate services.

Race, ethnicity and language data, provided by the OHA to CPCCO, as well as included within EMRs, is used to identify health disparities across the CCO membership. These data on health disparities are used by the CPCCO Quality Improvement Analyst to develop data extracts and reports to review health disparities for key quality measures based on race, ethnicity and language, to develop specific clinical interventions and trainings, and to address staffing gaps in participating clinics. Additionally, staff developed geo-maps of Spanish speaking populations across the CPCCO service area (Spanish is the predominant non-English language spoken), and a primary data collection process that includes micro-narratives from Hispanic and Tribal members on supports and barriers to health and well-being.

10.E.2.b. Please describe the strategies used to recruit, retain, and promote at all levels, diverse personnel and leadership that are representative of the demographic characteristics of the Service Area.

The CPCCO Board of Directors requires the CCO, CAP, CACs and the Board's own Nominating Committee to develop recruitment plans for engaging diverse personnel within clinics, community councils, and for the CCO itself. Strategies used by CPCCO include:

- Funding organizations and deepening partnerships with local communities that work with diverse populations, such as the Migrant Education Parent Advisory Committee, DHS/OHA Community Assistors, and the local school superintendents, to recruit personnel representative of the demographics of our area.
- Funding local provider recruiters to help find MDs, PAs, NPs, MA, behaviorists, addiction specialists and others who represent our local demographics to work with CPCCO, with a specific focus on finding providers to work on the coast

All CPCCO-dedicated staff are employees of CareOregon. That affiliation drives many approaches that help CPCCO with diverse personnel and leadership. During our employee recruitment and hiring process, we value the lived experience that people of diverse backgrounds bring to the work and the organization by actively promoting our positions on job boards that promote diversity from within the community, including sites that engage veterans and people with disabilities. We participate in job fairs throughout Oregon that promote equity and diversity for all positions and for our organization. CareOregon has developed standard questions in our interview process that serve to inform prospective employees of our values around equity and diversity, and allow us to understand candidates' perspectives of how they might reflect their own experience as an employee. Further, CPCCO intentionally works to cultivate a workplace culture that values diversity of employees.

10.E.2.c. Please describe how Applicant will ensure the provision of linguistically appropriate services to Members, including the use of bilingual personnel, qualified and certified interpreter services, translation of notices in languages other than English, including the use of alternate formats. Applicant should describe how services can be accessed by the Member, staff, and Provider, and how Applicant intends to measure and/or evaluate the quality of language services.

Through its parent company, CareOregon, CPCCO has contracts with two interpretation vendors: Passport to Languages and Linguava. To ensure availability of linguistically appropriate services, the vendor contracts include specific performance metrics and reports: less than 1% no shows per month, less than 1% interpreter issues/complaints per quarter, and at least 80% in-person interpretation for all requested appointments. Vendor management and performance will be reported to CPCCO's Language Access Workgroup monthly.

In addition, on behalf of all its enrolled members, CareOregon oversees the provision of both interpretation services through its customer service staff and the preparation of translated materials through its communications department. In collaboration with the DHS/OHA Assistors, CPCCO leadership monitors complaints and grievances about inadequate quality or lack of access to timely and high quality certified assistors. This data is then used to address any issues and improve the availability of linguistically appropriate services.

The CPCCO Language Access Workgroup seeks to encourage providers to utilize interpreters (or bilingual staff) and the interpretation vendors. To support this, it has created measurable goals for: completed trainings for all PCP and CMHP clinics; improvement over baseline for utilization of interpreters; standards for percent of population served and number of copies distributed for translated materials; and funding for certification of local interpreters.

CPCCO has hired a bilingual staff member to work on building trauma informed and culturally responsive community networks across service sectors.

10.E.2.d. Please describe how Applicant will ensure Members with disabilities will have access to auxiliary aids and services at no cost as required in 42 CFR 438.10, 42 CFR part 92, and Section 1557 of the Affordable Care Act. Response should include a description of how Applicant plans to monitor access for Members with disabilities with all contracted providers.

CPCCO/CareOregon's provider agreements require and will continue to require compliance with non-discrimination practices including providing access to persons with disabilities. All new primary care clinics require site visits by CPCCO staff to ensure ADA compatibility of the office, including street level access or an accessible ramp and wheelchair access to lavatory.

Through the member appeal and grievance process, and through CareOregon's Medical Management Department, staff will monitor and analyze all complaints and will follow through until resolved. If a member receives a denial for services related to a disability or makes a complaint regarding discrimination, the ADA Coordinator will be notified for oversight of the process. Should a member receive a denial of a service that could assist with their disabilities and that is covered under another state program, CPCCO/CareOregon will assist the member getting services through the Oregon Department of Disability Services. Further, if a service is not billable to OHP but could assist the member in avoidable health utilization or cost, we will use HRS Flex dollars to assist, in coordination with the primary care team, to the extent practicable.

10.E.3. Requested Documents

- ***Policies and procedures describing language access services, practices, evaluation, and monitoring for appropriateness and quality.***
- ***Policies and procedures related to the provision of culturally and linguistically appropriate services.***

10.F. Traditional Health Workers (THW) Utilization and Integration

10.F.1.a. Does Applicant currently utilize THWs in any capacity? If yes, please describe how they are utilized, how performance is measured and evaluated, and identify the number of THWs (by THW type) in the Applicant's workforce.

CPCCO began building our Traditional Health Worker (THW) network in 2018, with a plan to expand the network broadly across our entire region over the next three years. This began through our CAC in Tillamook County. The CAC, with CPCCO staff support, developed and sponsored a project in partnership with the local YMCA. This project included working with OSU Extension Service to bring a Community Health Worker (CHW) Certification Program to Tillamook. Two of the participants who were certified from that program live and work in Tillamook County.

In 2018, we funded two Peer Support Specialists who specialize as "recovery allies" in each of our counties. These recovery allies work through our CMHPs and coordinate with CPCCO's Regional Care Teams (RCTs). They focus on outreach to members who might not yet be contemplating changing their substance use behaviors and then support them through a strengths-based, wellness-informed, client-centered approach to achieve person-driven goals. The recovery allies are also a part of our interdisciplinary Regional Care Team that meets weekly to discuss high complexity members, develop a collaborative plan of care, and identify a primary care coordinator for each member. As appropriate, the recovery allies will take lead on members where their shared lived experience and understanding can enhance the level of support, interaction, and engagement in the member's treatment and recovery journey.

CPCCO has also been providing technical support to our local doulas to help them navigate our claims system and apply for grants. We work closely with the Oregon Doula Association to improve access to doula services for our enrollees. We provide billing support to community and clinical partners who bill for OHA approved doula services (*i.e.,* meet state criteria to bill for Medicaid).

Currently we have funded THW programs through grants and have evaluated performance using general milestones as our performance measures, such as hiring, training, and staff retention. As CPCCO moves towards alternative payment methodologies (APMs) in the next year to support THWs more sustainably, we will utilize stronger evaluation metrics that build from our existing clinical APMs, for instance: population reach, clinical outcomes, and number of engagements.

10.F.1.b. If Applicant currently utilizes THWs, please describe the payment methodology used to reimburse for THW services, including any alternative payment structures.

CPCCO has established an open-network for all doulas who meet OHA billing requirements to receive payment for services to our members. This supports members in self-referring to services.

For THWs, the majority of funding is currently through grants, but in 2019 CPCCO will transition management of the behavioral health benefit from GOBHI to CareOregon and will reconfigure our Alternative Payment Models. Integrating the physical and behavioral health benefits will allow us to expand our APM programming beyond our primary care providers to include our behavioral health providers. We will build sustainable funding models for peer supports that encourages their integration into the treatment team. Similarly, we will update our APM funding to support our primary care clinics integrating CHWs into their treatment teams. Our current Behavioral Health Integration APM provides a good model that we can replicate for Traditional/Community Health Workers. That APM provides startup funding for clinics to hire and train a behavioral health clinician and then provides a monthly per member per month (PMPM) based on population reach and clinical outcomes. In a similar vein, we will build a Community Health Worker APM that will provide one-time startup and then an ongoing PMPM funding based on assigned population engagement levels and clinical outcomes. Finally, we will work to build sustainable funding models for our community-based organizations that employ THWs but are not traditional healthcare facilities with billing capabilities.

Our goal in 2019 is to reconfigure our Alternative Payment Model to incorporate THWs in 2020. This will enable us to leverage our evaluation infrastructure to measure and monitor the performance of our THWs, create financial incentives that reward positive outcomes, and creates more sustainability for the workforce. CPCCO's parent organization, CareOregon, currently holds a seat at the Traditional Health Worker Payment Models Sub-committee of the Traditional Health Worker Commission, providing ample opportunity to participate at the forefront of this transformation strategy.

CPCCO is exploring billing options for community based organizations in our region that are using Community Health Workers to provide Diabetes Prevention Programming.

10.F.2. Evaluation Questions

10.F.2.a. Please submit a THW Integration and Utilization Plan.

Please see THW Integration and Utilization Plan

RFA4690-CPCCO-RFA Community Engagement Plan Tables

Applicants must provide a detailed plan for community engagement according to the required components in the RFA Community Engagement Plan Reference Document, including identified gaps and plans to address gaps. **Applicant's Community Engagement Plan must be no more than 4 pages (according to the RFA spacing and font restrictions), excluding tables. Tables should be completed in the format provided below and submitted with Applicant's Community Engagement Plan (narrative).**

Table 1: Stakeholders to be included in the engagement process			
All applicants must complete this full table. Applicants may add rows as needed.			
Part 1a. List stakeholder types to be included in the engagement process. Applicants must include, at a minimum, plans to engage the following stakeholder types: OHP consumers, community-based organizations that address disparities and the social determinants of health ("SDOH-HE"), providers, including culturally specific providers as available (includes physical, oral, behavioral, providers of long term services and supports, traditional health workers and health care interpreters), Regional Health Equity Coalitions (if present in the service area), early learning hubs, local public health authorities, local mental health authorities, other local government, and tribes. Add additional rows as needed.	**Part 1b.** List specific agencies, organizations and individuals, based on the stakeholder types identified in Part 1.a, with which the applicant will engage. Add additional rows under the stakeholder type as needed.	**Part 1b.** Describe why each listed agency, organization and individual was included.	**Part 1b.** Describe how Applicant plans to develop, maintain or strengthen relationships with each stakeholder and maintain a presence within the community.
OHP consumers (list in first column below)			
Community Advisory Councils	CPCCO Local and Regional Community Advisory Councils	CPCCO has one local advisory council in each county and a regional council consisting of representatives of each local council. There is bi-directional communication with the CPCCO Board regarding areas of investment, issues of concern and recommended health improvement priorities.	CPCCO has developed and incorporated into the CAC regional Charter a recommended "best practice" for advisory council members roles, types of membership and the process for making informed decisions about health and well-being improvement activities in their communities. We will continue to support and engage advisory council members, specifically our OHP representatives.
	Migrant Education Family Advisory Group	Sponsored by NW Regional ESD and offered in each county this group participated in the collection of primary data via micro-narratives as part of our new Community Health Assessment (CHA)/Regional Health Improvement Plan (RHIP) and gave culturally specific input.	CPCCO will work to have on-going engagement with the group by presenting results and asking for feedback on activities that occur to address the goal areas of the RHIP. Translation and interpretation support will be part of all communication efforts.
	County sponsored health advisory groups	Public Health and County Officials have mental health and addiction advisory councils in each county of our service area. Their activities and process are similar to the CCO's and often includes individuals who participate in the CCO advisory councils as well.	CPCCO will continue to align and cross- communicate as appropriate especially when activities support shared efforts of the County and CPCCO.
Community Support Groups	National Alliance on Mental Illness	NAMI is in two counties of our service area and is active in supporting the prevention of suicide and improving access to services that support those with long term mental health conditions.	CPCCO will work to improve alignment with NAMI for the RHIP focus area of improving access to behavioral health services.
	Oregon Family Support Network	OFSN supports mentoring services that help families and communities who have children with developmental and Intellectual disabilities including children with mental illness.	This organization is aligned with CPCCO commitment to support families, reduce entry into foster care and reduce absenteeism in schools. We will work to increase our collaborative efforts and alignment with supporting families who have children with developmental and intellectual disabilities.
	Youth Era	Youth Era works closely with System of Care services, including the development of "Drop" Centers for at risk youth.	CPCCO will fund h Youth Era in Columbia County initially and work to develop additional Drop Centers in the service area.
Networks and Community Coalitions	Clatsop Childhood Trauma Informed Network (CTIN)	This six-sector network is under-development and is funded/staffed by CPCCO. The sectors of the network include healthcare, education, child welfare, criminal justice, community and economic.	CPCCO will continue the work of developing CTIN across sectors to support the growth of sustainable trauma-informed practices for the six sectors.
	Columbia Childhood Trauma Informed Network (CTIN)	This six-sector network is under-development and is funded/staffed by CPCCO. The sectors of the network include healthcare, education, child welfare, criminal justice, community and economic.	CPCCO will continue the work of developing CTIN across sectors to support the growth of sustainable trauma-informed practices for the six sectors.
	System of Care Youth and Family Representatives	Each county's SOC/WI program includes participation by CPCCO staff, to provide supports as needed.	CPCCO will continue to improve the work of SOC and WRAP in the service area, as we integrate the behavioral health benefit effective June 1 2019.

	Tillamook County Wellness	This group is focused on improving outcomes related to diabetes in Tillamook County.	The coalition has worked closely with the CPCCO CAC, including having a CAC member on their steering committee. CPCCO will continue to support CCO staff and CAC members to interface with local health improvement initiatives, continue to support CPCCO OHP members to be aware of and involved in activities of local health improvement coalitions.
	Columbia County Health Coalition	This health coalition focuses on supporting suicide prevention and increasing social support networks.	CPCCO will support and investin the increase of supportive adult advisors, diverse peer leaders and strategic messaging campaigns to support the increase of social networks in the region beginning with Columbia County.
	Columbia United Way	Engagement across sectors for social safety net providers.	CPCCO will support the United Way partners to engage in the Trauma Informed Network in Clatsop and Columbia counties.
	Clatsop United Way	Engagement across sectors for social safety net providers.	CPCCO will support the United Way partners to engage in the Trauma Informed Network in Clatsop and Columbia counties.
Community-based organizations that address disparities and SDOH-HE (list in first column below)			
Nutrition and Food Access/Housing	Clatsop County Community Action- Clatsop Regional Foodbank	The organization has a primary focus on supporting low income individuals to access food, housing supports, head start, and through the home visiting Healthy Families program.	CPCCO will develop specific linkages between primary care, food pantries and other nutrition resources that support an increase in coordinated care as individuals access supports through Community Action programs.
	Community Action Team- Columbia County Columbia Pacific Foodbank	The organization has a primary focus on supporting low income individuals to access food, housing supports, head start, and through the home visiting Healthy Families program.	CPCCO will develop specific linkages between primary care, food pantries and other nutrition resources that support an increase in coordinated care as individuals access supports through Community Action programs.
	Community Action Resource Enterprises- Tillamook County Tillamook Regional Foodbank	The organization has a primary focus on supporting low income individuals to access food, housing supports, head start, and through the home visiting Healthy Families program.	CPCCO will develop specific linkages between primary care, food pantries and other nutrition resources that support an increase in coordinated care as individuals access supports through Community Action programs.
Affordable Housing	Northwest Oregon Housing Authority	NOHA supports the development of affordable housing in the region, including section 8 housing.	CPCCO will develop supported housing and programs that support the decrease of individuals who are housed who are at risk for homelessness.
	Helping Hands ReEntry	The organization supports homeless and transitional housing in Clatsop and Tillamook counties.	CPCCO will continue to support housing and transitional housing supports, including funding health care coordination for individuals who are experiencing homelessness.
	Community Action Clatsop, Columbia and Tillamook Counties	CPCCO co-created a Healthy Homes program for Community Action housing staff in each county to do a home assessment for environmental mitigation (e.g. mold elimination or new roofing) that will address health issues of the occupants.	CPCCO has regionalized this program from one county to all three and will continue to devote resources to fund housing staff doing home assessments, home mitigation projects that can't be funded elsewhere (e.g. with Section 8 dollars), and Flex Services for individual OHP members.
Social Exclusion/Social Support/Stress	Safe of Columbia County	Safe provides supports for those at risk for and experiencing interpersonal violence. The organization provides supports to health care through co-located DV advocates in clinics.	CPCCO supports the development of certification for advocates to be designated as a Traditional Health Worker in the region. When this happens, we will add them as a category of worker that we incorporate into the service array.
	Women's Resource Center- Tillamook	WRC provides supports for those at risk for and experiencing interpersonal violence. The organization provides supports to health care through co-located DV advocates in clinics.	CPCCO supports the development of certification for advocates o be designated as a Traditional Health Worker in the region. When this happens, we will add them as a category of worker that we incorporate into the service array.
Early Life	Early Learning HUB	The EL Hub supports the development of universal pre-school and other strategies aimed at 0-5 year olds and their families to be kindergarten ready.	CPCCO will continue to work with the Early Learning HUB to support shared strategies in the intersection of education and health care.
Addiction/Substance Use Disorder	Jordan's Hope for Recovery	Jordan's Hope supports recovery at a grass roots level including harm reduction in Clatsop County through needle exchange and Narcan distribution.	CPCCO will increase the network of providers of addiction and substance abuse including those that are peer run/natural supports.
Providers, physical health, including culturally specific providers as available (list in first column below)			
Primary Care Providers	Tillamook County Community Health Centers	PCPCH clinic with integrated behavioral health	CPCCO will continue to strengthen the partnership with our primary care clinics by including them in Clinical Advisory Panel work, in primary care learning collaboratives, behavioral health peer-to-peer learning collaboratives and other clinic-specific initiatives. In addition, CPCCO provides additional monthly PMPM payments through an APM methodology to support: co-located behaviorists, population health programs, quality improvement initiatives, technical assistance to

			develop team-based care, improved prescribing and evidence-based referral practices, programs and methods to integrate oral health and primary care, pathways to assess and wrap services around OHP members to address SDOH-HE, and new programs as requested by the clinic or prioritized by CPCCO, such as Medication Assisted Treatment, DPP, palliative care or maternal child health.
	Rinehart Health Clinic	PCPCH clinic with integrated behavioral health and on-site Medication Assisted Therapy	CPCCO will continue to strengthen the partnership with our primary care clinics by including them in Clinical Advisory Panel work, in primary care learning collaboratives, behavioral health peer-to-peer learning collaboratives and other clinic-specific initiatives. In addition, CPCCO provides additional monthly PMPM payments through an APM methodology to support: co-located behaviorists, population health programs, quality improvement initiatives, technical assistance to develop team-based care, improved prescribing and evidence-based referral practices, programs and methods to integrate oral health and primary care, pathways to assess and wrap services around OHP members to address SDOH-HE, and new programs as requested by the clinic or prioritized by CPCCO, such as Medication Assisted Treatment, DPP, palliative care or maternal child health.
	Columbia Health Services and School Based Health Centers	PCPCH clinic and four school-based health centers with on-site behavioral health	CPCCO will continue to strengthen the partnership with our primary care clinics by including them in Clinical Advisory Panel work, in primary care learning collaboratives, behavioral health peer-to-peer learning collaboratives and other clinic-specific initiatives. In addition, CPCCO provides additional monthly PMPM payments through an APM methodology to support: co-located behaviorists, population health programs, quality improvement initiatives, technical assistance to develop team-based care, improved prescribing and evidence-based referral practices, programs and methods to integrate oral health and primary care, pathways to assess and wrap services around OHP members to address SDOH-HE, and new programs as requested by the clinic or prioritized by CPCCO, such as Medication Assisted Treatment, DPP, palliative care or maternal child health.
	OHSU Scappoose Family Medicine Clinic	PCPCH clinic with integrated behavioral health and on-site Medication Assisted Therapy	CPCCO will continue to strengthen the partnership with our primary care clinics by including them in Clinical Advisory Panel work, in primary care learning collaboratives, behavioral health peer-to-peer learning collaboratives and other clinic-specific initiatives. In addition, CPCCO provides additional monthly PMPM payments through an APM methodology to support: co-located behaviorists, population health programs, quality improvement initiatives, technical assistance to develop team-based care, improved prescribing and evidence-based referral practices, programs and methods to integrate oral health and primary care, pathways to assess and wrap services around OHP members to address SDOH-HE, and new programs as requested by the clinic or prioritized by CPCCO, such as Medication Assisted Treatment, DPP, palliative care or maternal child health.
	Legacy St Helens Family and Pediatric Clinics	PCPCH clinic with integrated behavioral health	CPCCO will continue to strengthen the partnership with our primary care clinics by including them in Clinical Advisory Panel work, in primary care learning collaboratives, behavioral health peer-to-peer learning collaboratives and other clinic-specific initiatives. In addition, CPCCO provides additional monthly PMPM payments through an APM methodology to support: co-located behaviorists, population health programs, quality improvement initiatives, technical assistance to develop team-based care, improved prescribing and evidence-based referral practices, programs and methods to integrate oral health and primary care,

			pathways to assess and wrap services around OHP members to address SDOH-HE, and new programs as requested by the clinic or prioritized by CPCCO, such as Medication Assisted Treatment, DPP, palliative care or maternal child health.
	Coastal Family Health Center/Community Health Center of Clatskanie	PCPCH Clinics with integrated behavioral health	CPCCO will continue to strengthen the partnership with our primary care clinics by including them in Clinical Advisory Panel work, in primary care learning collaboratives, behavioral health peer-to-peer learning collaboratives and other clinic-specific initiatives. In addition, CPCCO provides additional monthly PMPM payments through an APM methodology to support: co-located behaviorists, population health programs, quality improvement initiatives, technical assistance to develop team-based care, improved prescribing and evidence-based referral practices, programs and methods to integrate oral health and primary care, pathways to assess and wrap services around OHP members to address SDOH-HE, and new programs as requested by the clinic or prioritized by CPCCO, such as Medication Assisted Treatment, DPP, palliative care or maternal child health.
Primary care, specialty and hospital provider	Providence North Coast Clinics	PCPCH clinics with integrated behavioral health	CPCCO will continue to strengthen the partnership with our primary care clinics by including them in Clinical Advisory Panel work, in primary care learning collaboratives, behavioral health peer-to-peer learning collaboratives and other clinic-specific initiatives. In addition, CPCCO provides additional monthly PMPM payments through an APM methodology to support: co-located behaviorists, population health programs, quality improvement initiatives, technical assistance to develop team-based care, improved prescribing and evidence-based referral practices, programs and methods to integrate oral health and primary care, pathways to assess and wrap services around OHP members to address SDOH-HE, and new programs as requested by the clinic or prioritized by CPCCO, such as Medication Assisted Treatment, DPP, palliative care or maternal child health.
	Tillamook Adventist Clinics	PCPCH clinics with integrated behavioral health	CPCCO will continue to strengthen the partnership with our primary care clinics by including them in Clinical Advisory Panel work, in primary care learning collaboratives, behavioral health peer-to-peer learning collaboratives and other clinic-specific initiatives. In addition, CPCCO provides additional monthly PMPM payments through an APM methodology to support: co-located behaviorists, population health programs, quality improvement initiatives, technical assistance to develop team-based care, improved prescribing and evidence-based referral practices, programs and methods to integrate oral health and primary care, pathways to assess and wrap services around OHP members to address SDOH-HE, and new programs as requested by the clinic or prioritized by CPCCO, such as Medication Assisted Treatment, DPP, palliative care or maternal child health.
	Columbia Memorial Hospital Primary Care and Womens/Pediatric Clinics	PCPCH clinics with integrated behavioral health and on-site Medication Assisted Therapy	CPCCO will continue to strengthen the partnership with our primary care clinics by including them in Clinical Advisory Panel work, in primary care learning collaboratives, behavioral health peer-to-peer learning collaboratives and other clinic-specific initiatives. In addition, CPCCO provides additional monthly PMPM payments through an APM methodology to support: co-located behaviorists, population health programs, quality improvement initiatives, technical assistance to develop team-based care, improved prescribing and evidence-based referral practices, programs and methods to integrate oral health and primary care, pathways to assess and wrap services around OHP members to address SDOH-HE,

			and new programs as requested by the clinic or prioritized by CPCCO, such as Medication Assisted Treatment, DPP, palliative care or maternal child health.
Providers, behavioral health, including culturally specific providers as available (list in first column below)			
Clatsop Behavioral Healthcare	Community Mental Health Program (CMHP)	This CMHP provides the full spectrum of outpatient mental health and addictions services for youth and adults, including ICC, Supported Employment, EASA, ACT, Wraparound/SOC, case management, peer support and housing services and Flex services. In addition, CBH offers MAT services.	CPCCO will help develop enhanced staffing and programming to improve member access to and engagement in CMHP services, through: technical assistance, network development, alternative payment models, operational supports, learning collaboratives, care coordination, integration with primary care, and other strategies to help achieve the community health improvement priorities in CPCCO's RHIP as well as those identified by the providers.
Community Mental Health	**Community Mental Health Program**	This CMHP provides the full spectrum of outpatient mental health and addictions services for youth and adults, including ICC, Supported Employment, EASA, ACT, Wraparound/SOC, case management, peer support and housing services and Flex services. In addition, CCMH provides medical detox and adult residential services.	CPCCO will help develop enhanced staffing and programming to improve member access to and engagement in CMHP services, through: technical assistance, network development, alternative payment models, operational supports, learning collaboratives, care coordination, integration with primary care, and other strategies to help achieve the community health improvement priorities in CPCCO's RHIP as well as those identified by the providers.
Tillamook Family Counseling Center	**Community Mental Health Program**	This CMHP provides the full spectrum of outpatient mental health and addictions services for youth and adults, including ICC, Supported Employment, EASA, ACT, Wraparound/SOC, case management, peer support and housing services and Flex services.	CPCCO will help develop enhanced staffing and programming to improve member access to and engagement in CMHP services, through: technical assistance, network development, alternative payment models, operational supports, learning collaboratives, care coordination, integration with primary care, and other strategies to help achieve the community health improvement priorities in CPCCO's RHIP as well as those identified by the providers.
CODA	Opioid Treatment Program	CODA will provide new opioid treatment services on the coast, including methadone dispensing, suboxone and vivitrol. These services are currently only located in Portland and the Willamette Valley.	CPCCO is funding the new facility in Seaside and will offer all ongoing supports and services needed to ensure a successful program for OHP and other community members seeking medication assisted recovery.
Providers, oral health, including culturally specific providers as available (list in first column below)			
Arrow Dental	Primary Dental Provider, school-based services provider in Columbia county	Arrow Dental offers primary dental services in Clatsop and Columbia counties as well as provides school-based services in Columbia County. Their offices are important access points of care for our members. They also have partnered with CPCCO for an extension location in St Helens that utilizes a dental van as a primary dental home office extension of their other locations.	Arrow Dental recently acquired the 2 dental practices. The CCO looks forward to the opportunity to partner with Arrow to more fully develop strategies that support members to engaged in preventive and comprehensive oral health services in a variety of settings.
Willamette Dental Services	Primary Dental Provider; Specialty Dental Provider	Willamette Dental operates dental network that serves all 3 CPCCO counites. Their clinical system includes primary dental home and specialty services. Their strategic partnership.	Willamette Dental is a key strategic partner of CPCCO as they are active in all 3 counties and geographical regions. We are developing ongoing partnerships in medical-dental alignment, dental home development and other mechanisms to better integrate care across multiple disciplines by leveraging and developing cross-disciplinary systems.
Advantage Dental	Primary Dental Provider; Specialty Dental Provider; Contracts for primary and specialty dental services	Advantage Dental operates dental network in Columbia and Clatsop counties and contracts with additional providers within the 2-county region. They provide primary and specialty dental services.	We are developing ongoing partnerships in medical-dental alignment, dental home development and strategic initiatives to better integrate care across multiple disciplines by leveraging and developing cross-disciplinary systems.
Capitol Dental	Contracts for primary and specialty dental services	Capitol Dental contracts with dental providers across multiple geographical regions to provide dental services to CCO members. They are an active partner in the dental van services currently being provided by Arrow in the St Helens area.	We are developing ongoing partnerships in medical-dental alignment, dental home development and strategic initiatives to better integrate care across multiple disciplines by leveraging and developing cross-disciplinary systems.
Providers, long term services and supports, including culturally specific providers as available (list in first column below)			

Northwest Senior and Disability Services	Co-manage OHP members with medical conditions and in NWSDS services.	CPCCO has a current MOU with NWSDS outlining individual and shared accountabilities for patient co-management and care coordination.	CPCCO will continue to build out shared care planning with the organizations, including maximizing PreManage across the sectors.
APD of Columbia County	Co-manage OHP members with medical conditions and in APD services.	CPCCO has a current MOU with APD outlining individual and shared accountabilities for patient co-management and care coordination.	CPCCO will continue to build out shared care planning with the organizations, including maximizing PreManage across the sectors.
Providers, traditional health workers, including culturally specific providers as available (list in first column below)			
Providers, health care interpreters (list in first column below)			
Linguava, Passport to Languages	Interpretation vendors	Appropriate telephonic, video and in-person interpretation is a key cornerstone of CPCCO's equity strategy for primary care, specialty, behavioral health and oral health clinics.	CPCCO has set targets to improve in-person interpretation and will continue to fund certification of local interpreters and provide interpretation at community events we sponsor.
Early learning hubs (list in first column below)			
Northwest Regional Early Learning Hub (See also under Community-Based Organizations)	NW Regional ESD, Public Health, School Superintendents and others on the Hub Governance Council	CPCCO and the EL Hub have forged a strong partnership and shared initiatives since the Hub formation, including having the CCO Executive Director serve as the Hub Governance Council Vice Chair.	CPCCO will continue to represent the CCO populations by serving on the Hub Governance Council. In addition, CPCCO funded a project with the NWRELH and OPIP to develop an asset map and closed loop referral process for each county for kids screened in the Grey/Black via the ASQ. CPCCO will continue this work with clinics and community partners.
Local public health authorities (list in first column below)			
Clatsop County Department of Public Health	Local Public Health Authority	CPCCO has developed shared initiatives regarding tobacco cessation, suicide prevention, harm reduction, and home-based visiting services.	CPCCO will continue the existing work as well as enhancing the partnerships, including developing specific MOU's for division of resources to advance the Regional Health Improvement Plan.
Columbia County Public Health	Local Public Health Authority	CPCCO has developed shared initiatives regarding tobacco cessation, suicide prevention, harm reduction, and home-based visiting services.	CPCCO will continue the existing work as well as enhancing the partnerships, including developing specific MOU's for division of resources to advance the Regional Health Improvement Plan.
Tillamook County Community Health Centers/Public Health	Local Public Health Authority	CPCCO has developed shared initiatives regarding tobacco cessation, suicide prevention, harm reduction, and home-based visiting services.	CPCCO will continue the existing work as well as enhancing the partnerships, including developing specific MOU's for division of resources to advance the Regional Health Improvement Plan.
Local mental health authorities (list in first column below)			
Clatsop County	Local Mental Health Authority	CPCCO supports the initiatives developed by the local mental health and addiction advisory council sponsored by Clatsop County.	CPCCO will continue to develop the connections between the work of local government and those services they contract directly with the community behavioral health provider to assure the continuity of care and improved access for all individuals.
Columbia County	Local Mental Health Authority	CPCCO works closely with local mental health in Columbia County supporting the development of the local mental health and addiction advisory council sponsored by the county.	CPCCO supports the alignment of the work of the county council and the regional health improvement initiatives. We will work to align with this county sponsored council on community health improvement.
Tillamook County	Local Mental Health Authority	CPCCO has aligned with the local health and human services council sponsored by Tillamook County. They supported the development of the health needs assessment survey including hosting one of the community presentations related to the development of the2019 RHIP priority areas to address in 2020-24.	CPCO will continue to encourage and support the engagement of the local health and human services council to align with the projects that the CPCCO community advisory council develops and implements, including the activities that address the RHIP goals.
Other local government (list in first column below)			
City of St. Helens	Parks and Recreation Dept.	CPCCO has given the City of St. Helens a grant to support the development of their parks and recreation department and services that engage our OHP	CPCCO will work to align the RHIP priority areas as we seek to support the development of financially sustainable and equitable programs for the City of St.

		members in improving parenting skills and engaging in activities that support emotional wellbeing.	Helens Parks and Recreation Department and other Columbia County without parks and recreation programs.
City of Seaside	Needle Exchange, Methadone and MAT clinic	CPCCO has supported and developed harm reduction activities and improved access to addiction treatment resources in the region.	CPCCO will continue to work on increasing access to harm reduction and addiction treatment resources in the region.
City of Astoria	Needle Exchange	CPCCO has supported and developed harm reduction activities and improved access to addiction treatment resources in the region.	CPCCO will continue to work on increasing access to harm reduction and addiction treatment resources in the region.
Tribes, if present in the service area (list in first column below)			
Confederated Tribes of Siletz Indians	N/A	The Tribe has confirmed that they have tribal affiliated individuals in the three counties of the CPCCO service region and are interested in finding ways tribal members to engage in supports and services that improve their health and wellbeing	Through results of the CPCCO narrative story collection, stories of participants that identified as American Indian/ Alaskan Indian will be reviewed with the Siletz Tribe to assess and theme for program improvement and engagement of tribal affiliated individuals.
The Confederated Tribes of Grand Ronde	N/A	The Tribe has confirmed that they have tribal affiliated individuals in the three counties of the CPCCO service region and are interested in finding ways tribal members to engage in supports and services that improve their health and wellbeing	Through results of the CPCCO narrative story collection, stories of participants that identified as American Indian/ Alaskan Indian will be reviewed with the Confederated Tribe of the Grand Ronde to assess and theme for program improvement and engagement of tribal affiliated individuals.
Cowlitz Indian Tribe	N/A	The Tribe has tribal affiliated individuals in the CPCCO service region.	CPCCO will work to identify potential activities and/or programs that the Cowlitz Tribe would want promoted as available to support health and wellbeing for thier tribal members in the CPCCO region
Regional Health Equity Coalitions, if present in the service area (list in first column below)			
Add additional stakeholder types here (list in first column below)			
School Districts	13 school districts in the region and NW Regional ESD	CPCCO has worked with school districts and NW Regional ESD to support the implementation of trauma informed practices through collaboration, grant funding and training supports.	CPCCO has hired staff who will be developing a trauma informed network in Clatsop, Columbia and Tillamook Counties. School districts in the region are leaders in this work and serve as a touch point for all school age children and their families in the region.
Nehalem Bay Health District	Strategic Plan	Organization supports the expansion of services for older adults, supports high quality existing service delivery on-site, support programs and activities related to health promotion and the social indicators of health and is interesting in supportive housing.	CPCCO will seek to align with the Nehalem Bay Health District as appropriate though the goals and activities of the CPCCO 2020-2024 health improvement plan.
Add additional stakeholder types here (list in first column below)			
Sunset Empire Parks and Recreation	Low barrier access to healthy activities	SEPR has partnered with CPCCO through a pilot project that supports OHP members with scholarships to use the facility	CPCCO will continue process improvement work to support organizations to find sustainable pathways for funding to allow for OHP members to access healthy activities .
YMCA of Tillamook County	Low barrier access to healthy activities	Organization has participated in a pilot project supporting health plan members to use the facility and to have access to DPP programing for free.	CPCCO will continue process improvement work to support organizations to find sustainable pathways for funding to allow for OHP members to access healthy activities.
Add additional stakeholder types here (list in first column below)			
Add additional stakeholder types here (list in first column below)			

Table 2: Major activities and deliverables for which the CCO plans to engage the community	
All applicants must complete this full table.	
Part 2a. List and describe the five to eight major projects, programs and decisions for which the CCO plans to engage the community.	**Part 2b.** Identify the level of community engagement for each project, program and decision. Answers* must be 1) inform/communicate, 2) consult, 3) involve, 4) collaborate, or 5) shared decision-making. Applicant may include more than one level of engagement for each project, program or decision to account for differences among stakeholder groups.
Implement the trauma informed perspective across sectors- Childhood Trauma Informed Networks; schools, primary care, behavioral health, Department of Human Services, jails, probation, courts and others.	5
Behavioral Health Prevention: Suicide prevention, needle exchange, harm reduction programs, substance use disorders	4
Behavioral Health Intervention: Mobile Crisis Response, Traditional Health Workers, SUD's	4
Nutrition and Food Access: Food Rx, Food Bank Fresh, transportation	3, 4
Housing: Tenancy sustaining services, supportive housing, healthy homes, green and healthy homes, recovery supportive housing	4,5
Social Exclusion/Social Support/Stress: Maternal and child screenings for SDOH/ACE's, peer led social networks, co-located domestic violence advocates	4,5
Early Life: universal pre-school, Head Start, age appropriate screenings and follow-up, Maternal Child Programs	4
Health Care: Community Paramedicine, Traditional Health Workers, culturally responsive care, quality and access.	5

1. **Inform**: Provide the community with information to assist in their understanding of the issue, opportunities, and solutions. Tools include fact sheets, published reports, media releases, education programs, social media, email, radio, information posted on websites, and informational meetings.
2. **Consult**: Obtain community feedback on analysis, alternatives, and/or decisions. Tools include issue briefs, discussion papers, focus groups, surveys, public meetings, and listening sessions.
3. **Involve**: Work directly with the community throughout the process to ensure that community concerns and aspirations are understood and considered. Applicant provides feedback to the community describing how the community input influenced the decision. Tools include meetings with key stakeholders, workshops, subject matter expert and stakeholder roundtables, conferences, and task forces.
4. **Collaborate**: Partner with the community in each aspect of the process, including decision points, the development of alternatives and the identification of a solution. Tools include advisory committees, consensus building, and participatory decision making.
5. **Shared decision-making**: To place the decision-making in the hands of the community (delegate) or support the actions of community initiated, driven and/or led processes (community driven/led). Tools include delegated decisions to members of the communities impacted through steering committees, policy councils, strategy groups, Community supported processes, advisory bodies, and roles and funding for community organizations.

Table 3: Engagement with other agencies in the service area that have responsibility for developing community health assessments and community health improvement plans					
All applicants must complete this full table. Applicants may add rows as needed.					
Part 1. Applicants with an existing CCO CHA and CHP will submit their most recent CHA and CHP with the community engagement plan.					
Part 2. List of all local public health authorities, non-profit hospitals, other CCOs that share a portion of the service area, and any federally recognized tribe in the service area that is developing or has a CHA/CHP. Add additional rows as needed.	**Part 3.** The extent to which each organization was involved in the development of the Applicant's current CHA and CHP. Answers* must be a) competition and cooperation, b) coordination, c) collaboration, or d) not applicable (NA).**	**Part 4.** For any organization that is a collaborator for a shared CHA and shared CHP priorities and strategies, the applicant will list the shared priorities and strategies.**	**Part 5.** For any organization that is not a collaborator for a shared CHA and shared CHP priorities and strategies, the applicant will describe the current state of the relationship between the applicant and the organization(s), including gaps.	**Part 6.** For any organization that is not a collaborator for a shared CHA and shared CHP priorities and strategies, the applicant will describe the steps the applicant will take to address gaps prior to developing the next CHA and CHP, and the dates by which the applicant will complete key tasks.***	**Part 7.** Applicants **without an existing CHA and CHP or that intend to change their service area** will demonstrate that they have reviewed CHAs and CHPs developed by these other organizations. List the health priorities from existing plans.
Local public health authorities (list in this column below)	*(Note: Part 4 shared priorities and strategies are the same for Clatsop Public Health Department, Columbia Public Health and Tillamook Public Health Department). Also note that the following are shared priorities but each participant is currently evaluating how best to support each priority.*				
Clatsop Public Health Department	Coordination and Collaboration. The organization signed an LOA for a shared regional CHA and RHIP.	1.Support the trauma informed care perspective across all sectors: a. Trauma informed care network implementation b. Increase awareness of resources 2. Increase access to quality behavioral health services: a. Expand the availability of resources b. Expand the Traditional Health Worker network 3. Increase access to prevention activities with a focus on preventing drug/alcohol abuse and tobacco use and preventing suicide: a. Increase shared investment across the region in evidence			
Columbia Public Health	Coordination and Collaboration. The organization signed an LOA for a shared regional CHA and RHIP.				
Tillamook Public Health Department	Coordination and Collaboration. The organization signed an LOA for a shared regional CHA and RHIP.				

		based or best practice prevention activities 4. Increase access to supported housing services: a. Increase of transitional support services from higher to lower levels of care b. Increase of tenancy-sustaining services c. Increased utilization of barrier removal to sustain tenancy d. Increase of housing supports as a part of crisis intervention 5. Improve access to primary care providers: a. Rx for Health projects in the region b. Coordinated referrals and supports from social safety net to clinical care settings 6. Improve nutrition and food access supports: a. Spread the Foodbank Fresh concept across the region b. Increase the coordination of supports and services from social safety net providers to primary care providers.			
Non-profit hospitals (list in this column below)					
Tillamook Adventist Hospital	Competition and cooperation	N/A	The organization has not signed the LOA for a shared CHA/RHIP but participated in the primary data collection process for the CHA	CPCCO will work with the supports and services for CHA/CHP development in the Adventist Hospital system and work to	

			.Adventist staff are also involved in CPCCO's Tillamook CAC.	align their CHA/CHIP with the goals of CPCCO's 2020-2024 Regional Health Improvement Plan and to offer to join the collaboration by signing of the Letter of Agreement that was signed by the other regional community partners.	
Columbia Memorial Hospital	Coordination and collaboration The organization signed an LOA for a shared CHA and RHIP.	1.Support the trauma informed care perspective across all sectors: a. Trauma informed care network implementation b. Increase awareness of resources 2. Increase access to quality behavioral health Services: a. Expand the availability of resources b. Expand the Traditional Health Worker Network 3. Increase access to prevention activities with a focus on preventing drug/alcohol abuse and tobacco use and preventing suicide: a. Increase shared investment across the region in evidence based or best practice prevention activities 4. Increase access to supported housing services: a. Increase of transitional support services from higher to lower levels of care			
Providence Hospital	Coordination and collaboration The organization signed an LOA for a shared CHA and RHIP.				
Clatsop Behavioral Health	Coordination and collaboration The organization signed an LOA for a shared CHA and RHIP.				
Columbia County Behavioral Health	Coordination and collaboration The organization signed an LOA for a shared CHA and RHIP.				

		b. Increase of tenancy-sustaining services c. Increased utilization of barrier removal to sustain tenancy d. Increase of housing supports as a part of crisis intervention 5. Improve access to primary care providers: a. Rx for Health projects in the region b. Coordinated referrals and supports from social safety net to clinical care settings 6. Improve nutrition and food access supports: a. Spread the Foodbank Fresh concept across the region b. Increase the coordination of supports and services from social safety net providers to primary care providers			
Tillamook Family Counseling Center	Collaboration	The organization has not signed the LOA for a shared CHA/RHIP but participated in the primary data collection process for the CHA through the local mental health and addiction advisory council.			
Current coordinated care organizations, as of 2019 (list in this column below)					
Columbia Pacific CCO	N/A				
Federally recognized tribes that have or are developing a CHA/CHP					

(list in this column below)					
N/A	N/A				

*

a) Competition and Cooperation: Loose connections and low trust; tacit information sharing; ad hoc communication flows; independent goals; adapting to each other or accommodating others' actions and goals; power remains with each organization; resources remain with each organization; commitment and accountability only to own organization; relational time frame short; low risk and reward.
b) Coordination: Medium connections and work-based trust; structured communication flows and formalized project-based information sharing; joint policies, programs and aligned resources; semi-interdependent goals; power remains with parent organizations; commitment and accountability to parent organization and project; relational time frame medium and based on prior projects; medium risk and reward.
c) Collaboration: Dense interdependent connections and high trust; frequent communication; tactical information sharing; systems change; pooled and collective resources; negotiated shared goals; power is shared between organizations; commitment and accountability to network first, community and parent organization; relation time frame long (3 years or more); high risk and reward.
d) Not applicable

**If the applicant does not have a current CHA and CHP, the applicant will enter not applicable (NA).

***Engagement activities must begin by March 31, 2020 and applicant will report on progress through the June 2020 CCO CHP progress report.

Table 4: Engagement with social determinants of health and health equity (SDOH-HE) partners for CHA and CHPs **Applicants may add rows as needed.**					
All applicants must complete Part 1.	**Applicants <u>with an existing CHA and CHP</u> must complete Parts 2, 3 and 4. Applicants <u>that intend to change their service area</u> must also complete Parts 2, 3, and 4.**			**Applicants <u>without an existing CHA and CHP or that intend to change their service area</u> must complete Parts 2a and 4a.**	
Part 1. List of organizations that address the social determinants of health and health equity in the applicant's service area. Add additional rows as needed.	**Part 2.** Applicants **with an existing CHA and CHP** will describe existing partnerships with each identified organization, including whether the organization contributed to the applicant's current CHA and CHP.	**Part 3.** Applicants **with an existing CHA and CHP** will describe gaps in existing relationships with identified organizations.	**Part 4.** Applicants **with an existing CHA and CHP** will describe the steps the applicant will take to address the identified gaps prior to developing the next CHA and CHP and the dates by which the applicant will complete key tasks for engagement. **	**Part 2a.** Applicants **without an existing CHA and CHP or that intend to change their service area** will demonstrate that they have reviewed community partnerships in place for other LPHA/non-profit hospital/tribal/CCO CHAs and CHPs in the service area. For each organization listed in Part 1, the applicant will document the organization's level of involvement in developing any other CHAs or CHPs by entering one of these responses: a) The organization was explicitly involved in developing one or more CHAs or CHPs; b) The organization was not explicitly involved in developing a CHA or CHP; c) unknown.	**Part 4a.** Applicants **without an existing CHA and CHP or that intend to change their service area** will demonstrate that they have reviewed community partnerships in place for other LPHA/non-profit hospital/tribal/CCO CHAs and CHPs in the service area by describing the steps the applicant will take to form relationships and secure participation by each organization prior to developing the first or next CHA and CHP, and the dates by which the applicant will complete key tasks for engagement. **

The following list of organizations and community groups who address the SDOH-HE as part of the CHA data collection sites in the fourth quarter of 2018. Clatsop Community Action: food bank, law clinic The Harbor: DV services Helping Hands: shelter and supported housing Clatsop Behavioral Health: drop in center Columbia Community Mental Health: client waiting area Community Action Team: client waiting area Food Pantries: in all three counties Veterans Stand Down: community event WIC: client waiting area	The organizations listed in part one participated in the 2018 community health needs assessment, narrative story collection. 1252 narratives were collected in the region. Organizations were given results of the survey and population health data was compiled for community presentations that occurred in the first quarter of 2019. These organizations were also offered an opportunity to give input into CPCCO's RHIP areas of focus. On-going, for the 2020-2024 RHIP focus areas and the implementation of the strategies, these organizations will be included as partners, along with other organizations that assisted with data collection but don't directly address SDOH.	Most organizations in the region providing social safety net services have limited staffing, capacity and budget to provide the valuable community resource they offer. This limits: a) capacity to coordinate and collaborate with each other and with the health care providers in the region. b) Ability to engage in formal agreements for coordinated systems c) ability to coordinate care with health care providers and acute care settings for their clients.	Through the 2020-2024RFIP, CPCCO will support the development and implementation of regional processes, procedures and policy to increase the coordination of care between the social safety net providers and the providers of primary care and behavioral health services. Components of the key tasks will include but are not limited to: a) Identification of technology platform for data sharing and referrals b) Signing of formal agreements regarding coordination of services c) Integration of staffing through use of Traditional Health Workers and other workforce as appropriate d) Reporting quarterly through RHIP dashboard the progress towards meeting the goals and objectives of the 2020-2024 RHIP.		

Adventist Community Services: food pantry Tillamook Community Action: client waiting area Champion Park: low income housing DHS One Stop: community outreach Food Roots: store front Food Pantries: multiple in all three counties North Coast Recreation District: parks and recreation YMCA: members					
All tribes that are present in the service area (list in this column below). If no tribe is present in the service area, note there are none.					
There are none					
All regional health equity coalitions (RHECs) that are present in the service area (list in this column below). If no RHEC is present in the					

service area, note there are none.					
There are none					
Local government, including counties					
Clatsop County	County Commissioners participated in community presentations related to CPCCO's health needs assessment and opportunities to improve health in their communities including voting on priority areas of focus for the2020-24 RHIP.	Gaps exist with county departments that address health improvement *i.e.*: public health and housing and other community services that address the SDOH.	See above plan for addressing SDOH gaps in the region through the 2020-2024 RHIP.		
Columbia County	County Commissioners participated in community presentations related to CPCCO's health needs assessment and opportunities to improve health in their communities including voting on priority areas of focus for the2020-24 RHIP.	Gaps exist with county departments that address health improvement *i.e.*: public health and housing and other community services that address the SDOH.	See above plan for addressing SDOH gaps in the region through the 2020-2024 RHIP.		
Tillamook County	County Commissioners participated in community presentations related to CPCCO's health needs assessment and opportunities to improve health in their communities including voting on priority areas of focus for the2020-24 RHIP.	Gaps exist with county departments that address health improvement *i.e.*: public health and housing and other community services that address the SDOH.	See above plan for addressing SDOH gaps in the region through the 2020-2024 RHIP.		
Organizations that address the four key domains of social determinants of health* (list in this column below).					
Helping Hands	See above.				
Clatsop Community Action	See above.				
Community Action Team	See above.				
CARE	See above.				
Traditional Health Workers (THWs) affiliated with organizations listed in OAR 410-141-3145 (list in this column).					
There are none					

Culturally specific organizations and organizations that work with underserved or at-risk populations (list in this column below).					
Lower Columbia Hispanic Council	LCHC participated in the development of the narrative survey instrument and consulted on the culturally specific aspects of the instrument design and how/where to respectfully collect narratives in the Hispanic community.	LCHC has limited funding and capacity to provide services. The current political climate related to immigration has created an environment making it challenging to engage this organization in community health improvement work as they are focused on supporting and protecting their constituents.	CPCCO will work through the 2020-2024 regional health improvement plan; specifically, through the priority area: 1. Support the trauma informed care perspective across all sectors: a. Trauma informed care network implementation b. Increase awareness of resources		
Columbia, Clatsop and Tillamook School Districts	All three counties have parent advisory groups through the Migrant Education Program. NW Regional ESD facilitated CPCCO staff to work with this program for the needs assessment/story collection for CPCCO's CHA.	Each individual school district has their own funding streams through local, state, and federal tax dollars limiting capacity to engage in collaborative coordinated efforts to improve health and wellbeing Each district is at a different state of readiness to support community health improvement efforts.	CPCCO will work through the 2020-2024 regional health improvement plan; specifically, through the priority area: 1. Support the trauma informed care perspective across all sectors: a. Trauma informed care network implementation b. Increase awareness of resources		
Other organizations (list in this column below).					
***The four key domains of social determinants of health are economic stability, education, neighborhood and built environment, and social and community health.					
****Engagement activities **must** begin by March 31, 2020 and applicant will report on progress through the June 2020 CCO CHP progress report.					

Table 5: Assessment of existing social determinants of health priorities and process to select Year 1 social determinants of health priorities		
All applicants must complete this full table to describe how the applicant will identify social determinants of health ("SDOH-HE") priorities to meet the CCO SDOH-HE spending requirements. Housing must be included as one of the SDOH-HE spending priorities.		
Part 1. List of existing SDOH-HE CHP priorities* in applicant's proposed service area from its own CHP or other existing CCO, local hospital, local public health authority and/or tribal CHPs, if applicable. Add additional rows as needed.	**Part 1a.** Source for priority (i.e. which CHP it came from).	**Part 1b.** Whether priority describes a health outcome goal (i.e. addressing food insecurity to address obesity as a health issue) **or** priority populations (i.e. addressing early childhood education for children as a priority population) **or** other.
Increase Access to Housing Related Services and Supports	CPCCO 2020-2024 Regional Health Improvement Plan to submit to OHA on June 30th, 2019.	Strategic planning to support the goals of: a) Increased primary care visit referrals from housing providers b) Decreased emergency department visits by health plan members receiving transitional housing supports c) Increased evidence based, best practice, transitional support services from higher to lower levels of care d))ncreased tenancy-sustaining services e) Increased utilization of barrier removal through the use of Health-Related Services and other sources of investment
Increase Access to Nutrition and Food Access	CPCCO 2020-2024 Regional Health Improvement Plan to submit to OHA on June 30th, 2019.	Strategic planning to support the goals of: a) Increased engagement in Food Bank Fresh b) Improved nutrition through increased access to healthy food c) Scaled out programming that supports access to fresh food through schools (e.g. Farm to School project)
Trauma Informed practices Implemented across sectors	CPCCO 2020-2024 Regional Health Improvement Plan to submit to OHA on June 30th, 2019.	Support the development of childhood trauma informed networks bringing together systems and approaches to support an integrated and sustainable effort toward integrated, trauma informed practices to support: a) Reduced entry into foster care b) Decreased youth suicide rate

		c) Increased coordination and engagement between healthcare, education, child welfare, community, and criminal justice sectors to integrate trauma informed care across systems and organizations

Part 2. Description of process through which the applicant will identify and vet SDOH-HE priorities** in line with CHP priorities for submission to OHA by March 15, 2020. This must include, timelines, milestones, methods for vetting selected priorities with community partners (such as those described in Table B, Part 1) and CAC, and planned actions to clarify and define CCO housing priority in line with statewide priority.
- Process may also include planned actions to identify additional community-based SDOH-HE priorities from CHP priorities.
- If housing has not been identified as a priority in existing CHPs, note that housing must still be selected as an SDOH-HE priority. Consider adding the housing priority in alignment with either a health outcome goal or priority population identified in Part 1b.

CPCCO start its second five-year community health improvement plan in late 2018 and into 2019 where regional health needs have been assessed. The plan, including the community needs assessment has been created using a participatory process that included key community stakeholders from the health care and social safety net sectors, OHP members, and others associated with providing and facilitating good community health. CPCCO's Regional Advisory Council members have oversight over the development of and process attached to the creation of CPCCO's 2020-2024 RHIP, including engaging in a shared decision-making process to make final recommendations for priority areas of focus.

In the fall of 2018, primary data collection for community health needs assessment in the region included collecting the micro-narratives of community members with an emphasis on those who have CPCCO as their health plan coverage. Using this quantitative and qualitative approach not only allowed us to collect the experiences of community members in their own voices, but also gave us a framework of meaning related to not only health care needs but also the social determinants of health and health equity. Representative samples of the 1252 narratives collected were obtained from individuals who self-identified as Latinx (8.5%) and included an over-sampling of survey respondents who self-identified as American Indian/Alaskan Indian (7.0%) which CPCCO will use to determine goals and strategies related to health equity for the 2020-2024 RHIP.

Overall objectives using this method included but were not limited to: prioritizing community driven strategies, empowering community members to make sense of their environment by using this process, promoting collaboration across the coalition of partners seeking similar goals, and amplifying service user voices and perspective of OHP members with a special focus on Latinx and Tribal communities.

All aspects of the CPCCO health needs assessment and the resulting health improvement plan for the region were done in a participatory and collaborative manner. From the survey and instrument creation, to working with the results to understand and identify patterns of emergent meaning (themes), participants gave input not only on what is important to them to improve health and well-being in their communities, but also how and where those activities might take place.

Survey results found that while it can be hard to get needs met in these rural communities in the health care system, addressing the social determinants of health were more important to survey participants. Difficulties with transportation was the most cited barrier. Housing transportation and food are needed but so are mental, spiritual, and emotional supports. All respondents want to be treated as equals, and it affects their health when they are not. The narratives also highlighted respondents' needs to be heard and needs for the flexibility and predictability that comes from organizations and individuals who use a trauma informed perspective.

These results will drive how CPCCO and their community partners will invest both time and financial resources to address SDOH-HE through the 2020-2024 RHIP.

CPCCO seeks to continue the work of changing the availability of resources at both the community and individual level and plans to take key steps in years 2020-2024 to build on the existing platform created over the last six years to increase investments, build stronger relationships, align goals, and define and measure outcomes related to health equity, diversity and inclusion. By leveraging the collective strengths and resources of our partners toward shared community health initiatives, and by using identified best practices and community and clinical data to work across

multiple sectors of the community, we will reach measurable progress towards the goals of reducing health disparities and improving the quality, integration and coordination of health services.

*Applicants must include description of housing priority if already identified in CHPs. (e.g. housing overall, housing for targeted populations).

**The four key domains of social determinants of health are economic stability, education, neighborhood and built environment, and social and community health. Refer to the Social Determinants of Health and Health Equity Glossary reference document.

POLICY AND PROCEDURE

Title: Language Interpretation Requests and Services	
Department: Health Plan Operations	**Team:** Member Services
Effective Date: 1/22/2015	**Revision Date: 9/18/18**
Applies To: Administrative ☒ CareOregon (Medicaid) ☒ and/or CareOregon Advantage (Medicare) ☒ OHC ☒ CareOregon Affiliated CCOs ☒	

POLICY

The purpose of this policy is to address the internal workflow for accessing language interpretation services for our members. All employees are expected to understand what interpretation services are available to our members and the process in which these services are accessed. This policy applies to all employees.

DEFINITIONS

Translation: the process of translating written text from one language into another.

Telephone Interpretation: service that connects human **interpreters** via **telephone** to individuals who wish to speak to each other but do not share a common language.

In person interpretation: an interpreter will **interpret** one language to another orally, through speech or sign language.

Passport to Languages (PTL): CareOregon's preferred vendor for in person language interpretation.

CryaCom: CareOregon's preferred vendor for telephonic interpretation.

POLICY STATEMENT

It is our policy that members who require language interpretation have access to such services at no cost to the member. CareOregon pays for in person language interpretation services through our preferred provider Passport to Languages. CareOregon employees have access to telephonic interpretation services through our preferred provider CyraCom, for in bound and out bound telephone conversations with our members. CyraCom is for CareOregon employee use only. The below information details which services are available to our staff, providers and members as well as the procedure to coordinate and access languages interpretation services.

FACE TO FACE LANGUAGE INTERPRETATION PROCEDURE

All contracted CareOregon physical,mental and oral health providers must make interpretation services available to CareOregon members. CareOregon staff and employees do not coordinate or schedule interpretation services for our members medical appointments.

Interpretation must be available during and after hours for consultation and provision of care. Interpretation should NOT be provided by a member of the patient's family.
Interpretation services are provided for the following:

- Visits to the Doctors office
- Ancillary services and hospital visits (e.g. surgery, therapy, testing)
- Prospective COA members who are scheduled for an in-home visit with a Health Plan Consultant/Broker (Broker will coordinate with PTL)

CareOregon interpretative services do NOT cover medical or mental health interpreter services for the following occurrences:

- Appointment reminders
- Scheduling or rescheduling appointments
- Relaying test results
- Registration for procedures/ admissions
- Telephonic services less than 10 minutes in duration

Providers may choose to coordinate interpretation services themselves instead of through CareOregon; however, the provider will be responsible for paying for the interpretation services. CareOregon only pays for interpretation services that are coordinated through our preferred vendor, passport to Languages.

To arrange for an interpreter to be present during a medical appointment a provider can:

- Complete the CareOregon Interpreter Request Form and fax to Passport to Languages at 503-297-1703. This is for all requests at least two days before the scheduled appointment. The CareOregon Interpreter Request Form can be found on the CareOregon website: http://www.careoregon.org/Providers/ProviderFormsandPolicies.aspx
- Access Passport to Languages online system to request and confirm: https://www.passporttolanguages.com/
- Urgent requests being made less than two business days from the date of the scheduled appointment, can be made to 503-297-2707

It is the providers responsibility to complete and fax the CareOregon Interpreter Request Form directly to Passport to Languages using the fax number provided and indicated on the form. All confirmations are provided by PTL. Calls to cancel a previously scheduled interpreter request need to be directed to PTL.

TELEPHONIC INTERPRETATION SERVICES PROCEDURE

CareOregon also provides telephonic interpretation through our preferred vendor CyraCom. CyraCom is for CareOregon employee use only and is for incoming and outgoing call language interpretation. Historically, CyraCom has been primarily used by CareOregon's customer service staff, however this is also an option for employee's making outbound phone calls to members as well (health care coordinators, case managers, health resiliency specialists, panel coordinators, etc.)

Please work with your Manager to determine how best to document telephonic interpretation services when working with members.

A full list of all languages available through CyraCom can be found on CyraCom's website: http://interpret.cyracom.com/langauge-list/

Telephonic Interpretation – Process Steps

1. Using ShoreTel, dial CyraCom…	CyraCom is in ShoreTel under ***CyraCom*** **- OR -** Toll Free at (800)481-3293
2. When prompted, enter CareOregon's account number and appropriate PIN…	**Account Number:** 501013528 **OHP PIN:** 5414 **COA PIN:** 1000
3. When asked which language you need, enter the language code…	The most commonly used language codes are outlined in the CyraCom Interpreter Services Job Aid For all other language codes, use CyraCom's extensive languages list: http://www.cyracom.co.uk/wp-content/uploads/2016/02/CyraCom-Language-List.pdf
4. Once connected with the interpreter, document the language being used, and the interpreter's ID# in ***QNXT Call Tracking***...	
5. Before conferencing in your caller, do the following…	1. Ask the interpreter to introduce themselves and you 2. Ask the interpreter to gather the spelling of the caller's name and the name of the

	person they are calling about (if not themselves) 3. Ask the interpreter to gather the member's ID# or SSN, as well as the member's DOB 4. Ask the interpreter to determine what the reason of the call is
6. Conference the caller in and ask the interpreter to proceed…	
7. Document the information in ***QNXT Call Tracking*** using the following template:	***(Language) Interpreter & nmbr:*** ***Caller NM & #:*** ***Mbr#:*** ***Mbr name:*** ***DOB:*** ***Re:*** ***Adv:***

Most Common Languages and Codes

Spanish 060	German 057	Portuguese 061	Swedish 053
Cantonese 031	Japanese 040	Nepali 081	Thai 047
Mandarin 035	Korean 041	Romanian 066	Vietnamese 049
French 058	Arabic 090	Russian 078	Tagalog 117

RELATED DOCUMENTS

Interpreter Service Requests Process Guide
Interpreter – Language Line – CyraCom Job Aid

410-141-0220 Oregon Health Plan Prepaid Health Plan Accessibility

CPCCO Community Engagement Plan Narrative

General Component Narrative

Describe the process for members (both CAC and non-CAC members, health care providers, other service delivery partners, and other stakeholders to provide input that will inform CCO decision-making. (for example, how the CAC could ensure a member voice in CCO decision making)

CPCCO secures member and community input through a variety of channels including three local advisory councils (CACs) and one regional advisory council. The CACs are comprised of providers and other stakeholders, including elected officials; at least 51% of members in each CPCCO CAC are OHP members. CPCCO has created bi-directional pathways for advisory councils to inform the decision-making process for community investment and for advisory council members and community partners to give input to components of CPCCO health plan benefits. Additionally, CPCCO sponsors community events where attendees are asked for input on CPCCO goals and projects.

Describe how the Applicant will ensure the member voice is elevated.

CPCCO will use several pathways to health equity at the community level to elevate member voice. Intentionally elevating member voice is especially important for CPCCO because of the health disparity issues that occur in our rural service region, which due to geographic constraints can limit member ability to engage in community health improvement initiatives.

1) CPCCO conducted a regional community health needs assessment in fourth quarter 2018 and first quarter 2019. The assessment specifically included elevation of member voices. Using a methodology that asked participants to share micro-narratives related to their experience of health and wellbeing and their vision of the future, 1,250 experiences were collected of which 508 of the participants self-identified as OHP. This primary data, combined with secondary health indicator data, was shared at 15 community presentations in the region where attendees were given an opportunity to hear survey results and to vote on which areas CPCCO and their community partners should prioritize for the 2020-2024 RHIP. This directly elevated member voice in determining CPCCO health improvement and investment priorities.

   All components of the community needs assessment were conducted in a collaborative and participatory manner that included key community stakeholders who support health and wellbeing from the health care and social safety net sectors, OHP members and others associated with providing and facilitating good community health. The participatory and community-engagement process used for the primary data collection will continue to be used as CPCCO and its regional health improvement plan partners evaluate and communicate quarterly to the public about the progress towards health improvement at the community and regional levels.

2) CPCCO has organized and staffed the three local advisory councils and one regional advisory council with a goal that all members are afforded the opportunity to consistently contribute, learn, and make recommendations and advise the CCO about community health improvement

and health plan benefits. This process supports advisory council members and key community stakeholders to learn and advise about health issues in their communities, including on-going community-wide health initiatives through advisory council sponsored projects. Activities that council members participate in throughout the year include but are not limited to: advise/give input on components of the health plan benefits that are working well or need improvement; advise on community health improvement strategies; rate, approve, and recommend community wellness investment fund grant proposals; create, inform, and evaluate advisory council supported projects that address health care quality improvement at the community level; and engage with the OHA Innovator agent to give input on state level health improvement activities.

3) Recent process improvements for the advisory councils have included: creating job descriptions; defining types of advisory council memberships to create flexibility and foster engagement with members who are interested but have limited capacity; inviting clinical and social safety net partners who have engaged with CACs or are CPCCO Board members to be Ex Officio members; and receive monthly updates regarding advisory council activities and act as on-going resources for consultation and input to CPCCO activities.

Describe potential barriers to community engagement and how the Applicant will address these barriers. The applicant will include:

Known or anticipated barriers for the community the Applicant intends to serve (e.g. transportation and costs, accessibility, childcare, language access, literacy and numeracy levels and dominance of oral culture, rural isolation, gaps in information)

Known barriers are transportation, time availability, childcare, language and literacy barriers, complexity in understanding and navigating the complex benefit and care systems for OHP coverage.

The methods the Applicant will use to address barriers. This must include description of strategies to avoid exclusionary practices and allocation of necessary resources, including funds and

CPCCO provides a monthly stipend and mileage and childcare reimbursement for CAC members who are on OHP or have an immediate family member on OHP. Members with limited mobility can use non-emergency medical transportation to CAC sponsored activities or CAC meetings. Interpretation/translation is available as requested and member materials are approved by OHA to meet literacy requirements. CPCCO seeks to meet community members at convenient locations and provides food at community events.

Describe the plan to ensure continual quality improvement of the high-level plan throughout the life of the contract, including how quality improvements will be shared back with engaged stakeholders and the larger community.

A collaborative effort is being developed regionally through the partnership developing the Regional Health Improvement Plan. Partners have signed an LOA and agreed to work together on the creation of the goals, objectives and strategies that could be done regionally to address the prevention of and the treatment for substance use disorder. This includes the creation of a quarterly dashboard that will be shared publicly through the participating organizations showing the progress (and challenges) towards meeting the goals of the regional health improvement plan.

CAC Component Narrative

The Applicant will describe its Community Advisory Council as follows:

An Applicant with one or more existing CACs will describe its current CAC structure and role(s) and, if applicable its plans for adapting its CAC structure based on a new or adjusted CCO service area.

CPCCO supports three local advisory councils and one regional advisory council which is comprised of the chair and co-chair of each local council and one elected official. Currently in the region there are 35 advisory council members, 21 of whom meet the definition to represent OHP (either they or a family member has the health plan). Local advisory councils meet monthly and the regional council meets quarterly.

CAC coordinators, staffed by CPCCO, work to recruit, engage, and support advisory council members to participate in the councils in a meaningful way. Effort is made to recruit members who represent different demographics of the service population and their respective county geographically.

CPCCO strongly supports the bi-directional pathways for communication of the advisory council's recommendations for community health improvement. Process improvement efforts to increase advisory council participation and address support needs have and will continue to result in adjustments to CAC structure and roles. Opportunities for process improvement will be evaluated at each meeting through rapid feedback forms. Advisory council members are advised of results and efforts to improve meeting outcomes through the meeting minutes. Based on these results, CPCCO has facilitated a stronger understanding of the role and expectations of advisory council members and staff through the creation of job descriptions. It also created flexibility for members to participate through three different types of job descriptions (monthly/quarterly, special projects and ex-officio). Another improvement was creating a process/curriculum for councils to use as a learning community to engage with the health indicator/improvement activities in their communities. This is then used to make informed decisions about advising on the activities to improve health and well-being in their communities. Additional structural improvements are expected to be identified and implemented over time.

With our six years of practice in building effective community advisory councils, CPCCO believes we can provide significant leadership to any new advisory councils in our service area.

The Applicant must also include:

A description of how it defines its population:
Any individual in our service area who meets the income or other eligibility requirements to be enrolled in OHP.

Any planned changes to CAC recruitment and engagement strategies to align CAC membership with that population and with CHP priorities.
CPCCO will implement "types of CAC membership" for advisory councils and when working on community health improvement projects. Specifically, we will recruit for advisory council participation specific to a population demographic or sector of the community, such as OHP representative or direct service staff actively participating in a project that CPCCO has invested in at the community level. Membership types will include monthly/quarterly attendance; focus on special projects; and ex-officio members. CPCCO's community needs assessment (micro-narrative story collection) sampled survey respondents who self-reported as American Indian/Alaskan Indian (7.0%) and Hispanic (8.5%). The resulting representative sampling for Hispanic and oversampling

for American Indian/Alaskan Indian will help us to better understand the health and wellbeing needs of potential CAC members from these populations, and how we might support and engage Hispanic and American Indian/Alaskan Indian in our advisory councils and the CPCCO Board.

Applicant will describe how they will meaningfully engage OHP consumer representatives on the CCO board, and how they will meaningfully engage tribes and/or tribal advisory committees (if applicable).

CPCCO will provide the necessary staffing to support the recruitment, engagement, and involvement of OHP representatives on the CPCCO Board. The structures will be similar to the staffing of the local advisory councils. The staffing process will be used to support community engagement and organizational learning, both of which will increase CPCCO's informed decision-making capacity. CPCCO will ensure that consumer representatives will be able to provide key information and insight to the COO at the Board level. Currently two Board members meet the criteria of representing OHP as a consumer. As stated above, the representative sampling for Hispanic and oversampling for American Indian/Alaskan Indian will help with supports for participation on our Board.

Applicant will describe strategies for collaborating with CACs from other CCO's that have overlapping services areas. Include strategies to ensure best use of local capacity and resources to avoid overtaxing the community (for example, if the same county, community-based organizations or OHP consumers being asked to participate in more than one CAC or more than one CHA/CHP process)

With our six years of practice in building effective community advisory councils, CPCCO believes we can provide significant leadership to any new advisory councils in our service area. CPCCO would follow a similar practice to other areas of shared work and collective impact with community and clinical partners. This includes having letters of agreement regarding areas of focus, information sharing and collaboration to leverage the limited resources of time and investment dollars in community health improvement.

CHA/CHP Component Narrative

Describe how the Applicants strategy for health-related services (HRS) community benefit initiatives will link with the Applicants CHP. Applicants may wish to refer to their answer to RFA Attachment 10, Part C.1.a in answering this question.

Please see answer to RFA Attachment 10, Part C.1.a.

CPCCO anticipates investing an average of $3 to 4 million annually in Health-Related Services (HRS) for clinics and community-based organizations that are linked to CPCCO's CHP. Investments by CPCCO in HRS Community Benefit Investments (CBI) will be consistent with the definition in OAR 410-141-3150 and complement the investments CPCCO makes in partner organizations that address SDOH-HE. The bulk of CBI investments will be made to clinical partners in the CPCCO service area for proposals that **integrate services**, especially between clinical and community settings, and for **clinical capacity-building** to reduce health disparities and access barriers, improve quality and member outcomes, and address provider recruitment and retention challenges. Once the 2019 CPCCO Community Health Improvement Plan is completed, the categories for both CBI and SDOH-HE may be amended. Our CACs will be responsible for reviewing and recommending investments for CBI and SDOH-HE partners related to the RHIP improvement priorities.

THW Integration and Utilization Plan

Applicant's proposed plan for integrating THWs into the delivery of services

CPCCO is committed to supporting the build out and maintenance of a thriving THW workforce. To do this, we must create an infrastructure that supports both the individual THW and the organizations that hire them. We have identified the following key components as responsibilities of the CCO and will build out this infrastructure over the next two years, as we:

- Fund certification opportunities for Community Health Workers to bolster the number of CHWs in our region
- Create training opportunities for organizations that decide to incorporate THWs into their treatment team
- Establish a learning collaborative for THWs where they can learn from one another and support each other throughout the region
- Create sustainable funding options

This supportive infrastructure will be the foundation upon which we will integrate THWs as part of the overall CCO population health strategy being implemented over the next 1 to 3 years.

The following is a list of areas in which CPCCO will utilize THWs:

- **ED Utilization Reduction***:* we will integrate Peer support specialists to engage with Members who present to the ED with SUD-related concerns/conditions. Peers meet with Members during an ED visit and conduct follow up in the community as appropriate. They will support the member's journey towards engagement with treatment, mental health services, or both. In addition, CHWs will engage with members who present frequently to the ED for non-acute physical concerns and will conduct follow up in the community as appropriate.
- **SUD Treatment Engagement:** we will use Peer support specialists or Peer wellness specialists to engage members with SUD diagnoses to support the member's recovery pathway, focused on a harm reduction approach. Initial SUD diagnosis focus will be on OUD, to extend to a broader focus long-term. The THWs will work in compliance with SAMSA best practices and overall commission best practices.
- **Maternal Child Health (MCH):** we will use MCH trained CHWs to support various areas of focus in the MCH area. MCH CHWs will work with primary care providers conducting ASQ screening to provide follow up and connect families/care providers with resources for those children who screen positive for one or more gaps. MCH CHWs will work in collaboration with community-based organizations, primary care providers, and behavioral health to address gaps/needs identified during in-home assessments for children 0-5 years and families. In-home assessments will utilize the Family Assessment Form (FAF), which is a research-validated tool with proven reliability. The FAF covers the five protective factors, including: parental resilience, social connections, concrete support in times of needs, knowledge of parenting and child development, and social and emotional competence of

children. Acuity of in-home assessment timeliness will be determined by child complexity level, using the OPIP child health complexity data to stratify children into three levels of risk – Low, Medium, and High – as defined by health complexity score. For those identified with a health complexity score of 6 or higher, a MCH-trained CHW and Community Paramedic will do a co-visit to complete the in-home assessment. The MCH-trained CHW will conduct all follow up with the child and family, primary care, behavioral health, and early learning providers in the community.

- **Access to Doulas:** we will continue to build out access to Doulas within Clatsop and Tillamook counties. Many of our members who reside in Columbia County can take advantage of the doula network that CareOregon has built in the Portland metro region. This includes: doulas at Legacy and CODA that can provide integrated OB/SUD treatment, doulas at Providence, OHSU, and Legacy, and doulas at a variety of community-based organizations such as Doulas Latinas, PDX Doulas, Mother Tree Doula, and Birthing Way Doula. CPCCO intends to learn from CareOregon's work in the metro region to replicate similar opportunities along the coast.
- **Chronic Condition Prevention and Management:** we will integrate CHWS and Peer wellness specialists to work with members with poorly managed chronic conditions such as diabetes and hypertension. The THWs will work within scope of the CDC Community Preventive Services Task Force Guides for diabetes prevention and management, as well as cardiovascular disease prevention. Additionally, CPCCO will build off existing work focused on chronic disease prevention and management with community-based organizations.
- **Clinic-based THWs:** we will support clinics to hire and integrate THWs into their teams and models of care delivery. We will provide initial grant funding for position FTEs, with the intention to shift the funding model to an Alternative Payment Model (APM) for long term sustainability. Additionally, we will provide technical assistance to clinics on THW best practices, how to integrate THWs into clinical care, and guidance for supervision and monitoring of support.
- **Community-**based THWs: we know there are organizations in our communities that address SDOH, such as housing, healthy eating and access and physical activity programs (e.g. YMCA), that touch our members in important and necessary ways. For example, we will continue the partnership with the Tillamook YMCA to deliver the Diabetes Prevention Program (DPP), currently being led by a CHW. Similar to the clinic-based THWs, we will provide start-up funding and technical assistance to ensure success of the CHWs in community settings, shifting to an alternative payment for sustainability.

How Applicant intends to implement THW commission best practices

CPCCO will use the THW Commission best practices to design the scope and responsibilities of the THW liaison's role. CPCCO will use OHA and THW Commission guidelines, including those of the Payment Model Committee to inform our payment methodologies. CPCCO's goal is to reduce our reliance on grants or other forms of payment that result in underpay, underemployment or unemployment for the THW workforce and optimize funding structures that creates more sustainability within the workforce. CPCCO will hire a THW liaison who will work in collaboration with THW Commission to implement the Commission's best practices, and coordinate with the OHA Office of Equity and Inclusion for technical assistance on implementation as needed. Additionally, CPCCO's THW liaison will work to develop a THW community of practice in our service region, in collaboration with Oregon Community Health Workers Association (ORCHWA), to keep community partners up to date on THW best practices. The THW liaison will also serve as

resource to THWs working on the community when there is concern that a THW is being asked to work outside the scope of the given THW type and/or is not maintaining fidelity of the role. The THW liaison will escalate such concerns and mitigate any concerns with CBO's and clinics, should the need arise.

How applicant intends to increase THW utilization

CPCCO will increase THW utilization throughout the region by purposefully integrating THWs into larger population health strategies and community health initiatives. As a part of our larger strategy focusing on infusing an equity lens into all work, we will be utilizing THWs to ensure all programs are designed and executed with equitable access for all our members. The use of THWs throughout all strategic programming is also in line with our board of director's promise to develop safe and healthy communities that will help support the emotional, social and health needs of our children and their families so they can ultimately reach their highest potential and thrive.

How applicant proposes to communicate to members about the benefits and availability of THW services

CPCCO will utilize various methods of communication to members about the benefits and availability of THW services, such as the member handbook, CPCCO and Care Oregon website, and the **OHP & You** curriculum developed by CPCCO staff to educate community partners and members on the benefits and services of the Oregon Health Plan.

How applicant proposes to measure baseline utilization and performance over time

CPCCO will work with community partners to develop a measurement and evaluation framework that is informed by the THW measurement reporting template and will include policy measurement outcomes and key performance indicators. CPCCO will consult the Oregon Community Health Workers Association (ORCHWA) for guidance on framework development. We will start in 202 to assess and define a baseline from which to set future targets and goals.

Data potentially to be collected and submitted includes:

- An assessment of Member satisfaction with THW services
- Ratio of THWs to the total number of Members
- Number of THWs employed by Worker Type (FTE/Contracted)
- Number of requests from Members for THW services (by THW types)
- Number of engagements of THWs as part of the Member's Care Team (by THW types)
- Demographics of THWs and CCO Membership: including Race, Ethnicity, Language, Disability
- Number of clinic and community-based THWs

CPCCO will ensure that encounter claims are submitted for any THW interactions that are eligible to be submitted and processed as encounter claims.

CPCCO wishes to collect data for each of the following THW types:

- Community Health Workers;
- Doulas;
- Peer Support Specialists including Adult Addictions, Adult Mental Health, Family and Youth Support Specialists;

- Peer Wellness Specialists including Adult Addictions, Adult Mental Health, Family and Youth Support Specialists; an
- Patient Health Navigators.

CPCCO also would like to include interactions between THWs and members in each setting:

- Clinic Setting;
- Non-Clinic Setting; and
- Community-Based Setting.

CPCCO will report to OHA on each type of payment model used to reimburse THWs and the number of THWs paid under each payment model it utilizes.

How applicant proposes to utilize the THW liaison position to improve access to members and increase recruitment and retention of THWs in its operations

CPCCO will designate a THW liaison as the central point of contact for THW integration. The liaison will act as the hub of information for THWs, consumers, and the community. The liaison will also address the barriers to integration and utilization of THWs and their services. The THW liaison will:

- Coordinate CCO's workforce
- Consult on the THWs integration and utilization plan
- Provide technical assistance to THW's provider enrollment within the CPCCO network in coordination with the Provider Relations Specialist and other support staff
- Assist in coaching system navigation for THW's Workforce and members
- Provide support with establishing THW payments and rates, THW utilization both in clinical settings and Community-based settings, supervision and competencies, THW service delivery, and member accessibility to THW services and the Community within the CCO health care system
- Provide technical assistance as needed for partners to utilize our THW payment methodologies
- Work in collaboration with THW Commission to implement the Commission's best practices, and coordinate with the OHA Office of Equity and Inclusion for technical assistance on implementation as needed

Attachment 11 - Behavioral Health Questionnaire

11.A. Behavioral Health Benefit

Applicant must be fully accountable for the Behavioral Health benefit to ensure members have access to an adequate Provider Network, receive timely access to the full continuum of care, and access effective treatment. Full accountability of the Behavioral Health benefit should result in integration of the benefit at the CCO level. Applicant may enter into Value-Based Payment arrangements; however, the arrangement does not eliminate the Applicant's responsibility to meet the contractual and individual member need. Applicant must have sufficient oversight of the arrangement and intervene when a member's need is not met or the network of services is not sufficient to meet members' needs.

11.A.1. How does Applicant plan to ensure that Behavioral Health, oral health and physical health services are seamlessly integrated so that members are unaware of any differences in how the benefits are managed?

Columbia Pacific Coordinated Care Organization (CPCCO) has always valued integration and strives to provide a low-barrier, comprehensively integrated experience for our members. For the past six years we have found innovative solutions to achieve this. For example, we created a blended funding pool to pay for services that fell outside of traditional behavioral or physical health funding streams and represented significant steps towards integration. In June 2019, we are taking our next big step towards integration and will begin directly managing the behavioral health benefit across the CPCCO service area. At that time, we will contract directly with all physical health and behavioral health providers. As an integrated CCO, we will ensure seamless integration of services. No behavioral health risk or benefit management will be delegated to an outside organization.

As of June, members will be able to access outpatient behavioral health services from an open network, with no wrong door and no prior authorization for a comprehensive assessment of needs and referral to the most appropriate services. As is currently the case, behavioral health services will be provided in a variety of settings throughout the community, including in specialty behavioral health organizations, primary care clinics, schools, the jail, and in other community-based organizations. During this contract period, all three counties in CPCCO's service area have developed mobile crisis teams, making it possible for members to be seen anywhere in the region.

When a member is seeking services of any kind, they will be able to contact the CPCCO member services number for assistance with their physical, behavioral, and oral health needs. This includes access to benefit information, care coordination, grievances, appeals, or interpretation support, among other things. Members will be truly served by one entity, CPCCO, for their full spectrum of healthcare needs.

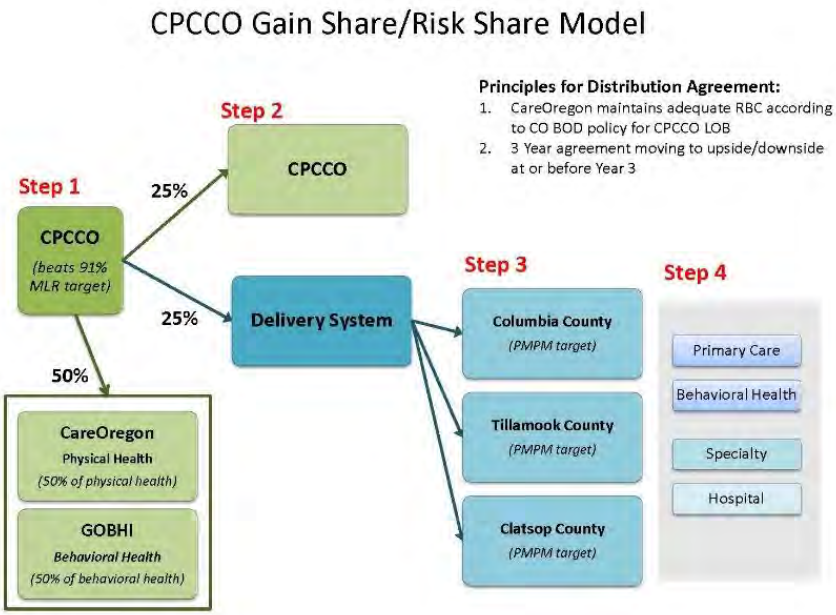
11. A. 2. How will Applicant manage the Global Budget (as defined in ORS 414.025) in a fully integrated manner meaning that Applicant will not identify a pre-defined cap on Behavioral Health spending, nor separate funding for Behavioral Health and physical health care by delegating the benefit coverage to separate entities that do not coordinate or integrate?

As mentioned previously, CPCCO has a history of integrating the funding streams so that the lines between behavioral and physical health services were blurred, and so we could spend more time providing services that are in the best interests of members, rather than figuring out who was going to pay for them. In 2014, we began withholding 1% of physical and behavioral health capitation payments to create a blended funding pool. We used this pool to fund initiatives such as:

- Case rates for behavioral health-based, non-opioid-prescribing pain clinics;
- Start-up funding for BHCs;

- A trauma informed screener working in primary care settings; and
- Behavioral health consultants in primary care settings.

In 2015, CPCCO entered into county-level collaborative gain/risk sharing agreements with the primary care providers, hospitals, community mental health providers and public health agencies in Clatsop and Columbia counties. The intent of these arrangements is to build shared ownership and accountability for CPCCO's member health at the community level and to incentivize providers to work together to improve quality care and reduce avoidable costs and utilization. The model triggers a payout when CPCCO achieves a combined member benefit ratio of 91% for our behavioral health and physical health benefits combined, and when each county achieves a specific PMPM target. Each county has a Steering Committee of participants that meets monthly to review county-specific cost targets and monitor progress of the strategies they have implemented. In 2016, the three counties received just under $1.3 million to invest in county-specific strategies to improve quality and cost of care. The counties are slated for another payout in 2019 and have chosen to focus on bolstering supports for substance use disorder.



Effective June 1, 2019, CPCCO will no longer delegate the management of the behavioral health benefit to another entity and will manage it internally as part of the global budget. By integrating the benefit, CPCCO sees an opportunity to achieve truly integrated care and to reduce administrative barriers for members and providers. This allows for an overall or combined medical benefit ratio. CPCCO tracks and will continue to track the revenue received by each designated category (*e.g.* physical, mental health, substance use disorders) for its own analysis and to inform the interplay between investments and program/benefit design. However, there is deep understanding at the leadership and board level that actual funding of services is not driven by siloed allocation by service type, but by the health needs of our members. We believe that by funding access to behavioral health and substance use disorder services in accordance with our members' needs, we will improve our population's health and decrease unnecessary emergency room utilization and hospitalization. These saved dollars can then be further invested in more upstream preventive and behavioral health services.

The integration of the physical and behavioral benefit administration will not only allow CPCCO to better serve members, but also it will also allow us to invest in community-based partnerships and initiatives that strengthen our community's social support infrastructure and improve overall well-being. These partnerships are described in detail throughout this section and the RFA.

11. A. 3. How will Applicant fund Behavioral Health for its Service Area in compliance with the Mental Health Parity and Addiction Equity Act of 2008?

CPCCO completed a full mental health and substance use disorder parity analysis during 2018 and had no findings from Oregon Health Authority or its contracted consultant. We will continue to ensure (a) that there are no prior authorization or concurrent review requirements that are creating a barrier to access, and (b) that any existing requirements are not at a higher level than those for physical health. Having the entire benefit managed by the same entity will allow for transparency and coordination to ensure CPCCO is not in conflict with the parity regulations. CPCCO's Audit and Compliance teams are aware of this obligation and will conduct periodic audits and ongoing monitoring of CPCCO's performance, as well as that of any subcontractors. Finally, the provider services team oversees network adequacy across all service types and reports findings to CPCCO's Clinical Advisory Panel (CAP), as well as the CareOregon Network & Quality Committee. Through all of these avenues, CPCCO will ensure that standards across service types are consistent and adhere to all regulatory requirements.

11. A. 4. How will Applicant monitor the need for Behavioral Health services and fund Behavioral Health to address prevalence rather than historical regional spend? How will Applicant monitor cost and utilization of the Behavioral Health benefit?

Monitoring access to services: CPCCO has robust tracking and monitoring systems in place that are used to ensure members have access to high quality, timely behavioral health services. CPCCO will require providers to report on access monthly. This information, along with waitlist data, member complaints, and penetration rates[1] will be reviewed on behalf of CPCCO by CareOregon's Network & Quality and Audit & Compliance committees, to assess trends in overall capacity and availability of services. These data will inform interventions and strategies to identify and connect members to needed services. The goal is to ensure that all members who require intervention are identified and linked to the most appropriate treatment setting. When capacity is limited, the Committees will review applications for additional providers and offer contracts to add needed capacity.

Population data analysis: CPCCO firmly believes that access to needed behavioral health treatment will improve health and reduce overall medical expenses. An example of this is our partnership with CODA to open a new Opioid Treatment Program in Seaside. Upon reviewing our NEMT utilization data CPCCO realized that we had many patients traveling to Portland and Salem daily for methadone treatments and that we could both reduce costs and improve member's quality of life by opening a local treatment program. CPCCO also tracks data regarding SUD prevalence, depression and other chronic behavioral health diagnoses. Analyzing these data, in combination with understanding the services that exist in the region, help to elucidate potential gaps in services that need to be built. An example of this has been Medication Assisted Treatment (MAT) services. We partnered with our local primary care providers and community mental health providers to build these services when population level analysis showed a need.

Community feedback: We partner closely with our clinical partners, receive feedback from the Clinical Advisory Panel, our Community Advisory Councils (CACs) and organizational leader. Improvements in access to quality behavioral health services has been an important improvement priority in both our 2014 and 2018 Regional Health Improvements Plans (RHIP). We continue to receive feedback regarding the need to expand outpatient behavioral health services and network of providers and we intend to do so in 2020 as we integrate the benefit.

[1] CPCCO has set penetration rate targets for both mental health and substance use disorder treatment based on national prevalence data.

Financial management approach. CPCCO believes that creating a cap or separate standalone budget for behavioral health services is antithetical to the efforts we are making to integrate benefit administration and promote clinical integration. Behavioral health services will be funded based on current utilization and prevalence targets, limited only by CPCCO's overall budget and medical benefit ratio, not by a discrete behavioral health medical benefit ratio. When overall funding becomes a limiting factor, CPCCO will first consider strategies to reduce utilization of high-cost, low-value services rather than limiting access or reducing payment to providers.

11. A. 5. How will Applicant contract for Behavioral Health services in primary care service delivery locations, contract for physical health services in Behavioral Health care service delivery locations, reimburse for the complete Behavioral Health Benefit Package, and ensure Providers integrate Behavioral Health services and physical health services?

CPCCO supports and will continue to support an integrated, team-based model of behavioral health services in primary care. We offer an alternative payment model to clinics that can demonstrate Tier 3 patient centered primary care home (PCPCH) certification and have a co-located, integrated behavioral health consultant (BHC). Funding for both integrated and co-located behavioral health services in primary care will come from the overall CPCCO budget and require clinics to have only one integrated contract. This includes internal medicine, family medicine and pediatric primary care, as well as school-based health centers. CPCCO uses a payment model for its PCPCH clinics that requires integrated behavioral health services in order to enhance alternative payment opportunities and incentivize greater integration. All clinics with 500 or more CPCCO members assigned to it are eligible for this alternative payment model. The model has a target of 12% or above unique members of the clinic's assigned population to be served by the behavioral health staff within primary care. In the past 12 months, this model enabled 1640 unique members to receive behavioral health supports within primary care.

CPCCO is currently funding integrated behavioral health care in ten of its primary care clinics that will inform future contracting and technical assistance needed to assure the success of this model across CPCCO. Currently the funding is for the limited intervention, integrated behavioral health consultant model, as well as specialty behavioral health services for addiction treatment. We expect to expand the benefit to cover co-located specialty behavioral health counseling, starting in 2020.

As described in 11.A.2, the county-specific community risk/gainshare model has promoted the collaboration between physical and behavioral health. In order to achieve the PMPM target in each county, organizations across the spectrum of care must work together to invest in health improvement and cost containment as well as develop systems and workflows to improve service delivery to members.

The development of MAT services in Clatsop County also reflects the possibilities afforded by integration activities. In this county, the services are provided through a partnership between Columbia Memorial Hospital (providing medical services) and Clatsop Behavioral Healthcare (providing behavioral health) that has created an integrated team.

Last, but not least, CPCCO will support physical health services that are integrated into specialty behavioral health settings through the same single contracting process. Specifically, CPCCO supports the Columbia Community Mental Health (CCMH) Certified Community Behavioral Health Center and will ensure sustainable funding, regardless of the federal and state support. These

services will be reimbursed through one single contract and funding stream to support innovation and the spread of value-based payment models. The implementation of the primary care aspect of the CCBHC model has been achieved through a partnership between CCMH, and one of our PCPCH's, OHSU Scappoose Family Medicine. This model allows CCMH patients with severe mental illness who are unlikely seek care in a primary care clinic to receive such services at CCMH. Through the partnership, OHSU and CCMH have access to one another's electronic health records and document integrated care plans into each. There is also an onsite pharmacy where patients can pick up their medications and receive vaccines or flu shots. CCMH's case managers attend the physical health appointments with the patients so that health maintenance behaviors, such as medication regimes for chronic conditions, are built into the patient's behavioral health treatment plan.

11. A. 6. How will Applicant ensure the full Behavioral Health benefit is available to all members in Applicant's Service Area?

As mentioned above, CPCCO will soon manage the behavioral health benefit for its members in Clatsop, Columbia and Tillamook counties. CPCCO already has contracts in place in its service area that provide most of the services, including: all levels of community-based services for children and adults; supported housing; respite for adults; substance use disorder residential and withdrawal management treatment; and a variety of specialty programs. We also have contracts with statewide resources for those services that are not available locally.

CPCCO has a robust care coordination program that works with members and their care teams to ensure they have access to services and to remove barriers to entry or authorization as needed. In addition, this care coordination team does proactive case finding work to identify and outreach to members who may not be getting their full health care needs met and offer support to them. (See more under section 11. E. 3. Care Coordination.) The care coordination team also helps members overcome factors such as lack of transportation; when transportation is a barrier, CPCCO works to ensure that members have access to health-related services benefits or coordinates with our contracted Non-Emergent Medical Transportation (NEMT) provider to offer access to services across the region. CPCCO recognizes the CMHPs in the region all provide case management/care coordination for their enrolled clients and will ensure that care coordination efforts at the plan level are coordinated and integrated with the efforts at the provider level.

11. A. 7. How will Applicant ensure timely access to all Behavioral Health services for all members?

CPCCO has tracking and monitoring systems in place that ensure members have access to high quality, timely behavioral health services. CPCCO requires providers report monthly on access and to offer members at least three referrals to other behavioral health professionals if the provider cannot see the member within state-required timelines. This will provide real time information about capacity of routine services in our continuum of care for both mental health and substance use disorder treatment. When capacity is limited, our CareOregon's Network & Quality and Audit & Compliance Committees will review applications for additional providers and either offer contracts to add needed capacity or solicit new providers to enter the region if no local providers are available. Internally, CPCCO tracks and monitors turnaround times for prior authorization and concurrent review decisions at all levels of care, both to ensure adherence to required timelines and to ensure that we are not causing any delays in access to treatment.

With its rural service area, CPCCO members face additional challenges in accessing health services.

For our more remote areas such as Clatskanie and Vernonia, CPCCO supports its providers in accessing telehealth services for members to ensure adequate capacity of psychiatric services. During the first 3 years of the current contract, CPCCO supported installation of sufficient access to the intranet to enable electronic access use and the roll out of telehealth hardware sites to enable it. This addition to the system added telemedicine capacity to CPCCO, who will reimburse for telehealth services, and assist providers in developing the capacity to provide telehealth services through technical assistance and support. We have also hired a Transportation Coordinator who works directly with our NEMT brokerage to provide technical assistance around optimizing the benefit for our members. This support let us identify barriers to transportation early and collaborate on innovative solutions to getting members to their care.

11.A.8. How will Applicant ensure that members can receive Behavioral Health services out of the Service Area, due to lack of access within the Service Area, and that Applicant will remain responsible for arranging and paying for such out-of-service-area care?

CPCCO's care coordination and utilization management teams work closely together to ensure that members have access to out-of-area services for those unavailable within the three counties. CPCCO's care coordination team will help ensure that members are referred to the most appropriate level of care to meet their needs. When services are required out of area, the care coordination team will work with the utilization management staff to identify a resource and process the authorization. CPCCO leverages CareOregon's expansive statewide network to minimize barriers to getting members served out-of-area. In the rare event that an existing contract is not in place, CPCCO will offer a contract, pay the provider as a non-participating provider using the DMAP fee schedule or develop a single case agreement to ensure payment. The care coordination team will stay involved to ensure that as the member returns to the community, services are in place to support a safe and successful transition.

When members are already out of the area before being identified as needing services, CPCCO will ensure payment for medically necessary services provided in accordance with our prior authorization policies and will provide retroactive clinical reviews for payment when prior authorization was not sought by the provider.

CPCCO will work closely with local CMHPs who are or will be responsible for providing ongoing treatment prior to or post placement. Transitions between services and/or levels of care are sensitive moments in a member's life and require a high level of coordination between providers and plan staff.

11.A.9. How will Applicant ensure Applicant's physical, oral and Behavioral Health Providers are completing comprehensive screening of physical and Behavioral Health care using evidence-based screening tools?

To support comprehensive screening using evidence-based screening tools, CPCCO will provide technical assistance and support in developing workflows for screening and referrals, as well as training on how to maximize electronic health records to support routine screening and referral.

We currently collaborate with our primary care providers to ensure they routinely use screening tools such as the PHQ 9, SBIRT, GAD-7 and oral health risk assessment. These tools are supported in several ways: through billing codes to provide reimbursement; through the CCO Quality Pool payments; and through our alternative payment model for patient centered primary care homes. We are currently working with our OB providers to ensure universal screening of pregnant women for depression and substance use disorders as well as referral for oral health services. Two CPCCO

clinics have recently piloted and developed processes for One Key Question. In addition, organizations are screening for appropriate development using the ASQ, which incorporates social and emotional development. CPCCO has funded in depth work to evaluate gaps regarding these screening efforts and ways to improve systems and workflows to make sure that members receive appropriate follow up care beyond the screening.
The dental network routinely screens and will continue to screen for blood pressure in addition to dental caries and periodontal disease. Diabetes screening, including HbA1c, will also be developed and implemented in the dental setting.

In CPCCO's behavioral health network, our providers routinely screen, and will continue to screen, for chronic disease and other medical conditions as part of the comprehensive assessment process. Columbia Community Mental Health's CCBHC model also allows patients to receive full physical integration within their behavioral health care setting. This model allows the physician to run labs, diagnosis, prescribe and have those prescriptions filled onsite at CCMH.

Behavioral health providers are also in the process of onboarding PROMIS—an evidence-based system which provides a suite of tools to measure functioning in both the adult and pediatric population. This system will be used across the network in 2020.

11.A.10. How will Applicant ensure access to Mobile Crisis Services for all members to promote stabilization in a Community setting rather than arrest, presentation to an Emergency Department, or admission to an Acute Care Psychiatric Hospital, in accordance with OAR 309- 019-0105, 309-019-0150, 309-019-0242, and 309-019-0300 to 309-019-0320?
CPCCO has relationships with each of the Local Mental Health Authority and Community Mental Health Programs in the region. We funded the startup of integrated mobile crisis services in Clatsop and Tillamook counties and we will continue to support enhanced community-based crisis services in all three counties. Our contracts with Tillamook Family Counseling Center, Clatsop Behavioral Health and Columbia Community Mental Health to administer these services all ensure compliance with the Oregon Performance Plan and Oregon Health Authority requirements for telephonic, walk-in, and mobile crisis services.

Each CMHP will continue to work closely with law enforcement, emergency departments, schools, and providers to ensure a coordinated and efficient response to members who are in a mental health crisis with a primary purpose of keeping members out of jail or the hospital. They will facilitate admission to child and adult crisis respite services after hours to avoid a hospital admission or as a discharge from or alternative to the emergency department.

11.A.11. Describe how Applicant will utilize Peers in the Behavioral Health system.
CPCCO strongly believes in the value of peer support for all members in the behavioral health system of care. To that end, we will fund a variety of peer support programming across the system. Our local Wraparound programs include youth and family peer support. CPCCO will fund the continuation of a new model of peer support for outreach and engagement to members with substance use disorders. This program, launched in 2018, funds recovery allies working out of each of our CMHPs to meet members at various locations in the community and promote engagement in treatment.
They focus on outreach to members who might not yet be contemplating changing their substance use behaviors and then support them through a strengths-based, wellness-informed, client-centered approach that assists members in achieving person-driven goals. The recovery allies are also a part of

our interdisciplinary Regional Care Teams that meet weekly to discuss high complexity members, develop a collaborative plan of care, and identify a primary care coordinator for each member. As appropriate, the recovery allies will take the lead on members where their shared lived experience and understanding can enhance the level of support, interaction, and engagement in the member's treatment and recovery journey. Peer support specialists are also a part of many rehabilitation services provided by the CMHPs including housing supports, transitions of care and drop in center supports.

We will use peer support specialists or peer wellness mentors to engage members with SUD diagnoses to support the member's recovery pathway, focused on a harm reduction approach. Initial SUD diagnosis focus will be on Opioid Use Disorder (OUD), to extend to a broader focus long-term. CPCCO will also deploy THWs to work in compliance with SAMSHA best practices and overall THW Commission best practices.

11.A.12. How will Applicant ensure access to a diversity of integrated community supports that mitigate SDOH-HE, increase individuals' integration into the community, and ensure all members access to Peer services and networks

Community-Based Investments. To ensure access to diverse, integrated community supports, CPCCO anticipates investing an average of $3 to 4 million annually in SDOH and Health-Related Services (HRS) for clinics and community-based organizations. Investments by CPCCO in HRS Community Benefit Investments (CBI) will be consistent with the definition in OAR 410-141-3150 and complement the investments CPCCO makes in partner organizations that address SDOH-HE. The bulk of CBI investments will be made to clinical partners in the CPCCO service area for proposals that integrate services, especially between clinical and community settings, and for clinical capacity-building to reduce health disparities and access barriers, improve quality and member outcomes, and address provider recruitment and retention challenges. Our CACs will be responsible for reviewing and recommending investments for CBI and SDOH-HE partners related to the Regional Health Improvement Plan (RHIP) improvement priorities. As part of our RHIP, CPCCO will work to improve and align with NAMI to improve access to mental health and addiction services. NAMI is in two counties of our service area and active in supporting the prevention of suicide and improving access to services that support those with long term mental health conditions.

Traditional Health Workers & Peers. To ensure members have access to a robust network of peer services, CPCCO will increase traditional health worker (THW), peer support specialist (PSS), and peer recovery mentor (PRM) utilization throughout the region by purposefully integrating THW, PSS, and PRM into larger population health strategies and community health initiatives. As a part of our larger strategy focusing on infusing an equity lens into all work, we will be utilizing THWs to ensure our programs are designed and executed with equitable access for all members. The use of THWs, PSS, and PRMs throughout all strategic programming is also in line with our CPCCO Board of Directors' promise to develop safe and healthy communities that will help support the emotional, social and health needs of our children and their families so they can ultimately reach their highest potential and thrive.

Community Outreach & Communication. CPCCO will utilize various methods of communication to members about the benefits and availability of THW, PSS and PRM services, such as the member handbook, CPCCO and Care Oregon websites, and the *OHP & You* curriculum currently in development by CPCCO staff to educate community partners and members on the benefits and services of the Oregon Health Plan.

Leadership & Staff Support. CPCCO will designate a THW liaison on its staff as the central point of contact for THW integration. The liaison will act as the hub of information for THWs, consumers, and the community. The liaison will also address the barriers to integration and utilization of THWs and their services. The THW liaison will:

- Coordinate with CPCCO's workforce;
- Consult on the THWs integration and utilization plan;
- Support enrollment of THWs within the CCO network;
- Assist in coaching system navigation for THW's workforce and members;
- Provide leadership establishing THW payments and rates;
- Support THW utilization both in clinical settings and community-based settings;
- Promote access to THW services in local health systems;
- Provide technical assistance as needed for partners to utilize our THW payment methodologies; and
- Work in collaboration with THW Commission to implement the Commission's best practices, and coordinate with the OHA Office of Equity and Inclusion for technical assistance on implementation as needed.

11.B. Billing System and Policy Barriers to Integration (recommended page limit 2 pages)
Applicant must identify and address billing system and policy barriers to integration that prevent Behavioral Health Provider billing from a physical health setting. Applicant will develop payment methodologies to reimburse for Warm Handoffs, impromptu consultations, integrated care management services and all services for evidence-based treatments (for example, Wraparound, ACT, PCIT, EASA, Peer Delivered Services). Applicant will examine equity in Behavioral Health and physical health reimbursement.
11. B. 1. Please describe Applicant's process to provide Warm Handoffs, any potential barriers to ensuring Warm Handoffs occur and are documented, and how Applicant plans to address them.
CPCCO is proud of the work we have done over the past several years to integrate behavioral health services into primary care medical homes using the primary care behavioral health (PCBH) model endorsed by the Oregon Health Authority, PCPCH standards, Primary Care Payment Reform Collaborative and SAMHSA. We will continue to use an alternative payment model that supports non-encounterable services such as warm handoffs and crisis interventions in the primary care clinic. The alternative payment model includes a per member per month (PMPM) payment in addition to fee-for-service (FFS) reimbursement on an enhanced fee schedule and tied to specific performance metrics. To ensure that practices are well-positioned for success, we will continue to employ a CPCCO-based behavioral health innovation specialist (BHIS) to provide technical assistance and supports to improve clinic workflow, documentation, team-based care, and payment/billing issues.

The BHIS will also work closely with the specialty behavioral health providers to develop improved referral pathways, processes for warm handoffs, and mechanisms for effective communication between primary care and behavioral health specialists. This will be accomplished through monthly peer-to peer meetings and quarterly learning collaboratives. Case management and care coordination are core services provided by the region's CMHPs. Coordination and clear role definition among the various care coordination resources deployed by CPCCO will be a focus, especially in the area of transitions of care.

CPCCO has implemented weekly care coordination huddles with our primary care and behavioral health networks. These occur weekly and allow the network to quickly identify and align on the needs of members who have recently visited the ED or had an inpatient admit. This collaboration was launched from a unique county-level community risk share model and CPCCO is currently working on building sustainable funding to continue to support the work. CPCCO also convenes a monthly county operations workgroup with clinical managers of the partners that participate in the huddles. These workgroups focus on process improvements for better collaboration between the partners. For instance, Clatsop County's workgroup has decided to focus on refining their warm handoffs with a closed loop referral process to ensure care providers are updated on treatment implications resulting from the handoff. (See 11.A.2 for additional detail on the model.)

CPCCO will also use practices that provide outpatient behavioral health services that go beyond the scope of the integrated, team-based PCBH model. Due to the integrated global budget, these services will all be billed to and reimbursed by the same entity and do not require any prior authorization.

CPCCO has engaged the OHA Transformation Center to provide technical assistance around the conflicts and inconsistencies in the credentialing and documentation requirements between the various sectors of the behavioral health provider community. That consultation has resulted in a just completed white paper that aims to start to align the various requirements. This paper will be presented through the OHA Behavioral Health Directors Workgroup in the near future.

11.B.2. How does Applicant plan to assess for need and utilization of in-home care services (Behavioral Health services delivered in the member's home) for members?

CPCCO will require all its contracted behavioral health providers, both agencies with a certificate of approval and individuals in private or small group practices, to evaluate each individual member's need for location of services, including in-home services. To ensure that providers can accommodate members who need in-home services, CPCCO will pay an enhanced rate for services provided outside of the provider office to account for travel time. Expanding CPCCO's and provider capacity to provide in home use of telemedicine will make the provision of home-based visits far easier to provide. CPCCO will work with the CMHPs to evaluate and select the cell phone based telemedicine platform that best meets the needs of the region.

CPCCO will review claims data routinely to understand volume of services provided in and out of the provider office to ensure that community-based services, including in-home services, are available and being provided. CPCCO will also review member grievances and complaints to ensure that availability of and access to in-home care is not being identified as a potential area of concern.

11.B.3. Please describe Applicant's process for discharge planning, noting that discharge planning begins at the beginning of an Episode of Care and must be included in the care plan. Discharge Planning involves the transition of a patient's care from one level of care to the next or Episode of Care. Treatment team and the patient and/or the patient's representative participate in discharge planning activities.

CPCCO has multiple methods of ensuring and participating in discharge planning, based on the level of care the member is currently receiving or needing to access. Multi-disciplinary teams are employed throughout the system to make sure that there is a broad approach to ensuring care plans are shared, as appropriate, and that families may access the care and services they need without barriers. Care coordination staff in programs like Choice, Wraparound and ICC help to facilitate

communication between members, their support systems other community-based partners and clinical care providers.

In higher levels of care, in which CPCCO is engaged in authorization or concurrent review, CPCCO's Utilization Management (UM) staff will ensure that the discharge planning process commences at the beginning of the treatment episode. UM staff will partner with CPCCO's Regional Care Team (RCT) staff to ensure treatment recommendations are understood by the member and provider, and that the member has a smooth transition to the next level of care or treatment provider. CPCCO's RCT staff meet weekly with care coordinators from the county's PCPCH network and CMHPs to discuss discharges from acute care settings, particularly for those members who may qualify for Choice or Wraparound, or those who are transitioning from long term care, the Oregon State Hospital or other residential facilities. The intent of this meeting is to ensure that discharges are evaluated holistically from physical and behavioral health perspectives to ensure a smooth transition back to community-based supports.

In lower levels of care, CPCCO will hold providers responsible for their role in discharge planning through the Provider Agreement. CPCCO will evaluate adherence to this requirement during the compliance monitoring reviews. When a systems gap or issue is identified, CPCCO will work with its provider community to develop a solution. CPCCO convenes the clinical managers of each of the CMHPs and PCPCHs on a monthly basis to focus on process improvements within the county. At this meeting PCPCHs speak directly to the local CMHPs about any access or discharge issues related to lower levels of care. This enables CPCCO to identify areas for technical assistance in a timely manner.

11.B.4. Please describe Applicant's plan to coordinate Behavioral Health care for Fully Dual Eligible members with Medicare providers and Medicare plans, including ensuring proper billing for Medicare covered services and addressing barriers to Fully Dual Eligibles accessing OHP Covered Services.

CPCCO's primary objective is to ensure members with both Medicare and Medicaid get the behavioral health services they need. CPCCO's parent company, CareOregon, has a Medicare Advantage (MA) Dual Special Needs Plan (D-SNP) designed to meet the needs of those who are dually eligible. CareOregon's D-SNP covers two-thirds of the CPCCO service area and will provide seamless, integrated care and billing for CPCCO's dually eligible members. This allows providers to bill one entity for the majority of dually eligible members in our area. For those who are not enrolled in CareOregon's Medicare Advantage plan, we will work with our contracted providers to first bill Medicare for those services covered by Medicare. CPCCO will ensure secondary payments meet the full Medicaid rates, when those are higher than Medicare. If the service is not a covered benefit under Medicare, then providers will bill CPCCO as the secondary payer.

CPCCO's Regional Care Team works across all of CareOregon's lines of business, so they are particularly well-suited and trained to understand the specific needs of those who are dually eligible – regardless of whether those members are enrolled in CareOregon's D-SNP MA plan, or if those members are on traditional Medicare or are enrolled with another MA plan. CPCCO also works closely with the CMHPs, the main providers for Medicare-eligible individuals, to ensure continuity for members who gain and lose secondary OHP eligibility

Finally, once we are aware of which Medicare plans may offer MA options to CPCCO members in the region, we will reach out to develop coordination plans, as appropriate, to ensure that the

coverage is not bifurcated and so that the member understands how, when and where to utilize each part of his/her benefit.

11.C. MOU with Community Mental Health Program (CMHP) (recommended page limit 6 pages)
Applicant will enter a MOU with Local Mental Health Authority that will be enforced and honored. Improved health outcomes and increased access to services through coordination of safety net services and Medicaid services.

In the CPCCO region, the counties retain the LMHA status. CPCCO has current MOUs with each county. In addition, local CMHPs will be contracted providers in each county; that relationship entails a detailed agreement of mutual expectations and responsibilities.

11.C.1 Describe how the applicant plans to develop a comprehensive behavioral health plan for applicant's service area. Please include dates, milestones and community partners.

CPCCO, as per OAR 410-141-3145 and in compliance with ORS 414.627, has been conducting county specific needs assessments and completing a regional health improvement plan. This process has engaged key stakeholders and community partners in the three counties of the CPCCO service area including the LMHAs and the CMHPs. The needs assessment found that Clatsop, Columbia and Tillamook counties are designated as Mental Health Care Shortage Areas for the entire population and that at least one out of every four CPCCO members has a mental health or substance use condition, with numbers being significantly higher in Tillamook County for both children and adults.

To address the strong correlation between adverse childhood experiences and behavioral health diagnosis and the resultant health disparity, CPCCO's 2020-2024 Regional Health Improvement Plan (RHIP)will include the improvement of access to behavioral health services as one of its strategic priority areas. CPCCO has provided leadership for a regional collaboration and partnership to develop and implement the RHIP, and participants in the regional collaboration signed a Letter of Agreement stating their intent to share process, data, evaluation and results of the goals, milestones and progress towards meeting the goals related to improving access to behavioral health services in the region. This includes the development of a quarterly dashboard that is shared publicly by all the participants in the regional collaborative over the length of the five-year regional health improvement plan.

The current regional partnership includes but will not be limited to: county public health departments in all three counties, two hospitals, and two CMHPs. As CPCCO integrates the behavioral health plan benefit from June 2019 forward we will incorporate the strategies and activities of the regional health improvement plan into our contracting with LMHA and CMHPs.

Increase Investments Across Sectors		
Dates	Milestones	Community Partners
By 2023, leverage CPCCO investments in SDOH with funds from the RHIP partners, to achieve at least an additional 25% in braided funding in SDOH.	• Increased engagement in the trauma informed network currently being developed. • Increased utilization and support for traditional health workers in the region • Increased access to coordinated services that address the social determinants of health from behavioral health and primary care providers • Increased integration of behavioral health into the primary care setting	• Local Mental Health Authority • Community Behavioral Health Providers • Social Safety Net Providers • Primary Care Clinics • Public Health Departments • Hospitals

Build Stronger Relationships Across Sectors		
Dates	Milestones	Community Partners
By 2022, there are measurable improvements in the number of people accessing behavioral health care supports and services.	• Increase in the types of traditional health care providers • Increase in the penetration rate for behavioral health care services in the region	• Local Mental Health Authority • Primary Care Clinics • Social Safety Net Service Providers • Hospitals
By 2022, formal agreements for referral and coordination process, programs and metrics are in place connecting clinical and safety net providers.	Increase coordination of care between clinical and social safety net providers	• Local Mental Health Authority • Community Behavioral Health Providers • Primary Care Clinics • Social Safety Net Service Providers • Hospitals • Public Health Departments

Align Goals Across Sectors		
Dates	Milestones	Community Partners
By 2022, in the CPCCO service region, agreements to support shared investment in tobacco, substance use and suicide prevention are developed and implemented	• Agreements developed regarding shared prevention activities • Strategic plan developed for shared prevention activities • Strategic plan implemented across sectors	• Local Mental Health Authority • Community Behavioral Health Provider • Public Health Departments • Hospitals

Define, Measure, Improve Health Equity Across Sectors		
Dates	Milestones	Community Partners
By 2023, CPCCO reduces health disparities by building culturally-responsive networks and services within and across our communities using data to identify health disparities and on-going evaluation practices to measure progress towards goals.	• Health equity and diversity disparities defined • Agreements developed regarding strategic activities to improve networks and services • Dashboard and strategic plan developed to track and measure progress implemented • Progress towards goals shared with partners and public • Increased integrated care available improving access to mental health and substance use disorder treatment modalities that are culturally specific and includes integration between clinical and community supports	• Local Mental Health Authority • Community Behavioral Health Providers • Primary Care Providers • Hospitals • Public Health Departments • Social Safety Net Providers • Dental Health Providers • Child Welfare

11.C.2. Describe how Applicant plans to collaborate and coordinate with the Local Mental Health Authority in the development of the CHP. Please include dates and milestones.

CPCCO, as per OAR 430.630 and OAR 414.627, has collaborated with the local mental health authorities (Columbia, Clatsop and Tillamook Counties) to develop, distribute, and collect the needs

assessment survey which asked participants to share their experiences of health and well-being, including their vision of an improved future state. These experiences combined with epidemiological/population health data created a framework for a shared decision-making process for the community partners and CPCCO's Regional Advisory Council to create the priority areas of the RHIP and an agreement to implement a shared five-year regional plan for 2020 through 2024. The LMHAs are included as community partners in all aspects of the process. The following timeline gives dates and milestones.

2018-2019	Goal	Action
Jan-April 2018	Proposal developed	CPCCO Board approved project and budget
April-June 2018	Community partners invited to shared health assessment and improvement plan process for the region	Training held by OHA Transformation Center. Letter of Agreement proposed by CPCCO
June- August 2018	Begin development of narrative survey instrument	Participatory Action model utilized to develop survey instrument/narrative story collection process
August- November 2018	Survey/ story collection	Narratives collected at hospitals, behavioral health providers, dental providers, local safety net providers, primary care offices and on-line.
November-December 2018	Results analyzed and themed. Community presentations developed	Workshop held with regional stakeholders to review and discuss narrative results and to theme for areas of community needs and ideas of future state of supports and services.
January – March 2019	Community presentations of primary and secondary data/results. Participants vote on areas of priority	Results analyzed and reported to CPCCO Board, Advisory Councils, and regional partners
March- June 2019	Choosing priority areas of focus for 2020-2024 in the region.	Regional Advisory Council and Community Partner Workgroup choose areas of priority focus for 2020-2024 Regional Health Improvement Plan
June – December 2019	Completed Regional Health Improvement Plan submitted to Oregon Health Authority	Promotion of plan and associated investment supports to implement the RHIP regionally completed
January 2020 through December 2024	Quarterly tracking/dashboard, evaluation and reporting of progress towards RHIP goals and objectives begins	Social safety net, behavioral health and health care providers begin process of creating formal agreements to coordinate services and activities associated with the Regional Health Improvement Plan

11.C.3. Describe how Applicant plans to collaborate and coordinate with the Local Mental Health Authority in the development of the local plan. Please include dates and milestones.

As stated in 11.C.2, LMHA partners in the region were invited to participate and did participate in each component of the above timeline by attending trainings, hosting survey collection sites, promoting and sharing results, creating priority areas, signing of letters of agreement, and creating goals specific to the priority area of improving access to behavioral health care in the region. They will participate in the ongoing activities and reporting of results of the work in the region over the next five years to address the goals and objectives of the RHIP.

11.C.4. Does Applicant expect any challenges or barriers to executing the written plan or MOU extension with the Local Mental Health Authority? If yes, please describe.

CPCCO does not anticipate any difficulties with renewing the MOU. Currently CPCCO is working to administer the behavioral health benefit with CareOregon rather than with an external delegate with an expected completion of the contract change by June 1, 2019. This will make it easier, in contracting with the local mental health authorities, to incorporate the expectations and opportunities that exist for their organizations related to the development and implementation of the health needs assessment and community health improvement planning efforts.

11.D. Provision of Covered Services (recommended page limit 6 pages)
Applicant must monitor its Provider Network to ensure mental health parity for their members.
11.D.1. Please provide a report on the Behavioral Health needs in Applicant's Service Area.
CPCCO tracks penetration of both mental health and substance use disorder treatment services as a proxy to identify the gap between people with a behavioral health disorder and those accessing care. The table below demonstrates an unmet need for both mental health and substance use disorder treatment, which is significantly pronounced in the area of substance use disorders. Our target penetration rate for substance use disorders is 10-12%, and this table shows that we have a provider capacity gap of about 1200 members. For mental health services, our target penetration rate is 17%.

YEAR	Unique members served in Specialty MH Services	Unique members served in Specialty SUD Services
2016	3,057 (11.7%)	1065 (4.1%)
2017	3,256 (13.1%)	1132 (4.6%)
2018	3,413 (13.6)	1198 (4.8%)

In summer of 2019, after the management of the behavioral health benefit transitions to CareOregon, CPCCO will begin tracking mental health penetration by age and ethnicity. The plan is to include this as an area of focus for expanding capacity of specialized services, both in the specialty mental health system and within primary care and other community settings such as the Head Start and the schools. CPCCO has funded a Family Resource Coordinator to address multiple complex needs of high-risk kids and their families in the Tillamook School District. We anticipate that expanding the role of THWs and peers will significantly strengthen our outreach and engagement capacity, thus increasing our penetration rates. We will continue to look for opportunities to expand services in collaboration with community partners.

In 2020, we will also be developing a dashboard to show movement through the SUD treatment system, such as readmission rates to residential and withdrawal management services, as well as our rate of outpatient follow up post-discharge.

11.D.2. Please provide an analysis of the capacity of Applicant's workforce to provide needed services that will lead to better health, based on existing Behavioral Health needs of the population in Applicant's Service Area.
CPCCO uses several different approaches to assess capacity of the behavioral health workforce. One is the penetration rate, detailed above. However, it is also important that our provider network has capacity to engage and retain members in treatment, not just the initial intake/assessment. To that end, we track and report on initiation, engagement and retention in treatment, by provider. Currently we have this data for mental health treatment, and we are in the process of building this report for substance use disorder treatment to share with the network.

CPCCO defines engagement as having a second appointment within 15 days of the assessment and retention as having three (3) follow up visits within 45 days of the assessment. The target is not

100% because some members will not need follow up services, however this is still an opportunity to monitor trends in network capacity. In 2018, our average rate of engagement in treatment was 52% and the average rate of retention was 30%. We know that when there is not adequate workforce, second and third appointments are often pushed out for several weeks after the initial intake and this leads to a higher likelihood that the member does not return and complete a care plan.

We are actively working with the network to set improvement targets and identify opportunities for assistance and quality improvement initiatives, both overall and by provider. These targets will need to be calibrated; for example, some providers are closer to 100% due to having a smaller panel size. The metric also shows the impact of provider turnover and vacancies, which provides direction for focusing our workforce development efforts.

In addition to assessment, engagement and retention, we use the total number of providers serving our members as another data point to assess capacity.

11.D.3. How does Applicant plan to work with Applicant's local communities and local and state educational resources to develop an action plan to ensure the workforce is prepared to provide Behavioral Health services to Applicant's members?

CPCCO will continue its efforts to coordinate with the full array of stakeholders who work on behavioral health workforce issues. This area of focus includes increasing coordination and advocacy with OHA officials to streamline and clarify credentialing and training requirements among the emerging sectors of the work force including behavioral health consultants, peer mentors, recovery peer mentors and traditional health workers with special focus on behavioral health.

CPCCO will coordinate with all elements of the local provider system including local hospitals, primary care partners, and social service partners in order maximize training and recruitment efforts. We also will continue to directly provide a variety of trainings to upskill current workforce. All current providers will be supported in their efforts to provide field work and internship opportunities for students and prospective workers. Further, we will support training opportunities for traditional health workers and peers. CPCCO will also continue coordination with educational institutions, particularly community colleges and high school vocational programs, with a goal of developing more training opportunities for people interested in working in rural areas.

11.D.4. What is Applicant's strategy to ensure workforce capacity meets the needs of Applicant's members and Potential members?

CPCCO is committed to maintaining sufficient workforce capacity through a variety of approaches carried out in partnership with our provider network and community stakeholders. Recognizing that there is a long-standing challenge in keeping qualified staff in the community behavioral health system of care, CPCCO employs several interventions to mitigate this risk and ensure both capacity and quality of treatment for our members. We will:

- Work with providers to become qualified sites for federal and state loan payback programs.
- Provide consultation by national experts to help providers increase productivity and reduce no-shows to maximize capacity with current staffing resources.
- Provide 21 hours of training in assessment, service planning, and documentation to increase the skills of the current workforce.

- Pay for services provided by registered interns to ensure both training of new workforce and expanded capacity.
- Provide additional training opportunities for staff such as learning collaboratives, stipends to attend ECHO learning sessions, etc.
- Pay rates that are higher than the state fee schedule to assist providers to pay wages that support retention, with a commitment to evaluate opportunities to increase rates over time.

CPCCO also developed its own provider recruitment and retention program for clinics to offer partial loan repayments to providers unable to receive such supports from state or federal programs. Each eligible provider could receive up to $5,000/year for up to four years.

11.D.5. What strategies does Applicant plan to use to support the workforce pipeline in Applicant's area?
Continuing education and support activities are key to retaining current staff. Behavioral health learning collaboratives have been started to support those currently working in the field. These include collaboratives supported by CPCCO staff, access to Project Echo modules, and use of online resources like My Strength. Letters of agreement with local CMHP's will include joint initiatives to support local workforce development. To support workforce expansion, CPCCO will provide training opportunities, field work support, and opportunity information to all local residents who are or may be interested in working in the field.

CPCCO also intends to work with the largest providers of mental health and substance use disorder treatment services to adjust payment and rates so that they more accurately reflect and support the cost of the workforce. By integrating the behavioral health benefit during 2019, CPCCO has much more control over the payment rates and methodologies.

11.D.6. How will Applicant utilize the data required to be collected and reported about members with SPMI to improve the quality of services and outcomes for this population? What other data and processes will Applicant collect and utilize for this purpose?
CPCCO is excited to develop monthly and quarterly reporting for our SPMI member population to enhance the quality of needed services. Several key areas we will focus on in 2020 and beyond include:

- Review the number of members with SPMI who need housing supports when leaving emergency department and inpatient units. This data will inform the community conversation on investment in housing resources. CPCCO will work directly with our providers and the local housing authorities to create targeted housing where gaps are identified.
- Review data on readmission to EDs, inpatient units, Oregon State Hospital and jail within 30 and 180 days of discharge from Oregon State Hospital. This data will inform quality improvement in care planning for this population. We will do quantitative reviews to understand what led to readmissions, such as system gaps, lack of timely access, lack of guardianship, etc., to develop targeted system improvements.
- CPCCO is already reviewing data on members who readmit to psychiatric inpatient care to understand system trends and will continue to enhance this analysis. Early trends indicate lack of guardianship when needed, discontinuation of prescribed medications, and lack of housing stability as driving factors of readmission.
- Deploy PROMIS across the behavioral health provider community to have standardized functional assessment data.

CPCCO is also tracking the number of members with SPMI who would benefit from Electro Convulsive Therapy (ECT) or Ketamine to inform the capacity need for these services. Currently the only place for our members to receive ECT is in Portland, however we know that access to this service would likely reduce the number of admissions and readmissions to both acute care and the state hospital.

11.D.7. What Outreach and/or collaboration has Applicant conducted with Tribes and/or other Indian Health Care Providers in Applicant's Service Area to establish plans for coordination of care, coordination of access to services (including crisis services), and coordination of patient release?

For several years, CPCCO has actively built our partnership with the Tribes of Oregon, their Tribal clinics, and the NARA Urban Indian Center to improve and expand Tribal members' ability to access providers and healthcare services. In support of that partnership, we have ongoing training to expand our cultural understanding and competency, have met with Tribal clinic staff and learned about their facilities in person, and have ongoing discussion and feedback about the needs of Tribal members and their unique experience of barriers to care.

Further, through our care coordination and work in improving access to services, we have worked to improve the specific care that Tribal members experience. Throughout the state and in the CPCCO service area, our organization has worked in partnership with Tribal entities in specific cases to assist a member in finding success in their behavioral health care. We have partnered with Tribal clinics to find new avenues of access for key services such as neuropsychological assessments. We will continue to work to identify providers who can understand and respond to the cultural needs of Tribal members. When appropriate, we give feedback to service providers on the needs of the Tribal population. Our goal is not only to resolve the barriers of the moment, but also to seek ways to reduce systemic barriers for the future.

Our experience with crisis services and patient release frequently involves coordination with multiple entities beyond the member's immediate geographical area. When we have assisted in a member's return to the community, we consider the member's individual situation and work to develop plans that meet the member's complete needs. This can, and has, involved identifying and securing appropriate providers for continuity of care. We also consider the member's needs beyond behavioral health services to identify services that may improve their success. This work includes close integration with the responsible CMHP in local communities. We help the member identify and implement additional changes and services that address factors such as physical health, substance use, access to food and shelter, and reconnecting to their culture.

We also contract with all the residential SUD providers across the state to ensure there are no barriers to access if the local resources are not available.

CPCCO will also routinely evaluate payment models and rates to look for opportunities to increase rates as a strategy to reduce turnover and retain qualified staff of cultures representing our membership.

11. E. 1. b. How will Applicant provide culturally responsive and linguistically appropriate alcohol, tobacco, and other drug abuse prevention and education services that reduce Substance Use Disorders risk to members?

CPCCO partners closely with local public health to support prevention efforts related to SUD. This has also been a priority of the CPCCO RHIP. CPCCO plans to identify culturally specific programs

in the state to add to our network of resources for our members. We will provide all prevention materials in Spanish and other languages as needed. Education meetings that we support or are part of our network with offer the use of simultaneous interpretation as requested.

CPCCO is evaluating the current state of culturally responsive and linguistically appropriate services in our region for all health services – dental, substance use disorder (SUD), Behavioral Health (BH), and physical. Specifically, with BH and SUD services we are meeting with leadership of our Community Mental Health Programs (CMHPs) to understand how services are currently provided, areas where CMHPs need support, and opportunities for improvement and training. After this assessment, we will begin working on an improvement plan. Based on our current draft assessment, we imagine this will include the following work:

- **Provider Education**
  - Done in tandem with our interpretation vendor to reinforce best practices.
  - Offered through web-based CME accredited vendor. The first course will offer an initial base in person centered care, followed by specific courses for SUD and Behavioral Health.
- **Member Education**
  - Ensure that members know their rights to meaningful language access – including a FREE interpreter.
  - Use OHA preferred language access cards to help members advocate for themselves.
  - *OHP and You* training in Spanish, our largest LEP language with a special section for SUD and Behavioral Health.
- **Ensure Language Access across our network**
  - Expand the number of in person interpreters available in the network as we believe this provides the best care for patients.
  - Commitment to translate all documents into our membership's primary languages. If a language is spoken by 10% or more of our population, our standard to translate documents into that language

11.E.1.c. How will Applicant inform members, in a culturally responsive and linguistically appropriate manner, of SUD services, which will include outpatient, intensive outpatient, residential, detoxification and MAT services?

One of CPCCO's regional goals for 2019-2020 is to identify, publish, and maintain a list of currently available MAT and addiction services in the CPCCO region. Our goal for now through Jan 2020 is to collect and publish this information. Moving into 2020 and beyond, we will work with our clinical partners to make sure that the information is updated in real time and is translated into Spanish. As we develop patient education on SUD services, we will ensure documents are translated by a qualified translation vendor and then proofread by three (3) native speakers. Our 3 to 5-year goal is to evolve this into a real-time triage line that can actively respond to the SUD and mental health needs of members as well as providers. In the triage line, when patients or providers call asking for SUD and mental health services, they will be able to speak to a person, in their language, in a trauma-informed manner, and get connected with open beds, or learn where open capacity is for treatment. In addition, we are focused on addressing the stigma related to substance use disorder. This will be both a focus of our 4th Annual SUD Summit in October 2019 and a goal of our overall regional SUD strategy through the next five years. This will help the region to respond to SUD in a culturally appropriate, trauma-informed manner.

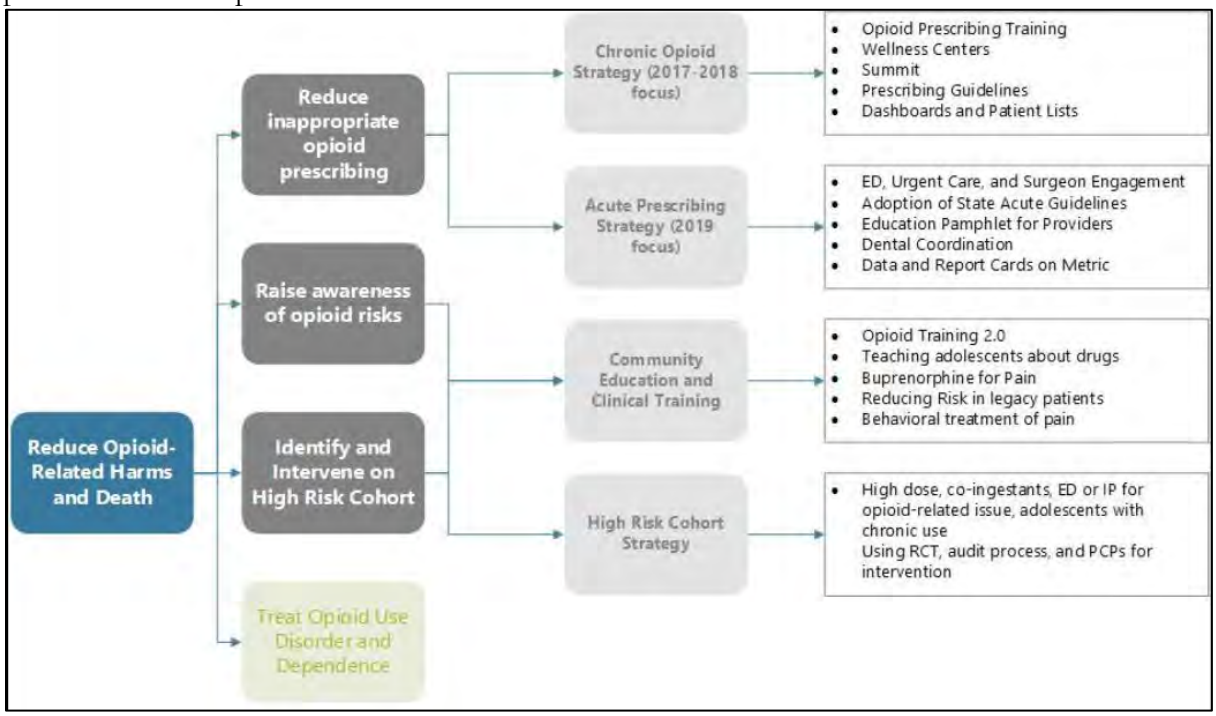
11. E. 1. d. In collaboration with local providers and CMHPs, ensure that adequate workforce, Provider capacity, and recovery support services exist in Applicant's Service Area for individuals and families in need of opioid use disorder treatment and recovery services. This includes: sufficient up to date training of contracted Providers on the PDMP, prescribing guidelines, buprenorphine waiver eligibility, overdose reversal, and accurate data reporting on utilization and capacity.

CPCCO has been a statewide leader in developing, implementing and spreading effective strategies to address opioid prescribing and opioid use disorder. Addressing opioid prescribing and addictions has been a primary focus of CPCCO since 2013. CPCCO's medical director serves on the

Governor's Opioid Task Force, and the state-wide opioid taper guidelines task force. CPCCO has been a recipient of OHA grant funds to help support their work given a recognition of their leadership in this arena.

CPCCO uses its Clinical Advisory Panel (CAP) to drive the collective vision and strategy for substance use treatment and a recovery-oriented system of care. The vision statement approved by the CAP is "Develop a local, trauma-informed network for all substance use disorders that ensures timely equitable access, reduces stigma, and supports extensive cross organizational coordination with a long-term system of recovery support." Each of CPCCO's three counties has a multi-organizational group of leaders both setting and acting on a local substance use disorder strategy. These workplans will be reviewed on a quarterly basis at the CAP.

CPCCO has a comprehensive strategy related to appropriate opioid prescribing as well as OUD, with the ultimate goal of reducing harm and deaths related to opioids. This driver diagram reflects our work across the overarching broad strategy in partnership with our clinical and community partners as well as public health.



Clinical Prescribing Guidelines: CPCCO's CAP created and adopted regional opioid prescribing guidelines for chronic pain in 2016. The CAP also recently voted to adopt the Oregon acute prescribing guidelines in March 2019. CPCCO's Medical Director and clinical pharmacist directly conducted clinical prescribing trainings for every clinical partner organization in 2016 and 2017. This training provided an overview of prescribing guidelines, tapering, difficult conversations, and pathophysiology of pain. CAP members also are important conduits for best practices spread across our network and clinical partners in all three service areas.

PDMP: We implemented trainings on PDMP utilization and facilitated prescribers and their delegates to sign up through a state grant that CPCCO was awarded. We have incorporated PDMP guidelines into clinical trainings on chronic pain management and best practices regarding opioid

prescribing and tapering; these trainings were given in every clinic and hospital system. We have seen an increase in PDMP adoption in our region.

Data and Dashboard: CPCCO has developed and created dashboards to track opioid prescribing. These data are shared with organizations to help them track opioid prescribing. We also share member lists so organizations can take action on developing plans to address inappropriate, unsafe prescribing. CPCCO uses our Clinical Advisory Panel to set and monitor targets.

Opioid Prescribing Dashboard Sample-February 2019

Feb 2019															Feb 2019						
Q4 2018	CPCCO TOTAL	Chronic Opioid Use - Quarterly Tracking													Q4 2018	CPCCO TOTAL	Chronic Opioid Use - Clinic Breakdown				
		Q1 (2016)	Q2 (2016)	Q3 (2016)	Q4 (2016)	Q1 (2017)	Q2 (2017)	Q3 (2017)	Q4 (2017)	Q1	Q2	Q3	Q4	Trend			Overall	Bay Ocean	Manzanita	Pacific City	Tillamook
# of Members w/ Chronic Opioid (Any MED)	510	98	75	92	86	79	83	90	95	104	105	98	103		# of Members w/ Chronic Opioid (Any MED)	510	103	25	5	26	47
Assigned Members w/ Chronic Opioid (Any MED) per 1,000 Members	19.6	45.0	31.9	39.5	36.3	34.2	37.2	38.1	41.0	39.0	37.5	34.9	36.6		Assigned Members w/ Chronic Opioid (Any MED) per	19.6	36.6	24.8	15.1	48.1	50.2
# at MED ≥ 50	142	31	32	40	38	33	26	29	29	34	30	25	24		# at MED ≥ 50	142	24	5	1	5	13
Assigned Members at MED ≥ 50 per 1,000 Members	5.5	14.0	13.6	17.2	16.0	14.3	11.7	12.3	12.5	12.8	10.7	8.9	8.5		Assigned Members at MED ≥ 50 per 1,000 Members	5.5	8.5	5.0	3.0	9.3	13.9
# at MED ≥ 90	68	15	15	20	17	17	10	12	11	12	11	13	10		# at MED ≥ 90	68	10	0	1	2	7
Assigned Members at MED ≥ 90 per 1,000 Members	2.6	7.0	6.4	8.6	7.2	7.3	4.5	5.1	4.7	4.5	3.9	4.6	3.5		Assigned Members at MED ≥ 90 per 1,000 Members	2.6	3.5	0.0	3.0	3.7	7.5
# at MED ≥ 120	42	12	10	14	12	9	7	7	6	9	6	7	6		# at MED ≥ 120	42	6	0	1	1	4
Assigned Members at MED ≥ 120 per 1,000 members	1.6	6.0	4.2	6.0	5.1	3.9	3.1	3.0	2.6	3.4	2.1	2.5	2.1		Assigned Members at MED ≥ 120 per 1,000 members	1.6	2.1	0.0	3.0	1.9	4.3
# with BZDs + Opioids (Any MED)1	100	7	8	19	22	19	21	25	24	24	29	34	32		# with BZDs + Opioids (Any MED)1	100	32	7	2	6	17
Assigned Members w/ BZDs AND Opioids1 per 1,000 Members	3.8	3.0	3.4	8.2	9.3	8.2	9.4	10.6	10.3	9.0	10.4	12.1	11.4		Assigned Members w/ BZDs AND Opioids1 per 1,000 Members	3.8	11.4	6.9	6.0	11.1	18.1

Chronic opioid use is defined by the 3 month average of a member's daily MED and excludes members with terminal cancer The MED calculations are based on the Washington State Agency Medical Directors' Group MED calculator.

Footnote 1 - Starting in Q3 2016, benzodiazepines (BZDs) are benefits paid by both physical and mental health are included. Previously the BZD + opioids flagged here did not include those paid by mental health and thus only represented a fraction of the total BZDs prescribed to CPCCO members.

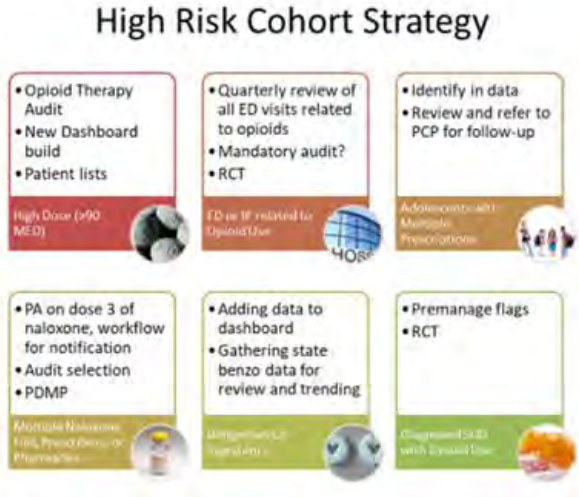
Chronic opioid use is defined by the 3 month average of a member's daily MED and excludes members with terminal cancer The MED calculations are based on the Washington State Agency Medical Directors' Group MED calculator.

Footnote 1 - Starting in Q3 2016, benzodiazepines (BZDs) are benefits paid by both physical and mental health are included. Previously the BZD + opioids flagged here did not include those paid by mental health and thus only represented a fraction of the total BZDs prescribed to CPCCO members.

Community Education: CPCCO has funded a community education campaign regarding pill disposal, as well as chronic pain treatment. We also hold an annual community summit in Seaside to help bring community members together to share in learning and the development of innovative solutions to a complex problem.

High Risk Cohort: To address our highest risk patients and prescribers, we have developed a High-Risk Cohort strategy focusing on six elements:

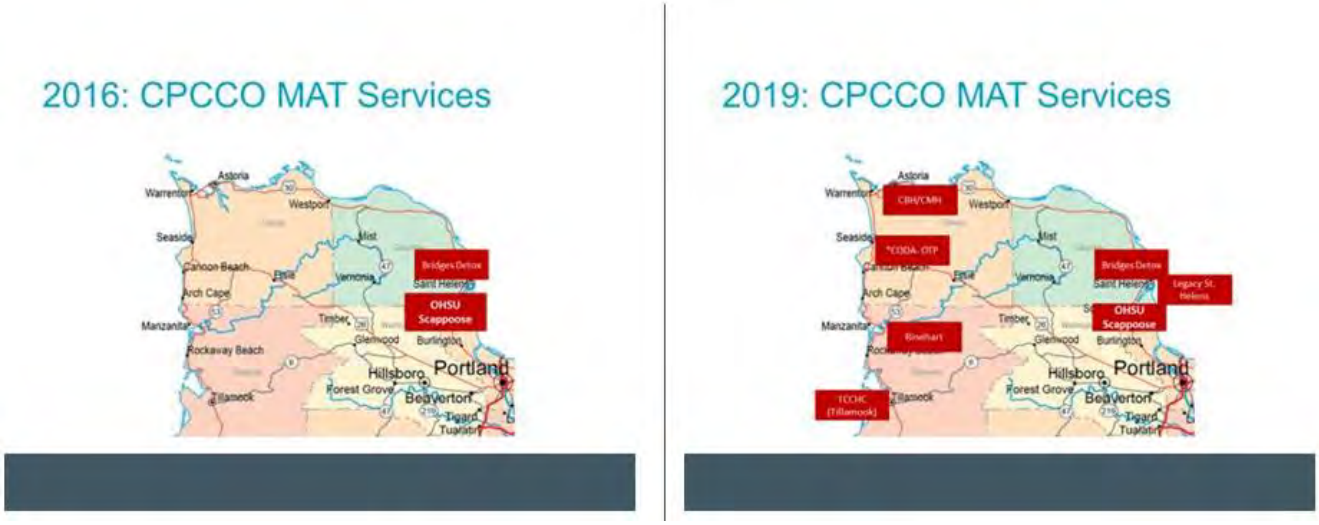
1) High Dose (>90 MED)
2) ED or Inpatient stay related to Opioid Use
3) Adolescents with Multiple Prescriptions
4) Multiple Naloxone Fills, Prescribers or Pharmacies
5) Dangerous Co-Ingredients
6) Diagnosed with SUD with Opioid Use



Audit: We are working with our CAP to develop a task force to focus on strategies related to our highest risk members. We have developed an audit tool and will send this to medical directors and prescribers who are prescribing to patients at high risk. The task force will prioritize developing a real-time overdose response strategy using PreManage data, and our RCT care coordination team as well as local physical and behavioral health clinics. They will help to decide if regionally the audit will become mandatory for as an overdose response intervention.

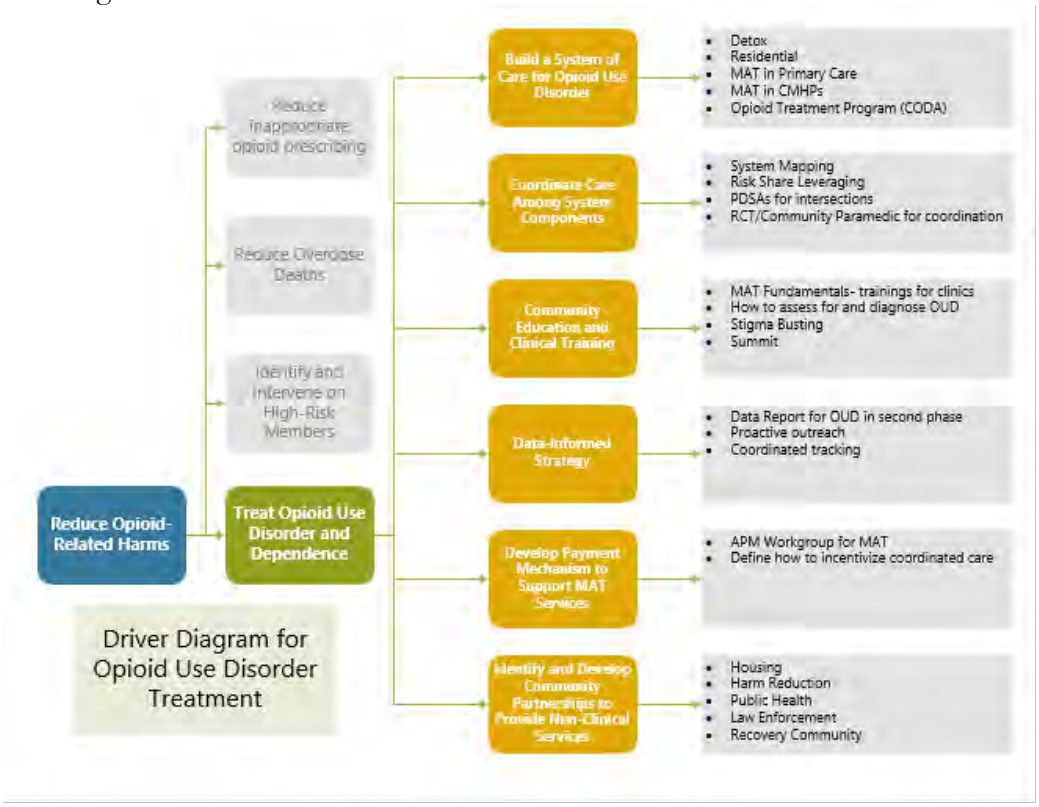
Increasing Access to Naloxone: We have given naloxone co-prescribing trainings at every one of our primary care clinics, regularly pull data regarding naloxone prescribing rates and are developing a comprehensive overdose response strategy within our region that includes emergency response personnel and law enforcement, EDs, community paramedics, CMHPs, and MAT programs including CODA.

Regional MAT Services: CPCCO has partnered with our local provider organizations to build local MAT programs over the last few years. We have funded large grants to expand MAT services at OHSU Scappoose and were awarded a SAMSHA grant to fund MAT services in our region. We have funded and facilitated partnerships with the CMHP and primary care in Clatsop County to start MAT services, as well as two primary care organizations in Tillamook County. We also are funding the startup of a CODA opioid treatment program to bring methadone services to the region, which will provide an important higher level of care. CPCCO has also funded and started a detox and residential center in 2015 in Columbia County. Prior to 2017, only one clinic in Columbia County provided MAT services, currently there is at least one in each county. Throughout this time, we have funded buprenorphine waiver training, as well as technical assistance to help organizations develop MAT programs. Our Innovation Specialist staff provide technical assistance and training through on-site coaching and learning collaboratives.



Recovery Support Systems: CPCCO is working to build a more inclusive recovery support community within the region for patients using MAT by supporting services such as housing for members using MAT and developing a Medication Assisted Recovery Anonymous (MARA) group, a 12-step group for members using medications in their recovery.

Population Data:
CPCCO has identified members with an OUD and whether they are receiving medication assisted treatment. This is used to ensure that members who are not engaged can receive outreach from their primary care provider or our regional care team (care coordination) to determine readiness for initiating treatment.



11. E. 1. e. Coordinate with Providers to have as many eligible Providers as possible be DATA Waived so they can prescribe MAT drugs.
CPCCO will support several venues for providers to learn about the DATA waiver process and will continue to sponsor DATA waiver trainings. CPCCO will host at least one DATA waiver training in 2019, with the first scheduled in May 2019 and will provide additional trainings in 2020 and subsequent years, as needed. We include all team members supporting MAT, including pharmacists, to participate in the training. To assess capacity, we are tracking the total number of waivered providers, the amounts on their current waivers, and the number of members for whom they are prescribing MAT drugs.

Since 2016, we have actively partnered with our physical and behavioral health organizations to develop MAT programs. We fundamentally believe that even though an X-waiver (DATA waiver) is required to provide MAT services, having organizational support surrounding the provider is vital to offering the best services available. In our region, some waivered providers are not prescribing due to this lack of organizational support. Given that fact, in addition to funding and supporting waiver trainings, we have also funded organizations to develop appropriate systems, processes and policies to provide comprehensive services for MAT patients. We provide technical assistance in this arena and have facilitated consultation by Synergy, an Oregon based consulting group, to support behavioral health development within MAT programs. We have added a dedicated staff member to

provide organizational TA in primary care to implement MAT programs. Our clinical staff are also faculty in a statewide ECHO program helping organizations improve their MAT programs within primary care. We are continuing to develop and improve on our alternative payment model to give additional dollars to organizations for providing these services. We will continue to support providers to get their X-waiver, but more importantly are supporting organizations in developing the systems necessary to provide effective substance use disorder services in the primary care and specialty behavioral health settings.

11.E.1.f. Coordinate care with local Hospitals, Emergency Departments, law enforcement, EMS, DCOs, certified Peers, housing coordinators, and other local partners to facilitate continuum of care (prevention, treatment, recovery) for individuals and families struggling with opioid use disorder in their Community.

Our opioid and OUD strategy has been broad and inclusive of all community stakeholders since 2013. We created a regional steering committee to address opioid prescribing and SUD in 2016. This body has helped to oversee the work throughout the region and has created multi-disciplinary county-level workgroups that include public health, recovery services, law enforcement, and clinical leaders to move the work forward. In tandem with these partnerships, since 2015 CPCCO has convened an Annual Opioid Summit that brings together stakeholders from the entire continuum of care in a shared forum for addressing opioid disorder. This summit produces invaluable partnerships that might otherwise take years to develop; for instance, we have partnered with law enforcement and EMS to encourage them to carry naloxone and provide assistance in getting grant-funding and training for equipping multiple agencies with rescue kits. We continue to use this Annual Opioid Summit as an ongoing forum for relationship-building to advance the continuum of care for individuals and families struggling with opioid use disorder in their communities.

Other strategies we are deploying include:

- **Dental Prescribing Strategy.** CPCCO is partnering with the DCOs to address acute opioid prescribing and have developed the first opioid prescribing dashboard exclusively for dental providers.
- **Traditional Health Workforce & Peers.** We have created a strategy for developing a traditional health worker network to include peers and engagement specialists to help with outreach and engagement in OUD treatment. In Clatsop County, we currently have two peer outreach specialists who work in the community as a part of the collaborative CMHP/Primary Care MAT program we helped develop in 2018. We are currently developing a strategy to address housing for patients on MAT and are creating a grant funding opportunity specifically for community partners to expand these much-needed services in our community.
- **MARA.** As previously mentioned, we are also exploring creating a Medication Assisted Recovery Anonymous (MARA) group to develop an inclusive recovery community that does not stigmatize people who choose medications to support their path to recovery.
- **Detox Referral Pathways.** In 2019, our region is focusing on partnerships with EDs and detox centers to develop referral pathways to behavioral health and primary care to improve coordination of treatment services. In 2020, we will start partnering with ED and hospitals to work towards MAT initiation at these higher levels of care and are learning from other CCOs and clinical partners, such as OHSU's IMPACT program, that are currently providing these services.

11. E. 1. g. Additional efforts to address opioid use disorder and dependency shall also include:

- ***Implementation of comprehensive treatment and prevention strategies***
- ***Care coordination and transitions between levels of care, especially from high levels of care such has hospitalization, withdrawal management and residential***
- ***Adherence to Treatment Plans***
- ***Increase rates of identification, initiation and engagement***
- ***Reduction in overdoses and overdose related deaths***
- ***How will Applicant work with OHA, other state agencies***
- ***Fewer readmissions to the same or higher level of care.***

Please see responses to 11.E.1.d, 11.E.1.e, and 11.E.1.f above, as they were responsive to this question.

CPCCO has analyzed its membership with opioid use disorders to assess the level of engagement in any SUD treatment and specifically medication assisted treatment (MAT). CPCCO will be enhancing this report during 2019 to be refreshed monthly and available, within the limits of 42 CFR part 2, to the provider network. This allows primary care providers to have member lists of their assigned patient with an OUD who are not receiving any MAT. Providers will then be given technical assistance to either begin a MAT program or develop referral pathways for those patients to a MAT provider. CPCCO is developing an alternative payment model to support this work in primary care; the model will be available in 2020.

CPCCO's clinical pharmacist works closely with the local Public Health departments to track overdose and overdose related deaths. Information on members who have overdosed will be given to care coordination teams and primary care providers to ensure members receive outreach and a review of their current medication regimen. CPCCO will also track community utilization of naloxone for rescues, and work with our pharmacy benefit management team to ensure low barrier access to naloxone for members.

With the assistance of our CACs, CPCCO will continue efforts in:

- Community education campaigns to address stigma and OUD prevention
- Community resilience building as a method to prevent SUD
- Partnering with local public health agencies to focus on prevention strategies

11.E.2.a. Prioritize Access for Pregnant Women and Children Ages Birth through Five Years (recommended page limit 6 pages) Applicant will prioritize access for pregnant women and children ages birth through five years to health services, developmental services, Early Intervention, targeted supportive services, and Behavioral Health treatment.

a. How will Applicant ensure that periodic social-emotional screening for all children birth through five years is conducted in the primary care setting? What will take place if the screening reveals concerns?

The CCO incentive metric, Developmental Screening in the First 36 Months of Life, ensures our provider partners are proactively screening all children using an approved screening tool, including the Ages and Stages Questionnaire (ASQ-3). We will review clinic progress monthly and provide member gap lists to providers, and in turn, provider teams conduct outreach to ensure all children receive developmental screening. For those children which the screening identifies developmental and behavioral delays, the child and parent(s)/caregiver(s) will receive follow up. Follow up will include referral to and coordination of resources to ensure early receipt of services that help at-risk young children be ready for kindergarten.

CPCCO provided a large grant to community partners for a 24-month project to improve the receipt of services for young children identified at-risk for developmental and behavioral delays. The project supports the development, implementation, and evaluation of improved follow-up after developmental screening (ASQ). The project is being led by Northwest Early Learning Hub (NWELH) with support from the Oregon Pediatric Improvement Project (OPIP). The team: 1) identified current pathways from screening in primary care, to early intervention, mental health or other services in the three CPCCO counties; 2) identified community-level assets and resources that currently exist to support follow-up; and 3) built understanding of where and how children are falling out of pathways and not receiving appropriate services. NWELH and OPIP convened county-level workgroups to help identify priority areas for follow up and early learning resources where improvement was needed.

Based on feedback, community-specific triage referral system maps (pathways) were developed in each county, and additional pathways are currently in the process of being developed. The pathways match the at-risk child and family/caregiver(s) with the most appropriate follow-up providers based on developmental screening risk scores and other child/family factors. Pathways include health care, early intervention (EI), and priority early learning providers identified in the county-level workgroups. A component of the pathways will include secondary referral and support strategies for children found ineligible for the initial services referred to. Referral pathways have built in feedback loops to improve communication and coordination. Primary care clinics participating in the initial two-year project have received on-site training and support, and refinement to improvement tools based on lessons learned and barriers identified. Next steps include finalizing a primary care toolkit, early intervention referral and care coordination methods, and family resources management and care coordination tools for early learning providers. The project will spread best practices and tools that will include (1) the use of CPCCO Innovation Specialist staff to provide clinic training and support and (2) community-based maternal child health focused Community Health Workers (CHWs) trained in the model to support the closed feedback loop communication and coordination, and secondary referral pathways.

11.E.2.b. What screening tool(s) to assess for adverse childhood experiences (ACEs) and trauma will be used? How will Applicant assess for resiliency? How will Applicant evaluate the use of these screenings and their application to developing service and support plans?

Initiative/Screening Tool	Experience to Date	Future Plans
Adverse Childhood Experience (ACE) Screening	CPCCO funded a behavioral health clinician in 2017 to pilot parental ACE screening at Columbia Memorial Hospital women's center. The ACE screens are done during prenatal care and postpartum, with quarterly reports to CPCCO that report the population reach of behavioral health clinician contact with families who received ACE screenings and the percentage of those who receive follow up as needed if ACE level is high and resilience low. We also received evaluations on connection and utilization of services and supports.	• This work will be expanded and replicated with our Providence network partner in 2019. CPCCO funds will support the hiring of behavioral health care management staff focused on ACEs at the Providence PCPCH. • CPCCO will work to identify more clinics appropriate to implement screening tools for parental ACEs.

PMCA Tool		PMCA among OHA/OPIP's pediatric health complexity data will be used to identify adverse childhood experiences among our pediatric membership.
Other Resilience Screening (ASQ-SE)	Many providers screen for resilience and family supports without naming it through the lens of trauma-informed care. CPCCO has funded ongoing assessment of ASQ follow up with OPIP and pathways; screening tools and an implementation toolkit are forthcoming in 2019 to improve on multiple aspects of care.	We will use the training opportunity technical assistance hours around ACEs and Resilience to highlight and build on existing provider screening practices during well-child checks to further promote a trauma informed lens.
Alternative Payment Model (APM)	The 2019 CPCCO pediatric alternative payment model (APM) is focused on incentivizing primary care to participate in: • Developing appropriate screening tools to identify social and medical complexities. • Integrative Behavioral Health target measures include screening for parental ACEs and follow-up (specific focus on ages 0-3 yo).	2019 efforts support a 2020 Pediatric APM focus of demonstrating population-level segmentation and targeted interventions to improve services and supports resulting in the triple aim.

For evaluation, CPCCO will look to partner organizations like the Children's Health Foundation in Portland which have developed ACEs measurements and implementation milestones for their network training that began in 2015. Proposed measurement for service and support plans may include assessing changes in providers' behavior from the parents' perspective via a survey asking if their provider talked with them about ACEs or resilience, and if they learned any new parenting strategies from their provider or care manager.

11.E.2.c. How will Applicant support Providers in screening all (universal screening) pregnant women for Behavioral Health needs, at least once during pregnancy and post-partum?

CPCCO will support clinics in following the American College of Obstetrician and Gynecologists (ACOG)'s recommendation that all obstetrician-gynecologists complete screenings related to mood, emotional well-being, and behavioral health needs, both perinatally and postpartum. To do this, CPCCO will provide a new staff position, Maternal Child Health Innovation Specialist, focused on maternal-child health in the primary care and obstetrics clinical settings. This position will be modeled on the successful Primary Care Innovation Specialist role that CPCCO has had for several years and will provide on-site technical assistance and support to providers. This new position, focused specifically on maternal-child health, will ensure that (a) screenings related to mood, emotional well-being, and behavioral health are implemented and use validated tools and (b) follow-up for behavioral health needs will be developed and supported by either on-site services from a co-located behavioral health consultant or services provided by specialty mental health providers. CPCCO will be assessing funding models to support co-located specialty mental health in primary care starting in 2020.

11.E 2.d. How will Applicant ensure that clinical staff providing post-partum care is prepared to refer patients to appropriate Behavioral Health resources when indicated and that systems are in place to ensure follow-up for diagnosis and treatment?

As described above, CPCCO is implementing a newly developed Maternal Child Health Innovation Specialist position. This staff person will focus on the integration of behavioral health and maternal child health in primary care and OB clinical settings. Part of the specialist's work will be to assist clinics to implement workflows that support behavioral health resources for follow-up needs (diagnosis and treatment); priority will be placed on postpartum care and screenings.

To ensure providers are prepared to refer patients and to follow up for diagnosis and treatment, CPCCO is developing an obstetrics alternative payment model to support clinics that offer integrated behavioral health and specialty behavioral health. CPCCO is considering a value-based payment model to incentivize a metric for postpartum care screenings and follow-up/interventions. Further, current and future primary care alternative payment models include integrated behavioral health to improve timely access to behavioral health services.

Finally, CPCCO will also engage community-based organizations and clinics with a goal of developing relationships with organizations/clinics that can support members of all backgrounds, languages, races, ethnicities, and needs. CPCCO will use these relationships to improve postpartum care engagement and follow-up for behavioral health related needs.

11.E.2.e. How will evidence based Dyadic Treatment and treatment allowing children to remain living with their primary parent or guardian be defined and made available to families who need these treatments?

CPCCO defines evidence-based dyadic treatments as those on the state's list of evidence-based practices.

CPCCO currently contracts with several organizations that provide dyadic treatment, including Columbia Community Mental Health, Tillamook Family Counseling Center and Clatsop Behavioral Health. Through these three providers, we have access to Child Parent Psychotherapy, Parent Child Interaction Therapy, and Make Parenting a Pleasure. In addition, our providers that serve young children treat them only in the context of their families.

CPCCO works closely with our local DHS-Child Welfare branches to ensure these services are available to both youth in the child welfare system and families who are at risk of entering the system and are identified through other areas such as self-sufficiency programs. We will do routine outreach and communication with the local branches to ensure they have current information on how to access available services. This treatment then supports children to remain living with their primary parent or guardian.

11.E.2.f. How will Applicant ensure that Providers conduct in-home Assessments for adequacy of Family Supports, and offer supportive services (for example, housing adequacy, nutrition and food, diaper needs, transportation needs, safety needs and home visiting)?

CPCCO will utilize community-based Maternal Child Health (MCH) trained community health workers (CHWs) to support our overall maternal and child health strategy. MCH CHWs will work in collaboration with existing home visiting programs such as Healthy Families and CaCoon, primary care providers, and behavioral health providers to address gaps/needs identified during in-home assessments for children ages 0-5 years and their families. In-home assessments will utilize the Family Assessment Form (FAF), which is a research-validated tool with proven reliability. The FAF

covers the five protective factors, including: parental resilience, social connections, concrete support in times of needs, knowledge of parenting and child development, and social and emotional competence of children. We will utilize OPIP child health complexity data to stratify children into three levels of risk, Low, Medium and High, as defined by health complexity score. For those identified with a health complexity score of 6 or higher, an MCH-trained CHW and other local providers, such as a community paramedic, will conduct a co-visit to complete the in-home assessment. The MCH-trained CHW will conduct all follow up with the child and family, primary care, behavioral health, and early learning providers in the community.

11.E 2 g. Describe how Applicant will meet the additional Complex Care Management and evidence-based Behavioral Health intervention needs of children 0-5, and their caregivers, with indications of ACEs and high complexity.

The causes of ACEs complexity factors are multifactorial and the interventions required to meet the needs of infants and young children and their caregivers must also be multifactorial. CPCCO's approach will include the following:

Focus & Oversight. CPCCO has established a steering committee, through CareOregon, focused on appropriately using the OHA/OPIP pediatric health complexity data to help identify areas of need in our community and ways to provide resources and appropriate interventions to our members. This committee focuses on the 0-5-year-old population. CPCCO will coordinate closely with the early childhood clinical specialists who are a part of the child and family teams at each of the local CMHPs. Through the regional care team structure CPCCO will ensure that young children and their families are able to access evidence-based treatment for early childhood mental health disorders. CPCCO will work with the local providers to fund additional training and certification in early childhood mental health, as this is an identified workforce issue in the region.

In addition, CPCCO will stand up a maternal child health specific regional care team that is dedicated to serving children 0-5 years and their families, with a targeted focus on children with high medical and social complexity as identified via the OHA/OPIP complexity data. The MCH-focused RCT will include medical and behavioral health provider partners, Early Intervention, the Northwest Early Learning Hub, and MCH trained community health workers to provide support and walk alongside families as they navigate resources and services. CPCCO will explore the use of an alternative payment model to support this work and stand up this regional MCH-specific RCT.

Alternative Payment Models & Incentives. CPCCO is reviewing pediatric alternative payment models to include case management and behavioral health supports for pediatric patients identified as complex or at-risk, with an emphasis on the 0-5-year-old population. Obstetrics payment models are also being developed to support integration of obstetrics care with substance-use disorder treatment. Through this, CPCCO will use a payment model that supports integration of behavioral health, addressing social complexities (including use of traditional health workers/THW), and complex case management for pregnant women with substance use disorders.

Education & Direct Support. CPCCO has included safe sleep materials and education to be used during the first six months of a newborn's life. CPCCO will develop and implement a maternal, child, and youth care team available for specialist case management needs and clinic support. This team will use OPIP/OHA data to assist in identification of complex pediatrics and engage in focused outreach to clinics and communities to support their meeting the additional Complex Care

Management and evidence-based Behavioral Health intervention needs of these children and their caregivers.

Coordination & Collaboration. The CCO metric for children placed in DHS custody has initiated internal (cross-regional) discussions focused on identifying ways to improve coordination and collaboration with DHS Child Welfare offices, caregivers, and internal staff. Discussions have begun around how to productively utilize trauma-informed trainings in a sustainable way. This will further support care for children 0-5, and their caregivers, with indications of ACEs and high complexity.

11.E.2.h. How will Applicant ensure children referred to the highest levels of care (day treatment, subacute or PRTS) are able to continue Dyadic Treatment with their parents or primary caregivers whenever possible?

CPCCO's goal is to keep children in their local communities whenever possible. By keeping children in their local communities, they can continue Dyadic Treatment with their parents or primary caregivers. Especially for young children under age 10, we strive to keep them in community-based settings rather than institutional placements such as subacute or PRTS. We know that research indicates that PRTS can in many cases be iatrogenic or harmful and should only be used when no other safe and medically appropriate alternative is available. In the rare circumstance where a youth may be placed out of the community in a higher level of care, we will work with our non-emergent medical transportation provider to ensure the family is able to attend regular visits and treatment appointments with their child. If that is not possible, we have the capability to use technology to support visits via video or telehealth.

11.E.2.i. Describe Applicant's annual training plan for Applicant's staff and Providers that addresses ACEs, trauma informed approaches and practices, tools and interventions that promote healing from trauma and the creation/support of resiliency for families.

Work in the CPCCO region targeting ACEs has been underway for several years. Below is our current (and ever-evolving) work plan in the area of ACEs and Resilience.

Intervention	Intended Audience	Experience	Future Plan
4-Hour All Staff Training (Trauma Informed Oregon)	Primary Care Clinics CMHPs CPCCO Staff Schools Law Enforcement	CPCCO partnered with trainers from Trauma Informed Oregon to deliver up-to-date content on ACEs, resiliency and using a compassion-based lens to understand trauma in their patients.	• Post-training, clinics are solicited to follow up with interest in becoming a trauma informed organization and adapting policies and procedures that will move clinics toward adopting a compassion-based framework. • CPCCO intends to finalize our initial round of introductory training on ACEs in Primary Care, CMHPs, schools, and law enforcement
Annual Opioid Summit	Community Members Providers Community-Based Organizations Policymakers	Summits in 2017 and 2018 featured speakers addressing trauma-informed difficult conversations and patient intervention as well as Community Trauma-informed Care for Addiction.	CPCCO will continue to include ACEs and trauma-informed content and expertise at future Opioid Summits

Trauma Informed Network	Cross-Sector Systems	Community discussions of ACEs and resilience have led to the formal pursuit of creating a trauma informed network in six sectors, including healthcare, education, child welfare and others in Clatsop and Columbia counties.	CPCCO funded and hiring a dedicated FTE in Q4 2018 focused on implementing a business model that will be self-sustaining once fully implemented in 2023. The position supports The North Coast Network and the Columbia County Steering Committee to implement trauma informed practices across sectors. Once these groups take root in Clatsop and Columbia counties, the CPCCO staff will begin to build out the model in Tillamook County.
Public screenings of *Paper Tigers* and *Resilience*	Community Members Partner Organizations Educators/Administrators	CPCCO worked with CACs and schools to offer screenings of *Paper Tigers* and *Resilience* films, which highlight ACEs and resilience in schools. We measured the impact of the film with pre- and post-testing. Training of the Northwest Regional Education Services District (NWRESD) for this work has been completed.	
Continuing Education	Primary Care Clinics CMHPs CPCCO Staff Schools Law Enforcement		CPCCO plans to develop an annual training for • Staff and network partners to retain & promote ACEs/ trauma-informed care/ resilience baseline and move partners along the continuum of trauma-informed orgs • Provider partners to assess for and promote resilience at each well-child check and developmental stage for: - Social and emotional competence of the child & family support system; - Promoting developmentally appropriate autonomy and problem solving; and - Helping families to orient to a sense of purpose and bright future.

11.E.3. Care Coordination (recommended page limit 12 pages)
Applicant is required to ensure a Care Coordinator is identified for individuals with severe and persistent mental illness (SPMI), children with serious emotional disorders (SED), individuals in medication assisted treatment for substance use disorder (SUD), and Members of a Prioritized Populations. Applicant must develop standards for Care Coordination that reflect principles that are trauma informed, linguistically appropriate and Culturally Responsive. Applicant must ensure Care Coordination is provided for all children in Child Welfare and state custody and for other prioritized populations (e.g., intellectual/developmental disabilities). Applicant must establish outcome measure tools for Care Coordination.
11.E.3.a.(1). How will Applicant determine which enrollees receive Care Coordination services?
All CPCCO members have access to care coordination through our Regional Care Teams (RCT) in each county. The RCT provides appropriate care coordination services and supports to meet member needs. RCTs are staffed with integrated multidisciplinary staff including telephonic and community-based behavioral health staff. Because many members will have additional needs, the team is also staffed with telephonic and community-based nurses, pharmacists, dental coordinators and healthcare coordinators. CPCCO recognizes that care coordination and case management is a core service provided by CMHPs for members with complex behavioral needs and emphasizes communication with the RTC in order to compliment efforts. The RTC uses a variety of methods to determine those members with behavioral health or substance use disorder conditions who would benefit from more formalized care coordination. CPCCO members can be referred into care coordination through several avenues:

- CPCCO sends an Initial Health Screening to all adult members at the time of enrollment. This screening asks members key questions regarding their health, social determinants of health, dental needs, substance use and behavioral health needs. If a member is identified by any of the above avenues as someone who could benefit from care coordination for behavioral health, substance abuse or physical needs, the CPCCO RCT Care Coordinator reaches out to connect the member to care coordination. Members are contacted by the prospective care coordinator via the most acceptable method: phone, face-to-face, or mail.
- Identification can also be done via segmentation of our member population, based on a combination of predictive analytics (cost and utilization), risk stratification, clinical judgment, community input, and member choice. Stratification is conducted to ensure that our population receives not only care coordination, but specific interventions tailored to the member need. For example, there is a cohort within the rising risk segment that is specific to members with comorbid behavioral health and medical issues, and in need of care coordination. These members are often not connected to their primary care provider, have been identified as needing specific behavioral health support, or appear uncoordinated as evidenced by seeing multiple providers including specialists and will benefit from care coordination.
- Members can self-refer to care coordination or be referred at their own request, by a provider, community partner, family member or care giver.

- Members with identified special healthcare needs are automatically referred to care coordination and receive outreach via a letter that informs them of their right to care coordination including information regarding how to reach the care coordination team.

The CPCCO RCT outreaches to members who have been identified as rising risk due to behavioral health or substance use disorder to any of these sources above. In addition, we upload a series of Program Eligibility Rate Codes (PERC) to our care coordination platform weekly, which creates reports of potential ICC members. The RCT Triage Coordinators review this weekly and the RCT proactively reaches out to members to assess for need, remind them of their right to care coordination, and offer support.

11.E.3.a.(2). How will Applicant ensure that enrollees who need Care Coordination are able to access these services?

One of our core operating principles is our belief that there is no wrong door when accessing care coordination services. CPCCO believes that our members' health is positively impacted when providers partner with community, county-based, and peer-run organizations that provide social and support services, and that these partnerships are key to facilitating access to care coordination. CPCCO facilitates collaboration among these providers and services with the goal of improving access to services and coordination between systems.

We consistently reach out to both primary care and behavioral health providers to explain how to access care coordination services. We encourage providers to call customer service or the RCT team directly to access the care coordinator who is dedicated to their clinic. The provider can also submit a referral via email or via our provider portal. Information is also readily available on the website. In addition, referrals to care coordination can come from the members; all members are informed of these services via their new member welcome packet. The Population Health Manager, Behavioral Health Manager and Innovation Specialists spend time connecting to those community partners that work closely with our members to inform them of the services available, because often community partners do not understand the complexity of the health plan structure and lack clear guidance on how to access care coordination on behalf of members. This team and other staff from the community engagement team routinely outreach to these partners to educate them on access. Community partners are also able to receive information via the CPCCO website. They can call customer service for support, call the care team directly, or use the emailed referral form.

Once a referral is received by our RCT, a needs assessment will be conducted at the time of referral to ensure appropriate care coordinator assignment and prioritization. The Care Coordination Assessment is comprehensive review of potential member-specific issues. A care plan is generated for all members enrolled in care coordination and the care team works as a multidisciplinary team to address all needs in the care plan including behavioral health, physical health, and social determinants or health.

We regularly inform CareOregon staff working on behalf of CPCCO of standard criteria and encourage internal staff to refer to care coordination when needs are identified. This includes, but is not limited to, Behavioral Health Benefit Review, Physical Health Benefit Review, Customer Service, and clinic-based CPCCO Panel Coordinators.

11.E.3.a.(3). How will Applicant identify enrollees who have had no utilization within the first six months of Enrollment, and what strategies will Applicant use to contact and assess these enrollees?

CPCCO has invested in a predictive analytics platform capable of conducting population segmentation analysis. Through this capability, we segment members in a series of cohorts who appear to need additional support. Care coordinators proactively outreach via phone to these members and attempt to engage them in care coordination. Members with no engagement or utilization in their first 6 months of enrollment are identified through analytics and are included in this process for targeted care coordination outreach. These reports are provided to the RCT for targeted telephonic outreach. CPCCO also has a New Member Incentive where new members with no primary care engagement are offered a gift card when they attend their first appointment. The expectation is that the primary care provider can then refer these members to behavioral health services or care coordination supports upon assessment.

11.E.3.b. How does Applicant plan to complete initial screening and Assessment of Intensive Care Coordination (ICC) within the designated timeline? (May submit work flow chart if desirable).

Upon enrollment, all adult members receive a welcome letter that includes an Initial Health Screening that gathers information about physical, dental and behavioral health needs and social determinants of health. Members are also placed in a call campaign with trained Member Services Representatives placing welcome calls with an invitation to complete the assessment over the phone. If the member does not return the assessment after 30 days, we mail a reminder postcard. This postcard indicates all the ways in which a member can complete the assessment, including calling Member Services, completing the initial form and mailing back, or by logging on to the member portal to complete.

Members with special health care needs who qualify for intensive care coordination (ICC) receive additional outreach about their right to ICC and how to connect to the care team. Once a member enters care coordination, a care plan is created based on identified needs and in collaboration with the member and the member's primary care provider.

11.E.3.c. Please describe Applicant's proposed process for developing, monitoring the implementation of and for updating Intensive Care Coordination plans.

For members with intensive care needs, including members with severe and persistent mental illness receiving home and community-based services, CPCCO's RCT works with the member and their supports, providers, appropriate agencies, and other community resources to develop an Individualized Care Plan (ICP). The ICP ensures that the member's physical, mental, oral and general support needs are identified, that the member and their family/caregiver preferences are incorporated into the plans, and that the plan reflects what is important to the member to ensure delivery of services in a manner reflecting personal preferences and ensuring health and well-being.

RCT Triage Coordinators are responsible for monitoring members who may have ICC needs. They will pull monthly reports of members meeting ICC criteria and who have been enrolled in care coordination (using OHA PERC codes) and route care plans for review to the assigned RCT care coordinator. Once care plans are reviewed and aligned, we communicate with providers and other care team members by sending the care plan to the provider portal or to providers' EMRs directly via secure messages (when authorized). Care plans will be reviewed and updated, at minimum, on a semi-annual basis or more frequently as requested or indicated by a change in patient status.

11.E.3.d. How does Applicant plan to provide cost-effective integrated Care Coordination (including all health and social support systems)?

In 2015, Columbia Pacific CCO entered into multiyear county-wide gain/risk sharing agreements with the primary care providers, hospitals, mental health providers and public health agencies in Clatsop, Columbia and Tillamook counties. The intent of these arrangements is to build shared ownership and accountability for CPCCO's member health at the community level and to incentivize providers to work together to improve quality care and reduce avoidable costs and utilization. The model triggers a payout when CPCCO achieves a combined member benefit ratio of 91% for our behavioral health and physical health benefits and when each county achieves a specific per member per month target that is determined by our actuarial partner. Each county has a Steering Committee of participants in the model that meets monthly to review their county-specific cost targets and monitor progress of the strategies they have implemented. In 2016, the three counties received just under $1.3 million to invest in county-specific strategies to improve quality and cost of care.

In 2017, Clatsop and Columbia counties moved to invest more deeply in their collaboration efforts by creating operational workgroups that are comprised of clinic, emergency department, and community mental health provider clinic managers. These groups work towards quality improvement with a focus on integration efforts across their systems. They run PDSA cycles to improve upon system barriers to access and integration. For example, the 2019 focus of Clatsop's Operational Workgroup's PDSA is launching standard closed-loop referral processes. Also in 2017, the Clatsop County partners decided to fund a Complex Care Hub in Seaside that featured a Triage Coordinator, a social worker, and a registered nurse to provide care coordination for CPCCO members throughout the county. This team evolved to establish weekly huddles around a centralized triage process. At the huddles, representatives from each of the primary care and behavioral health providers round on CPCCO members to develop aligned care plans and coordinate care. In 2018 Columbia County replicated this model and the partners funded a Community Paramedicine program. The Community Paramedic has been incorporated into an integrated care team along with the local primary care clinics and community mental health providers of that county. Tillamook county also decided to replicate the weekly huddles in 2018 and all three of these groups have been integrated into our broader Regional Care Team for CPCCO.

CPCCO has developed its care coordination program to be comprehensive and span the entire care continuum, as opposed to a traditional program like telephonic disease management, or catastrophic case management for acute health care episodes. Instead, we believe that cost-effective care coordination requires infrastructure that benefits a broader population of members to address those in most acute need, but also averts the progression of disease and disability among those individuals identified to be at risk of worsening health. An important aspect of CPCCO's Regional Care Team model is the use of specially trained, multidisciplinary teams who coordinate closely with primary care teams to meet the needs of patients with multiple chronic conditions, contributing socioeconomic factors, and other medically complex issues. The RCT model adapts to local needs and leverages data sharing to improve care quality and experience, while offering an opportunity to avert potentially avoidable healthcare costs.

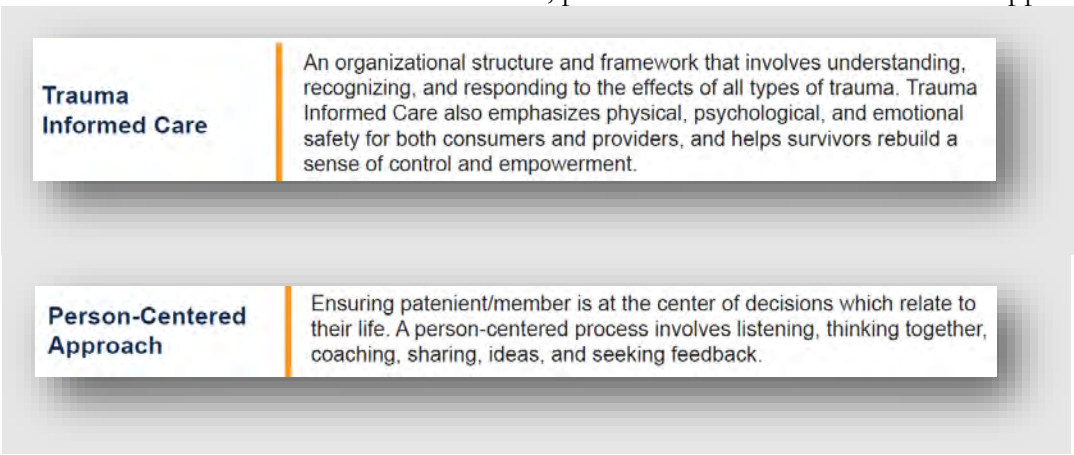
In 2019, CPCCO implemented a robust care coordination platform **(**GSI HealthCoordinator**)** that has dramatically increased efficiency. The platform has given CPCCO greater access to comprehensive and structured assessments of member needs. It uses strict workflows to improve efficiency and avoid errors, and it allows the RCT to work from a common care plan, dramatically reducing duplication of services or wasted time reassessing cases. The platform delivers a care plan

to the provider portal, so the provider is aware of what is happening for the member. CPCCO can deliver secure messages directly to the providers EMR (when authorized). For those providers without secure messaging, we will utilize the provider portal to communicate the care plan and we will generate a care plan via PreManage for those members with acute needs.

In addition to these strategies, CPCCO is leveraging payment methodologies to improve cost-effectiveness. In 2018, we added a Cost of Care Incentive Payment to our primary care APM program in all clinics with 500 or more assigned members. The Cost of Care components measures emergency department and inpatient visits for Ambulatory Care Sensitive Conditions (ACSC). The measure is adapted from the Agency for Healthcare Research and Quality (AHRQ)'s PQI 90. PQI 90 is one of the measures that OHA monitors as part of the CCO waiver. ACSCs are conditions in which an acute event (ED or inpatient) could have been prevented with timely, high quality intervention in primary care. As such, they focus specifically on domains that are impactable by primary care clinics. In addition, the measure is aligned with work we have been doing with our network partners by reinforcing concepts of population health management, care coordination and use of PreManage.

11.E.3.e. What is Applicant's policy for ensuring Applicant is operating in a way guided by person centered, Culturally Responsive and trauma informed principles?

The CPCCO Population Health Program adopted a set of clinical values and practice philosophies that describe its commitment to a trauma informed, person-centered care coordination approach:



To ensure that these philosophies and principles are upheld in service to its members, all staff are trained in trauma informed care, person centered care, and Motivational Interviewing. This training is provided at the time of employment and readdressed as needed. The completion of these trainings is tracked using CPCCO's Online Learn Commons application (OLC). Reports are readily available to leadership for auditing purposes and ensuring all staff have received consistent training. In addition, the team is trained regarding culturally appropriate supports, language access, health disparities, and unconscious bias. RCT supervisors audit case files on a regular basis using an in-house audit tool. Part of this tool requires the supervisor to look for examples of these best practices and whether culturally specific services were utilized and adhered to.

11.E.3.f. Does Applicant plan to delegate Care Coordination outside of Applicant's organization? How does Applicant plan to enforce the Contract requirement if Care Coordination delegation is chosen?

CPCCO does not delegate care coordination outside of our organization.

11.E.3.g. For Fully Dual Eligibles, describe any specific Care Coordination partnerships with your Affiliated Medicare Advantage plan for Behavioral Health issues.

CPCCOs parent, CareOregon, operates a D-SNP Medicare Advantage plan in Clatsop County. The Care Coordination program defined in this RFA applies to our Medicare Advantage members served by CPCCO. Because the RCT operates across CareOregon's supported lines of business, they are trained to meet the needs of those who are dually eligible, as well as those who are enrolled in OHP-only.

11.E.3.h. What is Applicant's strategy for engaging specialized and ICC populations? What is Applicant's plan for addressing engagement barriers with ICC populations?

Beyond the initial engagement activities upon enrollment and upon identification of specific needs, CPCCO will use its population segmentation capability to proactively identify and engage members with specialized or intensive care coordination needs. Once needs are identified, the CPCCO RCT will take special care to engage members using an individualized approach that takes into account the trauma-informed, person-centered principles of engagement that are critical to working with this population. In addition, CPCCO will prioritize the utilization of peer supports and traditional health workers; these are available to all members regardless of whether or not they are engaged in any kind of formal treatment. Members can take advantage of this valuable service at any time, and even if a member chooses to leave treatment, they do not lose access to their peer. Peer supports and THWs are often more successful in engaging with members with complex social determinants. Members identified as having behavioral health needs can also receive outreach services through various services (mobile crisis, case management or peer outreach).

We also believe that the use of health-related services offers an innovative opportunity to mediate an individual's social needs and barriers for better health outcomes and address a member's need in a more meaningful and tangible way.

11.E.3.i. Please describe Applicant's process of notifying a member if they are discharged from Care Coordination/ICC services. Please include additional processes in place for members who are being discharged due to lack of engagement.

Whether a member engages in care coordination fully, engages sporadically, or care coordination is not an identified need, members will always have access to RCT care coordination services when and if needed. This allows continuity of care for members and for the RCT care coordinators to truly know a member, their history and current needs. The initial care plan that was created for the member will stay with the member record for as long as they are a member of CPCCO. This allows the care coordination team to pick up where they left off if/when the member comes back into care coordination.

CPCCO's RCT care coordinators notify the member upon closure from an episode of care coordination services. If the closure is due to lack of engagement or response, the RCT care coordinator makes multiple attempts to connect with the member via phone. If there is no response, a letter is sent to the member indicating the closure from care coordination services and the member is provided information on how to access the care coordination team if needed in the future. If another need arises, members are re-engaged in care coordination services, at which time their health risk is reassessed and the care plan revised.

11.E.3.j. Describe Applicant's plans to ensure continuity of care for members while in different levels of care and/or episodes of care, including those outside of Applicant's Service Area. How will Applicant coordinate with Providers across levels of care?

The CPCCO RCT uses a common care plan within the GSI care coordination platform that enables information sharing across multiple systems and providers, care team collaboration, interoperability with HIEs, and consistent identification of issues and barriers unique to each member. This allows the tracking of member needs through different levels of care and different types of care. The care plan will remain with the member throughout their time as a CPCCO member and all documented interventions also follow the member. This allows for continuity if there is staff turnover, as members may change providers, levels of care, or move out of the area and then return. Care coordinators often utilize Interdisciplinary Care Team meetings (ICT) to coordinate care between providers, levels of care, and with those providers who are out of the CPCCO service area. This allows all members of the care team, in and outside of CPCCO, to come together to discuss a member's case. Any interventions discussed or plans set in motion are documented in the care plan and this care plan is shared with any authorized staff.

CPCCO members have access to and receive the necessary primary care, specialty care, mental health, substance use disorder, and oral care services whether the member receives those services within or outside of CPCCO's service area. When CPCCO members require services that are not available within CPCCO's service area, CPCCO ensures that members receive all necessary services and that providers are compensated for those services. CPCCO's behavioral health ICC provides care coordination for children and youth who are receiving behavioral rehabilitation services, children, youth and adults receiving psychiatric residential treatment services, and youth and adults receiving alcohol and drug residential services regardless of location. CPCCO RCT care coordinators work closely with DHS, OYA, and other community partners throughout the time members are receiving care out of the service area.

11.E.3.k. How will Applicant manage discharge planning, knowing that good discharge planning begins from the moment a member enters services?

CPCCO assigns a care coordinator to members *upon admission* to any of these facilities or services:

- Psychiatric acute care settings
- Oregon State Hospital: Secure Child Inpatient/Secure Adolescent Inpatient, Forensic
- Subacute
- Psychiatric Residential Treatment Services
- Oregon Youth Authority facilities
- Secure Residential Treatment Facility/Residential Treatment Facility
- SUDs Detox programs
- SUDs residential services

The RCT care coordinator will work with the treatment team on transition planning and will assist in the facilitation of discharge or transitions between levels of care. The care coordinator will document all activity in the member care plan, consult with other disciplines as needed, and provide appropriate documentation to the providers. When indicated, they will also document care guidelines in PreManage.

For CPCCO members who admit to the Portland-based psychiatric hospital, Unity, we have two health resilience specialists who work specifically with CPCCO members as they present at the Psychiatric Emergency Services and those who are hospitalized for a psychiatric reason. These health resilience specialists work with discharge planners at Unity and will refer those cases back to the CPCCO RCT managing their case. They will assure that follow up appointments are made. All information is documented in the care coordination platform via the member's common care plan so that the receiving RCT who is based in the community the member resides can pick up the case and support the member when they return home.

11.E.3.l. What steps will Applicant take to ensure Care Coordination involvement for ICC members while they are in other systems (e.g., Hospital, subacute, criminal justice facility)?

A care coordinator will be identified for members upon admission to:

- Psychiatric acute care settings
- Oregon State Hospital/Secure Child Inpatient/Secure Adolescent Inpatient, Forensic
- Subacute
- Psychiatric Residential Treatment Services
- Oregon Youth Authority facilities
- SUDs Detox
- SUDS residential programs

RCT care coordinators will work with the treatment team on transition planning and will assist in the facilitation of discharge or transitions between levels of care. Whenever possible and appropriate, the care coordinator will connect with the member and/or family in their current placement or level of care to begin facilitating the transition process. The care coordinator will ensure that the member has all they need when transitioning home or to another facility including looking into housing resources for members with unstable housing. The care coordinator and RCT will stay involved in the member's care to ensure a smooth transition and that the member's needs are met.

Even though members lose their OHP eligibility while incarcerated, CPCCO will work with the local corrections facilities during 2019 and 2020 to develop partnerships and referral pathways for individuals discharging from jails into behavioral health treatment services. All CMHP's have jail in-reach services in the region and work with jail staff to support transitions into community services. Conversations are underway to provide psychiatric services including medication management to residents who are in jail. We will also work with OHA to explore the possibility of getting notified when a member is incarcerated via PreManage.

11.E.3.m. Describe how Applicant will ensure ICC Care Coordinators will maintain the 15:1 caseload requirement.

Our GSI care coordination platform provides operational metrics to indicate caseload size by care coordinator. The ICC supervisor will diligently assess caseloads on a weekly basis and ensure that caseload size requirements are met. When caseloads exceed 15:1 for a sustained period of time additional staff will be hired to manage the requirements of ICC caseloads.

11.E.3.n. Which outcome measure tool for Care Coordination services will Applicant use? What other general ways will Applicant use to measure for Care Coordination?

CPCCO will utilize the reporting capabilities of its care coordination platform, GSI HealthCoordinator to measure the effectiveness of Care Coordination services. Reports will be

generated to determine efficacy of the care coordination activities. This will include process measures as key performance indicators:

- Are we identifying the right high-risk and rising risk patients?
- Do care coordinators have appropriate caseloads, both in terms of size and member complexity?

CPCCO will also monitor the movements within the population segmentation process with an RCT engagement overlay to determine if interventions employed during care coordination met goals identified within the segment. Each segment has an overarching goal such as keeping rising risk members from progressing to high risk or keeping health members healthy.

11.E.3.o. How will Applicant ensure that member information is available to Primary Care Providers, specialists, Behavioral Health Providers, care managers and other appropriate parties (e.g., caregivers, Family) who need the information to ensure the member is receiving needed services and Care Coordination?

Primary care providers and other providers involved in a member's care will be notified upon enrollment into the RCT care coordination program. Care plans developed will include provider input and will be shared with providers upon request and throughout the care coordination process. Providers, care givers, members, and family members will be invited to participate in ICT meetings as appropriate. Use of the GSI care coordination platform and a shared/integrated care plan will allow providers to better participate in care planning and care coordination activities. All care plans will be available via the provider portal. In addition, for providers who wish to do so, we can send them secure messages into their EMR for greater ease of communication. We will also continue to utilize the PreManage application to communicate critical information to providers. CPCCO is currently evaluating the universal release form developed by The Inland Empire Health. Adoption of this tool will enhance the system's ability to share information regarding SUDs status.

11.E.4. Severe and Persistent Mental Illness (SPMI) (recommended page limit 6 pages)

11.E.4.a. How will Applicant work with OHA, other state agencies, and other state funded or operated entities to identify areas where treatment and services for adult members with SPMI can be improved?

Both CPCCO's Behavioral Health Director and Behavioral Health Manager will continue to be actively involved in state level discussions about overall improvements to the behavioral health system for adults with SPMI. The Director participated in both the Behavioral Health Collaborative process and the workgroup advising OHA on the state hospital risk share. In addition, CPCCO, through our parent company CareOregon, has a very close relationship with ColumbiaCare Services, which is one of the primary statewide providers of adult residential treatment. We have a demonstrated commitment to collaboration with statewide entities to review data and look for opportunities and strategies to improve care and will continue this effort in the future.

CPCCO's Behavioral Health Director is a co-chair, with OHA's Deputy Behavioral Health Director, of the state-level CCO Behavioral Health Director's Meeting, which is now a sanctioned OHA workgroup. This group will be an important venue to bring local experience and data to the state-level conversation about the continuum of care for adults with SPMI. OHA has committed to participating in this group with staff who are content experts in various areas and using it as a forum to recommend policy changes and explore other strategies to improve and expand services to members with SPMI; CPCCO will continue to contribute to this effort.

CPCCO will be continuously involved in quality improvement discussions with local safety net providers. Initial improvement targets will focus on improving access and penetration.

11.E.4.b. How will Applicant provide oversight, Care Coordination, transition planning and management for members receiving Behavioral Health services, including Mental Health Rehabilitative Services, Personal Care Services and Habilitation Services, in licensed and non-licensed home and Community-based settings, to ensure individuals who no longer need placement in such settings are transitioned to a Community placement in the most integrated Community setting appropriate for that person?

CPCCO will be hiring a care coordination position specifically to focus on members receiving services in the Oregon State Hospital and the adult mental health residential system of care, including those receiving services in licensed and non-licensed community-based settings. This care coordinator will work closely with the member, the County/CMHP CHOICE Coordinator and ENC, treatment providers, and the state's third-party utilization management entity. When members are no longer meeting criteria to remain in their current placement, the care coordinator will facilitate transition to a lower level of care integrated into the community, based on the member's needs and preferences. The care coordinator will work with the CHOICE program to access any flexible funding needed to create a community-based plan, such as rental support, furnishings, etc.

The care coordinator will be part of the CPCCO Regional Care Team. This team is comprised of integrated multidisciplinary staff including nursing and behavioral health staff and non-clinical care coordinators; the team is supported by several other departments and disciplines such as pharmacists, medical directors, dental coordinators, and the benefit review team. This interdisciplinary approach will help ensure that members are transitioned to community placement in the most integrated community setting with appropriate supports in place. (See 11.E.3)

11.E 4 c. How will Applicant ensure members with SPMI receive ICC support in finding appropriate housing and receive coordination in addressing member's housing needs?

All CPCCO members referred for care coordination services will receive a full care coordination assessment that includes exploration of housing circumstances and needs. Each member will have an assigned Intensive Care Coordination staff who will work with the member to identify current housing resources and needs and ensure that a housing-related goal is included in their care coordination plan. CPCCO has a continuum of housing support targeted for members with SPMI, including shelters, transitional living, rental assistance, supportive housing, and respite. In addition, CMHPs in the region have supported housing funding that enables them to provide onsite supports through the case management teams that are a part of the array of services that the CMHPs provide. Each CMHP has Exceptional Needs Care Coordinators who focus on the needs of SPMI members as they transition between various levels of care and work with the local CMHP case management teams to ensure continuity of care. CPCCO is also providing support to local entities (CMHPs, local housing authority, Helping Hands and other social service agencies) as they increase their efforts to directly develop housing stock as they work to increase the pool of available special needs in the area.

11.E.4.d. How will Applicant assist members with SPMI to obtain housing, Supported Housing to the extent possible, consistent with the individual's treatment goals, clinical needs, and the individual's informed choice?

CPCCO's intensive care coordination staff will work individually with identified members who have SPMI and need housing supports. Our care coordination plans are member-centered and based on the goals that the members want to achieve, in collaboration with their treatment team, family, and other natural supports. Care coordination plans are also informed by clinician input to ensure that the member's clinical needs are addressed.

CPCCO will work closely with the CMHP in each of our communities and the Oregon Health Authority to create funding packages to develop additional housing supports for members to build out the continuum. CPCCO has supported new housing projects sponsored by Northwest Oregon Housing Authority and will continue to work with the local CMHPs to build out services and supports for special populations such as SPMI.

11.E.4.e. How will Applicant ensure ACT services are provided for all adult members with SPMI who are referred to and eligible for ACT services in accordance with OAR 309-019-0105 and 309-019-0225 through 309-019-0255?
CPCCO will use existing contracts with Columbia County Mental Health, Tillamook Family Counseling Center and Clatsop Behavioral Health to provide ACT services to our members. Currently, referrals to ACT come from the Oregon State Hospital, regional acute care psychiatric units, and internally from the CMHPs. All members discharging from the state hospital who are eligible for ACT will be referred and screened.

If CPCCO has five or more members on the waiting list for ACT services, CPCCO will enter contract negotiations with the CMHP in that county to expand capacity. To date, there has not been a waiting list for ACT services**.**

11.E.4.f. How will Applicant ensure ACT services are provided for all adult members with SPMI who are referred to and eligible for ACT services in accordance with OAR 309-019-0105 and 309-019-0225 through 309-019-0255?
(this is a duplicate of e above)
Please see answer to question 11.E.4.e.

11.E.4 g. How will Applicant engage all eligible members who decline to participate in ACT in an attempt to identify and overcome barriers to the member's participation as required by the Contract?
When members are determined to be eligible for ACT services and decline to participate, the assigned Behavioral Health Intensive Care Coordinator will coordinate with the ACT program and engage in outreach to the member. Intensive Care Coordination staff will use motivational interviewing and other engagement techniques to identify and remove barriers to participation in ACT services. Peer outreach specialists and peer recovery mentors will be utilized in the effort to engage members who need ACT level services. When members continue to decline ACT, the care coordinator will ensure the member is connected to an appropriate alternative such as intensive case management.

11.E.4.h. How will Applicant provide alternative evidence-based intensive services if member continues to decline participation in ACT, which must include Care Coordination?
CPCCO will assign an Intensive Care Coordinator to members who are eligible for ACT and decline participation, to ensure they are connected with an alternative evidence-based treatment to meet their individualized needs. CPCCO will contract with each local community mental health program for a range of services and supports including intensive case management as an alternative to ACT. CPCCO will also work with the CMHPs to develop individualized programs when needed, to include services such as supported employment and supported housing.

11.E.4.i. How will Applicant work with Secure Residential Treatment Facilities (SRTFs) to expeditiously move a civilly committed member with SPMI, who no longer needs placement in an SRTF, to a placement in the most integrated Community setting appropriate for that person?
CPCCO care coordination staff will work with the member's current SRTF provider to review recommendations for continued treatment and then meet with the member to create a care plan that is based on the member's goals and preferences for living arrangements. CPCCO has a close

relationship to the CMHPs, which oversee the adult foster homes in the region. In addition, CPCCO has access to an array of integrated community services with various levels of support, including foster care, supported and supportive housing, and flexible services created to meet a client's individualized needs. In the event there is not an existing program available to meet a member's individualized needs, CPCCO and the local providers will work closely together to create individualized housing support services.

11 E 4.j. How will Applicant work with housing providers and housing authorities to assure sufficient supportive and Supported Housing and housing support services are available to members with SPMI?

CPCCO recognizes that access to stable and supported housing is key to improving health outcomes. All the CPCCO CMHPs provide supported housing services and are in conversations with the local housing authority, Northwest Oregon Housing Associates, about collaborating to build additional supported housing. CPCCO participates in these projects and is prepared to offer technical assistance and financial support to grow these services and the availability of housing stock. CPCCO has additionally provided funding and consultation for housing staff support to local emergency and transitional housing organizations. The Traditional Healthcare Workforce now has a specialty training for behavioral health needs. This expansion will also be used to include and increase the role of THW in the supported housing workforce.

11. E. 4. k. Provide details on how Applicant will ensure appropriate coverage of and service delivery for members with SPMI in acute psychiatric care, an emergency department, and Peer-directed services, in alignment with requirements in the Contract.

CPCCO has contracts with regional acute care psychiatric facilities to provide coverage of and service delivery for members with SPMI. To further ensure care, CPCCO has a policy that non-contracted providers are eligible to be paid for medically necessary admissions. CPCCO's utilization management staff will work closely with our care coordination teams so that members are appropriately covered for discharge planning and transition to the next level of care. We will also work closely with the local CHOICE contractor to ensure coordination of referrals to long term care and the Oregon State Hospital.

When CPCCO members access services in an emergency department, CPCCO will use several methods to engage and follow up with those members. If the member is currently engaged in care with one of CPCCO's local contracted mental health providers, the mental health provider will receive a PreManage alert and is expected to follow up with the member. If the member is not engaged in care with a local mental health provider, but seeks care in the emergency department, we will use workflows already in place to ensure the member is connected to a mental health provider for same or next day services. If the member is in an emergency room out-of-area, our care coordination team will contact the member and offer support in accessing services as appropriate. CMHPs get notification and will provide services to members presenting in the ED whether they are enrolled or not. These activities will be coordinated with the RTC and can include mobile crisis, ACT team staff, outreach and engagement specialists and peer support specialists.

11.E.5. Emergency Department (recommended page limit 2 pages)

11.E.5.a. How will Applicant establish a policy and procedure for developing a management plan for contacting and offering services to each member who has two or more readmissions to an Emergency Department in a six-month period? The management plan must show how the Contractor plans to reduce admissions to Emergency Departments, reduce readmissions to Emergency Departments, reduce the length of time members spend in Emergency Departments, and ensure adults with SPMI have appropriate connection to Community-based services after leaving an Emergency Department and will have a follow-up visit within three days.

CPCCO has several initiatives in place and in development targeting reduction of ED utilization. Descriptions are included below.

CPCCO built a function within PreManage for an automated alert system that notifies the Triage Coordinator for CPCCO's Regional Care Team (RCT) and the local CMHP when any member has two or more admissions to an emergency department within a six-month period. All emergency departments within Oregon and Washington are participating in PreManage, which ensures reliable data about emergency room usage. When the Triage Coordinator is notified, they will review the member history and assign the member to the most appropriate RCT members, who will then reach out directly to the member. This may occur face-to-face in the emergency room, in the member's home, or in a social support organization in the community. Outreach could also occur by telephone depending on the circumstance. The goal of the outreach is to evaluate the member's current situation, including engagement in treatment, barriers to participation, housing status, and other factors that may contribute to use of the emergency department. The care coordinator will then work with the member to develop mutually agreed upon goals. When possible and relevant, the care plan will be uploaded into EDIE to be viewable in the emergency department, and also shared with the member's treatment team and primary care provider.

In addition to the RCT interventions, CPCCO will continue to lead a local initiative begun in 2017 to spread the adoption of PreManage throughout the provider network in both primary care and behavioral health. Our primary contract providers, the CMHPs, are all on PreManage with various levels of adoption. In 2019, CPCCO is actively increasing provider expertise in and utilization of PreManage. Specifically, for adults with SPMI, CMHPs will get notifications when CPCCO member patients are admitted to an emergency department. These organizations will send staff to respond in-person to try to avoid admission to the inpatient unit and reduce the length of time spent in the emergency room. CPCCO also convenes our behavioral health and physical health provider network on a weekly basis for a care coordination huddle in each county. At that meeting the county providers review their list of CPCCO members who have visited the ED that week and determine which agency should take the lead and how to collaborate on coordinating care for the member.

For members with behavioral health disorders, CPCCO will deploy care coordination offered by our Regional Care Team (RCT). This multi-disciplinary care coordination team includes expertise in pharmacy, oral health, physical health, behavioral health, and population health. Referrals to the RCT can be on a proactive or reactive basis. Proactive referrals will come from internal risk stratification processes and population surveillance data, while reactive referrals will come from the community, providers, members, and most commonly from PreManage notifications. All referrals will be triaged to ensure they are assigned to the most appropriate team member to meet that individual member's needs.

Each CMHP is well versed in the local continuum of care and has embedded care coordinators and case managers that can assist members in accessing needed services, including respite, housing, subacute, rapid access to more intensive services, temporary or transitional housing, case management, etc. To remove barriers to access, CPCCO has removed prior authorization requirements for most community-based services. CPCCO members will be able to access the following services without any prior authorization requirements:

- Subacute care for adults
- Respite for youth and adults

- Supported Housing
- Supportive Housing
- ACT
- Intensive Case Management
- Early Assessment and Support Alliance (EASA) for early psychosis interventions

CPCCO will offer health-related services funding to support members staying in the community and out of the emergency room, such as short-term rental assistance, hotel vouchers, and transportation.

Finally, CPCCO will ensure members are contacted within three days of discharge through the strategies outlined above, including care coordination, PreManage notifications, and work with partners. The primary point of contact between the RCT staff and the member's mental health providers will reach out within three days to members with SPMI who are admitted to the emergency room. Provider contracts between CPCCO and the CMHPs will require that providers reach out the same or next day. The RCT staff will have a flag in PreManage for anyone with an SPMI diagnosis to ensure we are following the three-day timeline for a follow-up visit either with the RCT staff or a community provider.

11. E. 6. Oregon State Hospital (recommended page limit 1 page)

11. E. 6. a. How will Applicant coordinate with system partners as needed regarding Oregon State Hospital discharges for all adult members with SPMI?

All members hospitalized at the Oregon State Hospital (OSH) will be assigned a care coordinator upon the initial referral, if they do not already have one. The care coordinator will participate as part of the member's OSH care team and will be an active participant in:

- Long Term Care planning
- Coordination with the county/CMHP CHOICE contractor
- Monthly Interdisciplinary Team meetings at OSH
- Ready to Transition (RTT) meetings
- Discharge/transition planning

The care coordinator will remain engaged in the member's care planning to facilitate the discharge and transition from the Oregon State Hospital into the most appropriate community-based setting. The care coordinator's primary objectives are to ensure:

- Members needs are met
- Members are placed in the appropriate setting and level of care
- Each member's provider team (medical, behavioral health, and oral health) is well informed of the member's needs and plans are in place to ensure continuity of medication and treatment
- Members have access to ACT services or another evidence-based intensive service for members who refuse ACT

During hospitalization and in preparation for discharge, the care coordinator will work with all individuals involved in the member's local care including but not limited to:

- Local community mental health program,
- CHOICE Care Coordinator

- Commitment investigator/monitor
- Acute Care SW/DC Planner (if member currently inpatient)
- Guardian (if applicable)
- Member and any other individual identified by the member as a support (i.e. family)
- Primary care provider
- Other providers involved in the member's care:
    - psychiatric provider
    - ACT team
    - mental health therapist, case manager, or treatment team

The RCT (including with behavioral health and medical director input) will review and sign off on all Oregon State Hospital discharges.

11.E.6.b. How will Applicant coordinate care for members receiving Behavioral Health treatment while admitted to the State Hospital during discharge planning for the return to Applicant's Service Area when the member has been deemed ready to transition?

As stated above, CPCCO collaborates and will continue to collaborate with the local CHOICE contractors through regular meetings and *ad hoc* communication to assure we are involved throughout our member's stay in the Oregon State Hospital. We are aware of member admission to the Oregon State Hospital, as CPCCO approval is required for the referrals. As a result, we will work closely with the CHOICE contractor to follow the course of treatment, the discharge timeline, and recommendations.

CPCCO will continue to contract with each CMHP in the region for a continuum of services to assist in transitions from the Oregon State Hospital, including supported housing and respite for situations in which a foster home is approved but not yet open. CPCCO will contract with each CMHP for ACT, which is offered to every member who is eligible for that program. CMHPs will create individualized plans for members with unique needs not easily met in the current continuum, and CPCCO will continue to work closely with providers to ensure funding is not a barrier.

11.E.7. Supported Employment Services (recommended page limit 1 page)

11.E.7.a. How will Applicant ensure access to Supported Employment Services for all adult members eligible for these services, in accordance with OAR 309-019-0275 through 309- 019-0295?

Local CMHP's outpatient mental health array of services in each county includes supported employment services, through those providers, CPCCO will provide access to supportive employment (SE) services for our adult population with serious mental illness. SE services will be offered to every qualified member receiving outpatient services, will be individualized, and will assist individuals to obtain and maintain integrated, paid, competitive employment. These services will allow individuals to work the maximum number of hours consistent with their preferences, interests, and abilities. SE services are individually planned based on person-center planning principles and evidence-based practices and adhere to the following principles:

- Access to and participation in an employment and/or education program is the goal,
- Eligibility is based on member choice,
- Supportive employment services begin soon after the member expresses interest,
- Supportive employment is integrated with behavioral health and physical health treatment,

- Follow-along supports are continuous,
- Member preferences guide services, and
- Supportive employment is strengths-based and promotes growth and hope.

Each CMHP will offer a Supportive Employment program that will meet a fidelity score of at least 100, as measured by an OHA-approved fidelity reviewer. Each program is certified by OHA as described by OAR 309-019-0100. Supportive employment services will be available to all members who are enrolled in mental health services and who meet program admission criteria.

11.E.8. Children's System of Care (recommended page limit 2 pages)
Applicant will fully implement System of Care (SOC) for the children's system. Child-serving systems and agencies collaborating in the SOC are working together for the benefit of children and families.
CPCCO will continue to build on the existing platform in the service area. The vision of the Children's System of Care is that all children and families in Clatsop, Columbia and Tillamook Counties will thrive and have the supports they need to feel empowered, independent, healthy and hopeful for their future to reach their full potential. Our mission is to support a collaborative system of care for children, youth and families which is trauma-informed, family driven, youth guided, culturally responsive and community based; empowering them to succeed and develop resilience. Resources will be culturally responsive, youth and families will be involved in all discussions, and there will be both an early intervention and prevention focus. Families and youth will feel hope for their futures and will experience measurable change. We will also have a Children's System of Care that provides the highest quality services and supports that are equitable and consistent.

11.E.8.a. What Community resources will Applicant be using or collaborating with to support a fully implemented System of Care?
CPCCO will work closely with the local CMHP in each county in its service area to support a fully implemented, local system of care. We will do this by partnering with the local child welfare program, juvenile justice, school districts and educational service district, and the following additional resources:

- Technical assistance, support and ongoing training from Portland State University's System of Care Institute and the Oregon Health Authority;
- A full time System of Care Coordinator employed by CPCCO to ensure fidelity to the system of care principles and to communicate with the state level system of care governance body;
- Formal partnerships with Oregon Family Support Network, NAMI and Youth ERA;
- Leveraging expertise of and coordination with the Early Learning HUBs.

11. E. 8. b. Please provide detail on how Applicant will utilize the practice level work group, advisory council, and executive council.
By the second quarter of 2020, CPCCO's System of Care Coordinator will ensure that for each of the three counties, each level of the SOC Governance Structure will not only be fully functional, but will have charters outlining their responsibilities, scope, and relationship to one another. The following generally indicates responsibilities within the SOC for each community in the CPCCO region:

- **Practice Level Work Group (PLWG).** Cross-sector work group comprised of frontline managers, supervisors, youth, and family representatives. This group will:
    - collect, track, analyze and prioritize barriers elevated by the Wraparound Review Committee

  - create necessary documents and forms (barrier submission form, tracking tools)
  - resolve barriers that are within scope of the PLWG
  - elevate issues, make recommendations and report to Advisory Council as needed or requested
- **Advisory Council.** Cross-sector group of mid to high-level managers, youth, and family representative that will:
  - provide ongoing assessment of the SOC
  - draft SOC strategic plan and submit it to the Executive council
  - track decision making on barriers elevated by the PLWG
  - forward specific barriers to Executive Council
  - coordinate the Advisory Council agenda and report to Executive Council as needed
- **Executive Council.** This council will:
  - assess SOC strategy at the local and regional level
  - approve the strategic plan
  - set direction for collaborative systems work
  - track decision making processes regarding barriers referred from Advisory Council
  - coordinate agendas and make recommendations to the state-level SOC Advisory Council

CPCCO will also work with the local Executive Councils during 2020 to evaluate whether a regional executive council would be warranted and potentially better serve the geographic area.

11.E.8.c. How does Applicant plan to track submitted, resolved, and unresolved barriers to SOC?

The Practice Level Work Groups in each community will track submitted, resolved and unresolved barriers. A Barrier Submission Form will be used to collect data that will then be catalogued on the System of Care tracking sheet. CPCCO's System of Care Coordinator will monitor this process in each community and submit an annual SOC report and updated SOC strategic plan to OHA. These reports will include evidence of CPCCO's commitment to upholding the principles of SOC, a summary of the local issues addressed through the local governance structure, issues currently being addressed, and priorities for the coming year. CPCCO will work with SOC partners, including family and youth, to identify mutual cross-sector outcomes to consider when setting strategic priorities.

Outcome Measures are being finalized and may include the following:

- Are youths
  - Getting basic needs met?
  - Able to reside at home/in a stable homelike environment and in a least restrictive setting?
  - Safe?
  - Engaged in problematic behaviors?
  - Receiving culturally competent services?
  - Making educational and vocational progress?
  - Receiving emotional and interpersonal support?
  - Experiencing improved behavioral health?
- Reunification with parents.
- Recidivism rates in the juvenile justice system.

11.E.8.d. What strategies will Applicant employ to ensure that the above governance groups are comprised of youth, families, DHS (Child Welfare, I/DD), special education, juvenile justice, Oregon Youth Authority, Behavioral Health, and youth and Family voice representation at a level of at least 51 percent?

CPCCO believes strongly in the SOC values of family and youth voice at all levels of the system of care governance in order to inform the process, goal and strategies. The System of Care Coordinator will inventory the existing governance groups to identify gaps in membership during the first quarter of 2020. CPCCO will partner with Youth ERA to not only engage youth in the process but also to provide the necessary leadership training and support to help them succeed as members of a governing body. In addition, we will partner with OFSN to identify parents of youth involved in the child serving systems who want to participate in the governance process and ensure that OFSN can provide training and support to help those family members succeed. The System of Care Coordinator will also work with each community to ensure that the meetings are held at times and locations that are convenient to youth and family members, and that they are well prepared to participate by having the agenda in advance and a venue to get questions answered prior to each meeting.

CPCCO will also work with system partners such as child welfare and the Oregon Youth Authority to ensure that the meetings are valuable to them and offer opportunities to provide feedback to inform the process and ensure they remain committed partners.

11.E.9. Wraparound Services (recommended page limit 4 pages)

11.E.9. Applicant is required to ensure Wraparound Services are available to all children and young adults who meet criteria.

11.E.9.A. Provide details on how Applicant plans to ensure administration of the Wraparound Fidelity Index Short Form (WFI-EZ)?

CPCCO will contract with Clatsop Behavioral Health, Tillamook Family Counseling Center and Columbia Community Mental Health to provide wraparound services to our members. The required deliverables of this contract will include the administration of the WFI-EZ at required intervals for each member being served in the wraparound program, with results submitted into the state database.

To ensure the success of each local program, the System of Care Coordinator will meet at least quarterly with each wraparound team to discuss and review the WFI-EZ administration with the goal of technical assistance, barrier removal and ensuring all youth and families are participating.

11.E.9.b. How will Applicant communicate WFI-EZ and other applicable data to the System of Care Advisory Council?

The System of Care Coordinator will work with local wraparound teams and advisory councils to determine what data and with what frequency will be useful to present. They will then work with the local teams to create reports to bring to the Advisory Councils at the requested frequency. This will ensure that each Advisory Council has the ability to use the local data to inform their strategies and recommendations for the local system of care.

11.E.9.c. How does Applicant plan to receive a minimum of 35 percent response rate from youth?

The CPCCO System of Care Coordinator will work with each local wrap team during the first quarter of 2020 to determine the baseline response rate. The Coordinator will convene a monthly Wraparound Consultation and Standardization workgroup with leads from each program. A recurring topic will be the WFI-EZ response rate and best practices for improvement.

CPCCO will also take advantage of the fact that its parent company, CareOregon, works with two other systems of care (Health Share and Jackson Care Connect) and convene at least biannual learning sessions across regions.

11.E.9.d. How will Applicant's Wraparound policy address:
11.E.9.d.(1). How Wraparound services are implemented and monitored by Providers?
CPCCO contracts with the local CMHPs for wraparound services.

CPPCO Utilization Management and care coordination staff will work closely with the wraparound programs to ensure high levels of coordination as youth move from one level of care to another. They will also provide support in accessing health related services funding.

The CPCCO Behavioral Health Manager will be the liaison between the wraparound programs and community providers and partners. The Behavioral Health Manager will ensure that identified barriers are either addressed or brought to the practice level workgroups for consideration.

11.E.9.d.(2). How Applicant will ensure Wraparound services are provided to members in need, through Applicant's Providers?
In partnership with the System of Care Coordinator, the local wraparound supervisors and coaches will conduct outreach activities, (often referred to as Wraparound 101) to various stakeholders in each community. Targeted outreach includes presentations to DHS-Child Welfare, DHS Self Sufficiency, Developmental Disabilities, primary care locations, school staff, supported employment, Early Learning Hubs, Judges, Juvenile Departments, and other various child serving systems. Through that targeted educational outreach families are identified alongside their system partners and referred for wraparound. While wraparound is often accessed through professionals involved in child serving systems, CPCCO and the CMHPs will create a low barrier referral process and screening criteria allowing member, families, or natural supports to self-refer to wraparound.

Wraparound Review Committees are held independently in each of the three counties partnering with CPCCO to ensure that localized needs are being met. CPCCO and each CMHP value family and member voice at the Wraparound Review process and concerted efforts will be made to ensure that families and members are invited to participate in the review process. CPCCO wraparound programs also honor the OHA wraparound criteria that is created, and all members who are in Secure Children's Inpatient Program (SCIP), Secure Adolescent Inpatient Program (SAIP), SAGE Youth Residential Program or Psychiatric Residential Treatment Services (PRTS) are offered wraparound at the time of program admission.

11.E.9.e. Describe Applicant's plan for serving all eligible youth in Wraparound services so that no youth is placed on a waitlist. Describe Applicant's strategy to ensure there is no waitlist for youth who meet criteria.
As stated above, CPCCO will make concerted efforts to ensure that all youth and families in need of wraparound are referred, either by themselves or a community partner. CPCCO will contract with each local CMHP for wraparound service slots in increments of 15 to ensure the 1:15 caseload ratio. When the program is full and there is a child or youth who is accepted for wraparound services, they will be placed on an ICC caseload in the interim to ensure they receive care coordination without delay (no waitlist). Intensive Care Coordination (ICC) caseloads will also be at a 1:15 ratio, which ensures adequate capacity for multi-system engagement and coordination. When there are

consistently more referrals than spaces in the program, CPCCO will work with the relevant CMHP to expand the contract to add more slots.

CPCCO will also ensure that each local system of care has a fully functional Wraparound Review Committee comprised of membership from child serving systems, youth and families, to routinely review new referrals to the program. CPCCO's System of Care Coordinator will work with local programs to ensure that Wrap 101 trainings are happening on a regular basis for schools, child welfare, juvenile justice and other community partners. This will ensure that community members know how to make referrals as well as which youth and families would be eligible.

11.E.9.f. Describe Applicant's strategy to ensure that Applicant has the ability to implement Wraparound services to fidelity. This includes ensuring access to Family and youth Peer support and that designated roles are held by separate professionals as indicated (for example: Wraparound coaches and Wraparound supervisors are filled by two different individuals).

Policies and procedures will be developed and adopted that align with wraparound best practices and ensure services are delivered to fidelity. Each CPCCO Wraparound program will have a wraparound supervisor and wraparound coach that are filled by two different individuals. The supervisors provide clinical and administrative supervision to care coordinators especially as it relates to agency policies and procedures. The coach has expertise in wraparound and provides specific and intentional support to care coordinators to further develop their skills and increase expertise in the Wraparound process. Additionally, coaches observe team meetings, utilizing the Team Observation Measure (TOM) during all phases of the wraparound process to offer feedback and targeted coaching. Coaches also utilize WFI-EZ (Wraparound Fidelity Index) survey data to develop targeted, individualized group and individual coaching.

CPCCO will ensure that each program has access to peer supports. We will explore contracting directly with Youth Era and Oregon Family Support Network (OFSN) to ensure access to peer supports if needed.

All three wraparound programs within CPCCO receive technical assistance support and ongoing training through partnership with Systems of Care Institute (SOCI). Care coordinators and peer delivered service providers attend a foundational training in wraparound, as well as supervisors and coaches attend training individualized to their positions. Care coordinators will attend quarterly ongoing regional coaching opportunities that focus on wraparound best practices.

Applicant Company Name : Health Share of Oregon
Columbia Pacific CCO, LLC
Jackson Care Connect, LLC

NAIC No. _____
FEIN: 45-5093195
45-5532847
45-5499608

BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

HealthShare of Oregon		Columbia Pacific CCO, LLC
Jackson County CCO, LLC d.b.a, Jackson Care Connect	2101 SW Broadway Dr., Suite 200	315 SW 5th Avenue
33 N Central Avenue Medford, OR 97501	Portland, OR 97201	Portland, OR 97204
855.722.7208	(503)-416-1460	503.416.4100

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. Affiant's Full Name (Initials Not Acceptable): First: Eric Middle: Charles Last: Hunter

[redacted]

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

©2019 National Association of Insurance Commissioners

Applicant Company Name: Health Share of Oregon

NAIC No:

FEIN: 45-5093195

[redacted]

Applicant Company Name: Health Share of Oregon

NAIC No.

FEIN: 45-5093195

[redacted]

12. [redacted]

13. [redacted]

14. [redacted]

15. [redacted]

©2019 National Association of Insurance Commissioners

Applicant Company Name : Health Share of Oregon NAIC No. _____
FEIN: 45-5093195

[redacted]

Dated and signed this 18th day of April 2019 at Portland, OR. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

✓ I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

Eric C. H
(Signature of Affiant)

State of: OR County of: Multnomah

The foregoing instrument was acknowledged before me this 18 day of Apr, 2019 by Eric Hunter.

and:

☒ who is personally known to me, or

☐ who produced the following identification: _____.

[SEAL]

Lorinda S. Koller
Notary Public
Lorinda S. Koller
Printed Notary Name
2/22/20
My Commission Expires

OFFICIAL STAMP
LORINDA SUE KOLLER
NOTARY PUBLIC-OREGON
COMMISSION NO. 947695
MY COMMISSION EXPIRES FEBRUARY 22, 2020

Applicant Company Name : Health Share of Oregon

NAIC No. _____

FEIN: 45-5093195

BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

_____

_____

_____

1. Affiant's Full Name (Initials Not Acceptable): First: Eric Middle: Charles Last: Hunter
IF ANSWER IS "NONE," SO STATE.

©2019 National Association of Insurance Commissioners

Applicant Company Name : Health Share of Oregon

NAIC No. _____

FEIN: 45-5093195

[redacted]

Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this 18th day of April, 2019 at Portland, OR, I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

✓ I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

E Z W

(Signature of Affiant)

State of: OR County of: Multnomah

The foregoing instrument was acknowledged before me this 18 day of Apr, 2019 by Eric Hunter and:

☒ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

Lorinda S. Koller

Notary Public

Lorinda S. Koller

Printed Notary Name

2/22/20

My Commission Expires

OFFICIAL STAMP
LORINDA SUE KOLLER
NOTARY PUBLIC-OREGON
COMMISSION NO. 947695
MY COMMISSION EXPIRES FEBRUARY 22, 2020

Applicant Company Name : Health Share of Oregon NAIC No.:

FEIN: 45-5093195

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS

(All states except California, Minnesota and Oklahoma)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of Health Share of Oregon **[company name]**("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both)("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact _____ **[company's designated person, position, or department, address and phone]**.

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act."

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

Eric Charles Hunter 311 NW 12th Ave #304, Portland OR 97209

(Printed Full Name and Residence Address)

(Signature) 4-18-19 (Date)

State of: OR County of: Multnomah

The foregoing instrument was acknowledged before me this 18 day of Apr, 2019 by Eric Hunter, and:

☒ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

OFFICIAL STAMP
LORINDA SUE KOLLER
NOTARY PUBLIC-OREGON
COMMISSION NO. 947695
MY COMMISSION EXPIRES FEBRUARY 22, 2020

Lorinda S. Koller
Notary Public

Lorinda S. Koller
Printed Notary Name

2/22/20
My Commission Expires

©2019 National Association of Insurance Commissioners

Applicant Company Name: Columbia Pacific CCO, LLC NAIC No. _____
FEIN: 45-5532847

Uniform Certificate of Authority Application (UCAA)
BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names). Columbia Pacific CCO, LLC

315 SW 5th Ave. Portland, OR 97204 503-416-4934

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE. ALL FIELDS MUST HAVE A RESPONSE. INCOMPLETE FORMS COULD DELAY THE APPLICATION PROCESS or REUSLT IN REJECTION OF THE APPLICATION.

1. Affiant's Full Name (Initials Not Acceptable): First: Marian Middle: Mae Last: Haley

[redacted]

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

[redacted]

13.

14.

15.

a

b

c

Applicant Company Name: Columbia Pacific CCO, LLC NAIC No. _____
FEIN: 45-5532847

BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Columbia Pacific CCO, LLC

315 SW 5th Ave. Portland, OR 97204

503-416-4934

[redacted]

Applicant Company Name: Columbia Pacific CCO, LLC NAIC No. _____
FEIN: 45-5532847

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS

(All states except California, Minnesota and Oklahoma)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of Columbia Pacific CCO, LLC **[company name]**("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both)("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact HR-315 SW 5th Ave. Portland, OR 97204- 503-416-5766 **[company's designated person, position, or department, address and phone]**.

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act."

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

Marian Mae Haley 17125 SE Royer Rd., Damascus, OR 97089

(Printed Full Name and Residence Address)

(Signature) 4/18/19 (Date)

State of: OR County of: Multnomah

The foregoing instrument was acknowledged before me this 18 day of Apr, 20 19 by Marian Haley, and:

☒ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

OFFICIAL STAMP
LORINDA SUE KOLLER
NOTARY PUBLIC-OREGON
COMMISSION NO. 947695
MY COMMISSION EXPIRES FEBRUARY 22, 2020

Lorinda S. Koller
Notary Public

Lorinda S. Koller
Printed Notary Name

2/22/20
My Commission Expires

Attachment 12 - Cost and Financial Questionnaire

12.A. Evaluate CCO performance to inform CCO-specific profit margin beginning in CY 2022

12.A.1. Does Applicant have internal measures of clinical value and efficiency that will inform delivery of services to Members? If so, please describe.

Understanding, managing and sharing measures of clinical value and efficiency are critical to understanding the health of CPCCO's enrolled population and managing associated risk borne by CPCCO and its parent organization, CareOregon. CPCCO uses the data infrastructure of CareOregon to measure clinical and financial performance. CPCCO staff then bring these data to a variety of internal cross-departmental workgroups to inform prioritization and decision-making. In addition, CPCCO staff bring data to governance committees such as the Clinical Advisory Panel (CAP), the Community Advisory Councils (CAC) and the Board of Director's Finance Committee, as well as to the full Board.

The CPCCO CAP uses measures in the most direct fashion to inform delivery of services to members. The CAP reviews cost and utilization data in bimonthly meetings and advises on solutions and areas requiring prioritization. The CAP regularly reviews dashboards in the following five areas, stratified by specific sub-populations, as appropriate, to understand different utilization and cost patterns between groups and where there may be opportunities to target inequities and efficiencies:

- **Specialty referral rates** across multiple specialties serve as a starting point for CPCCO to partner with providers to identify low-value care, discuss potential unnecessary referral patterns and develop strategies to address them.
- **MRI/imaging rates** across the CCO as well as variant MRI cost across regional hospitals. This data allows CPCCO and providers to address unnecessary imaging as well as excessive charges.
- Opioid Use Disorder and associated **Medication Assisted Treatment (MAT) utilization rates** help inform delivery of MAT treatment to individuals who would benefit from this highly effective intervention.
- **Emergency Department Utilization PMPM rates** to inform strategies for reducing avoidable ED use.
- **Pharmacy PMPM cost** to highlight trends and cost drivers and inform formulary structures.

Further, the CAP and the Board Finance Committee meet jointly at least once per year to ensure alignment of clinical and investment strategies, and to ensure that priority initiatives are supported from a clinical value perspective, as well as from a cost efficiency perspective.

By using dashboards that track measures of clinical value and efficiency, CPCCO has identified opportunities to improve efficiencies and clinical best practice related to delivery of services to members. Examples of this include:

- *Removing* prior authorization requirements (e.g., naloxone to address opioid overdose; new start insulin and diabetic supplies to improve diabetes management)
- *Implementing* prior authorization requirements (e.g., MRI/Imaging to help control cost in concert with clinical evidence)
- *Educating network providers* (e.g., guidelines for MAT)

These measures of clinical value and efficiency have informed CPCCO's approach to reducing low value care as a cost containment strategy as well as a quality improvement strategy. In 2019 and subsequent years, we will continue to expand our ability to analyze utilization data in the context of low-value care, and we will continue to move appropriate strategies into implementation.

CPCCO also uses a Population Risk Segment tableau reporting initiative to inform delivery of services. This robust population segmentation model allows us to segment the entire CCO population to easily identify how our membership is utilizing the healthcare system. The model contains four cohorts: healthy, low risk, rising risk, and high risk. Each of these cohorts are further apportioned into 11 segments. This segmentation process allows us the ability to use Health-Related Services (HRS) and other interventions on three levels.

- **Healthy/Low Risk**. On the population level, we work to keep our healthy members and communities healthy. This is accomplished by understanding the needs of those in the heathy segments and where they are located geographically. This upstream approach gives us the ability to leverage our HRS approaches with clinics and community-based organizations. We are also able to employ additional population health initiatives such as community benefit or social determinants of health remediation to keep these members healthy, ultimately avoiding unnecessary hospitalization in the distant future.
- **Rising Risk.** More immediately, we proactively engage those members in the rising risk segments. These members demonstrate usage of the medical system that indicates they may be moving to more high-risk cohorts but may not currently have had a hospitalization. By proactively enrolling members in care coordination, connecting to HRS, and developing member-specific interventions to address their needs, we believe we can avoid hospitalization.
- **High Risk.** We continue to employ robust transition support, especially for those members in the high-risk segments. We strive to connect these members to the appropriate level of resources and use evidence-based approaches to prevent future readmission. By understanding our entire population and by matching the appropriate intervention with the right segment, we can demonstrate a comprehensive system of preventing unnecessary hospitalization from very upstream to immediate readmission prevention.

The CCO Incentive Metrics serve as key measures of clinical value for our members, and we employ robust quality measurement and reporting programs for these measures, as well as incorporate them into our value-based purchasing arrangements, member engagement campaigns and ongoing quality improvement. Through the CAP, we continually measure and report on these quality indicators, systems to close gaps in care and increase prevention and wellness activities, programs to reduce ED utilization and improve patient safety, and many other innovative strategies to increase clinical effectiveness in service delivery.

CPCCO, through the CareOregon Utilization Management department, uses PreManage to drive efficiency for providers and internal staff. Authorizations are created using PreManage notifications reducing manual faxing of notifications. CPCCO has been a leader in the implementation and spread of PreManage in our region. PreManage is an HIE tool that allows hospital event information (ED and inpatient admissions and discharges) to be sent in real time to CPCCO staff and clinics for specified member or patient populations. PreManage has several unique functionalities that allow users to create targeted groups, cohorts and reports that directly align with strategic initiatives and inform clinical workflows, such as primary care review and follow up after an ED visit. The tool supports care coordination among providers and between providers and CPCCO. Disparities for

service access for members who are mentally ill has been well documented. The shared use of PreManage between primary care, EDs and CMHPs is intended to bring attention and coordinated intervention to those members who present in emergency service settings.

In terms of inpatient admits, we perform concurrent review for all critical access (A/B) hospitals to ensure medical necessity criteria are met throughout the inpatient stay. Utilization Management RNs and Medical Directors reviewing inpatient admits identify members who may need additional follow up from CPCCO's multi-disciplinary Regional Care Team (RCT). The UM team makes the referrals to RCTs or other appropriate staff for follow up.

From a health plan perspective, the Prior Authorization team (including Medical Directors, RNs, and line staff) continually identify patterns and opportunities to improve the overall process. This can include identifying services which should be reconfigured to no longer require prior authorization, services which should require prior authorization, and provider patterns which are questionable compared to their peers. The identified opportunities are reviewed by Medical Directors and Clinical Operations Manager to investigate the relevant rules and guidelines as well as most recent evidenced-based care. Recent examples of reviewed services are coding practices for acupuncture, and surgery outcomes and evaluation best-practices for bariatric surgery. We identified providers performing testing on members which were out of line with peers of like specialties. Examples of these are tongue tied surgery, skin biopsy with nerve analysis for small fiber neuropathy, allergy testing units, and visual evoked potential testing. Once identified, we reach out to the outlying provider, implement prior authorization process changes, and as necessary in some instances, refer to CCO or state Fraud, Waste, and Abuse units.

Finally, CPCCO introduced a performance accountability measure with financial implications in its 2018 contractual agreements with its delegated dental plan partners; these will be ongoing in future agreements. The measure specifically addresses increasing the percentage of adult and child members who receive a dental service during the year. Tying performance accountability to payment allows CPCCO to work with its dental plan partners to improve access to both preventive and restorative dental services.

12.A.2. What tools does the Applicant plan to deploy to identify areas of opportunity to eliminate Waste and inefficiency, improve quality and outcomes, and lower costs?

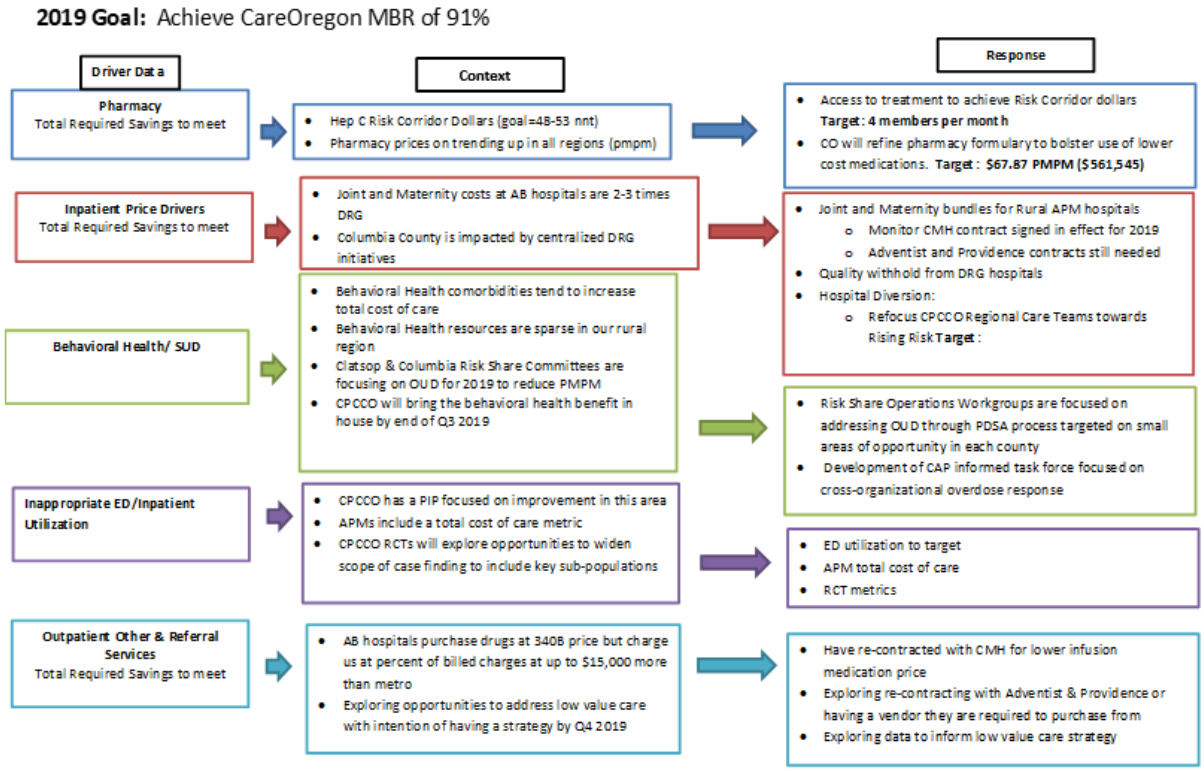
As outlined in 12.A.1, CPCCO uses several dashboards to identify areas of opportunity. In addition to those tools, CPCCO has a robust system in place to monitor achievement of the CCO incentive measures which are indicative of quality care for our members and help us to (1) identify high-performing clinics where high-value care is delivered and (2) provide technical assistance to clinics with identified areas to improve.

Tools to eliminate waste and inefficiency. CPCCO has a robust Compliance Program that includes recent focus and investment on Payment Integrity activities. The CPCCO Payment Integrity program identifies claims outliers or anomalies to ensure that claims paid are accurate, clinically appropriate, and that they adhere to regulatory requirements. In addition, CareOregon's claims team identifies other primary payers, coordinates benefits with other payers and employs claims editing tools to ensure that claims are adjudicated appropriately.

Tools to improve quality and outcomes and lower costs. CPCCO is an active participant in the CareOregon Cost and Utilization Steering Committee to (1) monitor cost and utilization trends

across regions and for CPCCO specifically, (2) identify low-value care opportunities and (3) make strategic, evidence-based, data-driven decisions to better manage cost and appropriate utilization. This steering committee's work is rooted in data analysis, including a strong understanding of OHP financial trends. CPCCO will continue to leverage data analytics to identify opportunities to incentivize clinically-effective care, discrete segments and patterns for investment or intervention, and strategies to address underlying drivers of cost and utilization.

The Cost and Utilization Steering Committee creates a portfolio of strategies, developed by the CPCCO Work Group, to include monitoring and outcome metrics, an implementation plan and timeline for the region. Additionally, an annual dashboard monitors cost and utilization trends throughout the year, informs how strategies are performing, and identifies whether refinement is needed. An example of an opportunity identified and acted upon in the past is inpatient hospital stays. As a result of data presented in the Cost and Utilization Steering Committee, CPCCO re-contracted with an A/B hospital in the region for specific procedures by creating payment bundles; this strategy was informed by DRG hospital payment bundles as best practice. The cost and utilization strategies for CPCCO are reviewed and advised on by the CAP at CAP meetings throughout the year. This allows CAP members to provide best practice clinical feedback to CCO leadership on proposed strategies, with a consideration for patient safety and care quality.



Further, future provider contracting (VBP) will include contractual provisions tied to agreed upon performance and quality metrics to help drive optimal efficiency and effectiveness. CPCCO is also leveraging innovative payment models to advance care coordination. In 2018, CPCCO added a Cost of Care Incentive Payment to the primary care APM program. The Cost of Care APM measures emergency department and inpatient visits for Ambulatory Care Sensitive Conditions (ACSC). The measure is adapted from the Agency for Healthcare Research and Quality (AHRQ)'s PQI 90. PQI 90 is one of the measures that OHA monitors as part of the CCO waiver. ACSCs are conditions in

which an acute event (ED or inpatient) could have been prevented with timely, high quality intervention in primary care. As such, they focus specifically on domains that are impactable by primary care clinics. In addition, the measure is aligned with work we have been doing with clinic partners using HRS grants to build clinic capacity to reinforce concepts of population health management, care coordination and use of PreManage.

As we implement our low value care strategy noted above in 12.A.1, we will use our internal analytic capabilities to also use a standard Waste Index tool on our claims data to identify unnecessary care and provide a launch point for understanding opportunities for cost savings and improved patient care.

12.A.3. Does the Applicant have a strategy to use Health-Related Services to reduce avoidable health care services utilization and cost? If so, please describe.

CPCCO reviews and delivers Health-Related Services (HRS) in a way that is strategically designed to reduce avoidable health care service utilization and cost; these include both member-specific flexible services, as well as community benefit initiatives funded via larger strategic investments. CPCCO's HRS program makes HRS resources available to address a member's immediate social needs or barriers, and to achieve positive health outcomes when community resources are unavailable, limited or nonexistent. However, the larger HRS strategy is integrated into (1) clinical and non-clinical interventions, (2) partnership programs with community-based organizations, medical provider networks and other social service agencies, and (3) CPCCO's care coordination program. By integrating the HRS strategy into these services, organizations and programs, CPCCO maximizes member support and reduces avoidable health care services utilization and cost, while also allowing the HRS to meet critical, immediate member needs. See 12.A.1 regarding HRS and CPCCO's population segmentation model.

When CPCCO staff or providers identify that a member has a critical, immediate need, CPCCO care coordinators convene an interdisciplinary care conference that includes the member's primary care team. Based on the member's health needs and treatment plan, the primary care team, care coordinator and relevant agencies work with the member and collaborate on the social needs that are projected to lead to avoidable health care services utilization and cost. If other resources are unavailable in the community, primary care teams may submit a request to CPCCO for an HRS-eligible item, in accordance with OAR 410-141-3150. CPCCO's regional care team (RCT) coordinates engagement with care team participants across systems to gather pertinent member information to determine whether the requested item/services are an appropriate means of reducing avoidable health care services utilization/cost or improving a health outcome. Members are informed of the decision in writing and CPCCO follows up with the member and/or their community-embedded case worker to coordinate payment and delivery of approved items or services. CPCCO's ultimate goal is to address a member's social need within an immediate, short-term timeframe, while simultaneously working with their community supports to ensure the intervention has sustainable next steps and that it is part of a broader care plan.

As a specific example, CPCCO's partnership with the Community Action programs in each county, called Healthy Homes, provides flexible services funding directly through the home assessment and environmental mitigation programs of Community Action. When the home occupant is a CPCCO member and requires an item, like a bed frame to get a mattress off the floor, to alleviate health impacts of unhealthy air or dust mites, the Community Action staff use HRS Flexible services funds directly through CPCCO.

12.A.4. What is the Applicant's strategy for spending on Health-Related Services to create efficiency and improved quality in service delivery?

CPCCO's strategy for spending on HRS, including community benefit funding, is intended to create efficiency and improved quality of service delivery in all CPCCO-covered services. This strategic approach takes seriously the reality that the urgent social needs addressed by HRS items/services or by community-based organizations are the downstream manifestations of social determinants of health on the community. The demand for immediate interventions to address social needs will not stop until the true root causes are addressed.

CPCCO's strategies will target the intersection of individual and population health to bridge the profoundly siloed structures of clinical medicine and public health. CPCCO understands the relationships between individual and population health as being highly interconnected and dynamic. The spending priorities described in more detail below will provide clinical partners with the flexibility to respond strategically to the increased demands mandated by health care reform.

CPCCO prioritizes HRS spending in the following categories:

- **Integration**-related proposals, especially between clinical and community settings.
- **Alternate payment model** proposals establishing arrangements with clinical partners for value-based care, and alternative payment methods that incentivize provision of high quality services that promote sustained (rather than temporary) positive health outcomes. Value-based care and alternative payment methods also have the potential to incentivize provider collaboration with the community to address health disparities.
- **Clinical partner capacity building** focus on building provider capacity to reduce health disparities, reduce access barriers, improve quality/health outcomes, and address provider recruitment and retention challenges.
- **Community Health Improvement Plan (CHIP) Priorities** to begin in 2019 have been established by a broad-based community collaborative (including hospitals, FQHCs, CMHPs, and county Public Health) to be (1) behavioral health, (2) housing, and (3) parenting skills. Our HRS spending will align with these community priorities moving forward.

The intent of these strategies is to 1) deliver care differently by integrating care delivery, improving clinic efficiencies and increasing capacity in number of staff, appointments or exam rooms, and 2) strengthen clinic workflows, team-based care, internal processes and operations. Additionally, these strategies encourage the providers to consider their individual patients' holistic health, including the social determinants of health factors that influence their individual behaviors, which in turn impacts their physical, behavioral and dental health outcomes.

12.A.5. What process and analysis will the Applicant use to evaluate investments in Health-Related Services and initiatives to address the Social Determinants of Health & Health Equity (SDOH- HE) in order to improve the health of Members?

CPCCO uses a variety of processes and analytic tools to evaluate the effectiveness of investments in Health-Related Services and Social Determinants of Health and Health Equity (SDOH-HE), in community agencies and clinical programs depending on the investment, and based on our experience, .

For Health-Related Flexible services, each member case is evaluated (1) against the care and treatment plan for the individual member and (2) as directed and documented by the member's primary care provider. With the support of CareOregon, CPCCO will continue to use data and analytics tools that are available to evaluate the effectiveness of Flex services to address SDOH-HE, along with other clinical supports and care coordination that individual members – and populations – need.

For Health-Related Community Benefit Investments, as well as for investments to address SDOH-HE, CPCCO uses a logic model process, outlining anticipated investments in time, money, staff or other inputs against the proposed activities, target population(s), and expected short-, medium- and long-term outcomes or impacts. The purpose of evaluation for every program or investment is four-fold: assist in decision-making; identify process improvements (during and after implementation); monitor performance; and understand relative impacts. The elements of evaluation used by CPCCO include gathering information relative to each program, designing the appropriate evaluation, collecting and analyzing data, and reporting the results.

With each investment, CPCCO and the funded organization enter into a Letter of Agreement that includes the metrics monitored throughout the project or program, outcomes to date and projected outcomes, and the reporting schedule to CPCCO in order to review the metrics against expected deliverables. Because of the length of time it takes to impact health outcomes related to investments in SDOH-HE, we generally develop process metrics for review and evaluation.

Overall, CPCCO will use a rigorous program evaluation framework to guide evaluation of Health-Related Services and initiatives that address SDOH-HE. This framework will be tailored to each program or initiative in order to assess the efficacy of the distinctive program design, strategies and activities that drive improved health outcomes and cost efficiency. This framework will apply both to internal programs and to CPCCO's investments in programs run by community-based organizations.

Evaluation Process and Components: The evaluation framework will focus on both process evaluation and outcome evaluation. Analysis for both of these will draw on relevant program data, claims data, health related services data, member interviews or survey data, and other sources. Evaluation design for both areas will be developed jointly with systematic program planning, so that data collection choices and processes 1) are aligned with program goals, 2) can be targeted to track critical program activities, outputs and potential barriers, and 3) can be embedded in program design and implementation to assure that all necessary data is available for analysis.

12.B. Qualified Directed Payments to Providers

Beginning in 2020, OHA will develop a program of qualified directed payments (QDP) for the repayment of most provider taxes paid by Hospitals in Oregon. The specific parameters and methodology of the QDPs for fiscal year 2020 will be determined following completion of the 2019-21 Legislatively Adopted Budget and will rely on input from a variety of stakeholders. OHA will promulgate administrative rules to include a Quality and Access pool for Hospitals reimbursed by Medicare based on diagnostic-related groups (aka, DRG Hospitals).

12.B.1. Does Applicant currently measure, track, or evaluate quality or value of Hospital services provided to its enrollees? If so, please describe.

Hospital Quality Metrics Program

The Hospital Quality Metrics Program is currently a reporting-only program with the intent of entering into more meaningful dialogue around clinical quality performance with our hospital partners. We will transition the reporting-only aspect of this program to a withhold structure in 2020.

Measure	Data Source	Definition/Description
Hospital Acquired Infection Composite Measure	CMS Hospital Compare	Count of HAI measures (CAUTI, CLASBI, SCIFF, MRSA[1]) where target is met. Must meet at least 3 of 4 targets to meet the composite measure
Reducing Revisits for Frequent ED User	CareOregon Claims	Percent of individuals who have 5 qualifying ED visits at the same facilities, who subsequently visit the ED of the same facility within 30 days of the 5th visit
All Cause Readmission	CareOregon Claims	Percent of inpatient visits returning as an acute care inpatient within 30 days of date of initial discharge
HCAHPS: Staff Always Explained Medicines	CMS Hospital Compare – HCAHPS survey	Percent of patients who said hospital staff "always" told them what their medication was for and possible medication side effects on survey

[1] The Hospital Acquired Infection (HAI) composite measure includes catheter-associated urinary tract infections (CAUTI), central line-associated bloodstream infection (CLASBI), clostridium difficile laboratory-identified events (CDIFF), and methicillin-resistant staphylococcus aureus (MRSA) laboratory-identified events. To meet the measure at least three of the four HAI measures must be met.

In addition, CPCCO currently offers its hospital pay-for-performance payments, based on their performance on metrics, including:

- HCAHPS
- ED utilization rates
- All-cause readmission
- Total resource use population based PMPM index (NQF 1598)
- Total cost of care population based PMPM index (NQF 1604)
- Standardized healthcare-associated infection ration

12.C. Quality Pool Operation and Reporting

12.C.1. Does the Applicant plan to distribute Quality Pool earnings to any public health partners or non- clinical providers, such as SDOH-HE partners or other Health-Related Services Providers? If so, please specify the types of organizations and providers that will be considered?

CPCCO has a long-standing policy, adopted by its Board of Directors in 2015 and continuing in the 2020-2025 period, of investing a portion of Quality Pool earnings in community organizations that serve OHP members and address SDOH, public health or other drivers (*i.e.*, adverse childhood experiences) of costly acute care services. The CPCCO Board adopted four categories for distribution: 1) integration and alternative payment models; 2) clinical innovations; 3) community

health; and 4) prevention and health promotion. CPCCO would consider any non-profit organizations, agencies and providers that provide services in any of these four categories, whether clinical or non-clinical. For example, CPCCO invested Quality Pool dollars in a van for a needle exchange program run by the Clatsop County Public Health department.

12.C.2. How much of the Quality Pool earnings does the Applicant plan on distributing to clinical Providers, versus non-clinical providers? Please discuss the approach as it relates to SDOH-HE partners, public health partners, or other Health-Related Services Providers.

Based on the current CPCCO Board policy, approximately 89% of investments will be for integration, innovation and alternative payments for clinics, with the remaining 11% to be directed towards community organizations and SDOH. Please see Attachment 10 B.1-2 for a list of key LOAs and criteria used by CPCCO in selecting community services organizations and SDOH.

12.C.3. How much of the Quality Pool earnings does the Applicant plan on investing outside its own organization? On what would Applicant make such investments?

With rare exceptions, CPCCO distributes all Quality Pool funds to external clinics, agencies and organizations. One exception is the use of Quality Pool earnings to embed CPCCO panel coordinators in key clinics, to help with population health and member outreach. It should be noted that even this internal investment was made at the request of CPCCO's clinic partners who advised that having CPCCO hire and embed panel managers would be more efficacious than granting the clinics the money directly to do the same.

The most current exception was an investment in one new CPCCO FTE to implement a self-sustaining business model for a six-sector, trauma-informed network focused on preventing or addressing childhood ACEs and building resilience. The sectors are education, health care, child welfare, criminal justice, economic and community (*i.e.*, faith-based). In this case, there was not an external organization doing this work in the CPCCO service area to invest in, so the CCO filled this gap directly, again with input from local stakeholders. In total, less than $500,000 a year is typically invested in CPCCO itself from Quality Pool earnings.

12.C.4. How will the Applicant decide and govern its spending of the Quality Pool earnings?

The CPCCO Board of Directors has established a policy to govern the distribution of Quality Pool earnings and investment cycle approved by the Board; see answer to 12.C.1 for a description of the decision and governance process. In addition, the CPCCO Board adopted a policy for Quality Pool funds distribution to clinics based on their relative contribution to meeting the incentive metrics.

12.C.5. When will Applicant invest its Quality Pool earnings, compared with when these earnings are received?

Because of the timing of receipt of quality pool earnings against the investment cycle approved by the CPCCO BOD, CPCCO distributes 35-40% of Quality Pool earnings in the year earned, with an attempt to distribute the remaining earnings from each year's Quality Pool in the subsequent two years. We are currently just completing distribution of remaining Quality Pool earnings from the 2016 incentive year.

12.C.6. Does the Applicant have sufficient cash resources to be able to manage a withhold of a portion of its Capitation Payments?

Yes, CPCCO has sufficient cash resources to manage a withhold of a portion of its capitation payments. Because of the delay we built into spending the quality pool dollars earned, we can make programmatic adjustments that allow us to accommodate cash flow impacts.

12.D. Transparency in Pharmacy Benefit Management Contracts

OHA seeks to address increasing pharmacy costs by increasing the transparency of CCO relationships with Pharmacy Benefit Managers (PBMs) and requiring no-spread contracts between CCOs and PBMs. CCOs will be required to ensure they are receiving competitive pricing from their PBMs by obtaining 3rd party market checks audits.

12.D.1. Please describe the PBM arrangements Applicant will use for its CCO Members.

On behalf of CPCCO, CareOregon uses OptumRx for PBM services not performed by CareOregon directly. Most PBM services are performed directly from CareOregon by CareOregon staff. Exceptions are pharmacy claims adjudication, pharmacy claim modules/programs to meet specific tasks (e.g. medication transition supplies, FWA), pharmacy network contracting and pharmacy rebate contracts.

12.D.2.Does Applicant currently have a "no-spread" arrangement with its PBM? If not, please describe the steps the Applicant will take to ensure its contracts are compliant with these requirements and the intended timing of these changes. If changes cannot be made by January 1, 2020, please explain why and what interim steps Applicant will take to increase PBM transparency in CY 2020. (In order for an extension in the timeline to be considered, Applicant must show it is contractually obligated to use non-compliant PBM and shall provide OHA a copy of PBM agreement as justification along with a plan to ensure compliance with transparency requirements at the earliest date possible)

[redacted]

12.D.3.Does the Applicant obtain 3rd party market checks or audits of its PBM arrangement to ensure competitive pricing? If not, does the Applicant have a plan to receive this analysis? If so, how often are these analyses performed, what is done with this third party data and what terms inside of your PBM contract allow this analysis to have power for the CCO to ensure its pharmacy contract remains competitive?

[redacted]

12.D.4.Does the Applicant plan to use the Oregon Prescription Drug Program to meet the PBM transparency requirements?

No, CPCCO does not plan to use the Oregon Prescription Drug Program to meet the PBM transparency requirements, however both PreManage and soon Reliance HIE platforms will have integrated PDMP for use by our network of providers which will broaden transparency and impact. We will continue to encourage providers to use the PDMP to inform appropriate prescribing and strongly support OHA's efforts to integrate the PDMP into EHRs. Please see Attachment 9 for further details on HIE adoption and impact in our region.

12.E. Alignment Preferred Drug Lists (PDLs) and Prior Authorization Criteria

OHA seeks to address increasing pharmacy costs by increasing the alignment of CCO preferred drug lists (PDLs) with the PDL used by OHA for the fee-for-service program with a particular focus on high- cost drugs and on alignment strategies that reduce overall program costs and/or improve the pharmacy benefit for OHP Members. OHA will work in conjunction with Successful Applicants to establish initial PDL alignment criteria and will take additional steps to modify alignment criteria over time. As part of this requirement, CCOs will be expected to make public and accessible their PDLs as well as the coverage and Prior Authorization criteria for all pharmaceutical products.

12.E.1. Does Applicant currently publish its PDL? If not, please describe the steps the Applicant will take to ensure its PDL is publicly accessible concurrent or in advance of the Year 1 Effective Date for prescribers, patients, dispensing pharmacies, and OHA.

Yes, the CPCCO formulary (PDL) is posted on our website and is updated after each P&T meeting when changes are made to the formulary.

12.E.2. Does Applicant currently publish its pharmacy coverage and Prior Authorization criteria concurrently with or in advance of changes made? If not, please describe the steps the Applicant will take to ensure its pharmacy coverage and PA criteria are both publicly accessible for prescribers, patients, dispensing pharmacies, and OHA and updated in a timely manner.

Yes, the prior authorization criteria are posted on our website after each P&T meeting when proposed changes have been reviewed and approved by the P&T Committee concurrent of the changes. However, in an event when members will be negatively affected by the formulary or PA criteria changes, impacted members and their prescribing providers will be notified in advance of changes made.

12.E.3. To what extent is Applicant's PDL aligned with OHA's fee-for-service PDL? Please explain whether and how supplemental rebates or other financial incentives drive differences in the Applicant's PDL as compared to the fee-for-services PDL.

PDL alignment - Upon review of the Myers and Stauffer report, CPCCO's PDL is mostly aligned with OHA's FFS Medicaid formulary today. CPCCO aligns the formulary with OHA's goals of benefit coverage, cost, quality and safety obligations and is producing significant pharmacy trend reduction. We are not fully aligned with OHA's fee-for-service (FFS) PDL in order to manage costs to meet the annual cost growth target. Our focus is on promoting the most cost-effective options within therapeutic classes and generic products to drive down the lowest purchase price. The differences in alignment are among the few brand drugs with significant state supplemental rebates, such as insulin and inhaler drug categories. Our formularies also have oncology, specialty, and rare disease state medications that are not on the FFS formulary.

Supplemental rebates and other financial incentives - The minimal supplemental rebates made available to CCOs do not drive formulary placement. Evidence-based decision making and safety are paramount in selecting the most cost-effective quality treatment. CPCCO, through CareOregon Pharmacy & Therapeutics Committees (P&T), allow local providers and specialists to participate throughout the P&T processes. These important provider inputs help to prioritize formulary decision making, which is vital in implementation staging.

PDL alignment – Supplemental rebates and other financial incentives – It is unclear whether state supplemental rebate misalignment will continue with the proposed changes by the Federal government to remove the rebate anti-kickback safe harbor. Drug companies have told us they are unsure how and if they will continue to provide significant supplement rebates considering all market populations, including Medicaid, since it all works together to affect drug utilization.

Should supplemental rebates continue, CPCCO supports the state proposal requiring PBMs to pass through 100% of supplemental rebates to CCOs. If the state were to do the same and pass through 100% of supplemental rebates to CCOs, we would have full alignment. We would retain and expand the strength of the CCO concept of growing local engagement and integration to serve our local populations medication needs in a financially sustainable way. We are proud of our respective formulary work and will work to continue to earn the right to keep our formulary responsibilities.

12.E.4. Does the Applicant plan to fully align its PDL with the fee-for-service PDL? If not, please describe exceptions.

CPCCO will meet the OHA requirements to work together with the other CCOs and OHA to partially align PDLs in specific drugs and drug categories. CPCCO fully supports lowering drug costs while ensuring we are meeting quality and safety obligations and improving our member experience.

12.F. Financial Reporting Tools and Requirements

12.F.1. Does Applicant or any Affiliate of Applicant currently report on NAIC health insurance forms? If so, please describe the reporting company or companies and its relationship with Applicant.

CPCCO has an Affiliate (Health Plan of CareOregon, Inc.) that operates a Medicare Advantage health insurance plan. This plan does file NAIC health insurance forms with DCBS. Both the Medicare plan and CPCCO are owned by CareOregon, Inc.

12.F.2. Does the Applicant currently participate and file financial statements with the NAIC?

No.

12.F.3. Has Applicant prepared a financial statement which includes a RBC calculation? If so, please submit.

No. CareOregon's finance department can prepare this reporting in the future as requested.

12.F.4. Does the Applicant currently have experience reporting in SAP either directly or through any Affiliate of Applicant?

Yes, please reference the question 12.F.1 for further details.

12.F.5. Does the Applicant seek an exemption from SAP and NAIC reporting for 2020? If yes, please explain in detail (a) the financial hardship related to converting to SAP for the filing, and (b) Applicant's plan to be ready to use SAP in 2021.

No.

12.F.6. Please submit pro forma financial statements of Applicant's financial condition for three years starting in 2020, using Enrollment, rates and cost projections that presume Applicant is awarded a Contract under this RFA. If OHA expects there may be more than two CCOs in Applicant's Service Area, OHA may require Applicant to submit additional pro forma financials based on the expected number of CCOs. OHA will evaluate Applicant's pro forma financials to assure that they provide a realistic plan of solvency. See the RFA Pro Forma Reference Document and UCAA Supplemental Financial Analysis workbook template for a complete description of the requirements and deliverables. The pro forma workbook templates and required supporting documents are excluded from the page limit.

Required Documentation

- ***Completed Pro Forma Workbook Templates (NAIC Form 13H)***
- ***Completed NAIC Biographical Affidavit (NAIC Form 11)***
- ***Completed UCAA Supplemental Financial Analysis Workbook Template***
- ***Three years of Audited Financial Reports***

12.G. Accountability to Oregon's Sustainable Growth Targets

OHA seeks to improve the connection between CCO Contracts and the sustainable growth targets established in Oregon's Medicaid waiver and the legislatively enacted budget.

12.G.1. What strategies will the Applicant employ to achieve a sustainable expenditure growth year over year?

CPCCO employs strategies aimed at producing high value care for members and reducing unnecessary cost in order to achieve sustainable expenditure growth year after year. More specifically, current 2019 strategies are to:

- Implement a contracting strategy that targets hospital cost such as administered infusion medications, joint surgeries, colonoscopies and maternity by Q4 2019.
- Implement one pharmacy cost savings initiative per quarter through both risk share and clinical venues.
- Create a network that produces high value care and reduces waste as evidenced by:
- Spine/knee/shoulder: 15% reduction
- New face-to-face Specialty referrals: 10%
- New face-to-face ortho referrals: 10%
- Knee arthroscopy reduction to <1%
- Partner with CPCCO's provider network to implement at least one Choosing Wisely recommendation in at least two organizations by Q4 2019.
- Reduce inappropriate NEMT utilization by 27% by Q4 2019.
- Manage chronic disease (physical and behavioral) and rising risk populations to prevent acute use of the hospital.
    - CareOregon's population segmentation model: share high and rising risk member specific populations with all major primary care and hospital systems to use community care coordination models to prevent hospitalizations.

- Opioid Use Disorder (OUD) and SUD treatment.
    - Database created for OUD and medication assisted treatment (MAT) engagement.
    - Pathways to Treatment collaboration for physical health, hospitals and behavioral health providers to create a hub and spoke model to maximize best practice MAT with engagement of people with OUD in any setting (ED, hospital, A&D treatment, PCP).
    - Expand access to OUD and MAT in the CPCCO service area through partnerships (e.g. new SUD facility in Seaside in partnership with CODA).
    - Engage PCP providers in best practice learning and workflow adoption for MAT.

While specific tactics may change over the course of the 2020-2025 contract, we believe the strategies described above will largely endure as they benefit the member through improved health outcomes and greater access to primary and preventive care services. See 12.G.5 for additional information.

12.G.2. How will the CCO allocate and monitor expenditures across all categories of services?

CareOregon provides comprehensive financial and management reporting on behalf of CPCCO, including medical cost data analysis and allocations. CareOregon has been managing financial reporting and data analysis for Medicaid plans since its inception in 1994 when it was founded to support the Oregon Health Plan. CareOregon has built a strong financial and data analysis infrastructure (people and technology) that fully supports the reporting and data analysis needs of its affiliated CCOs.

CareOregon uses Intacct accounting software to track financial transactions. This general ledger software can track a tremendous amount of detail, using its expansive chart of accounts and program codes to organize financial information. CareOregon also uses Axiom, a powerful, Excel-based reporting software, to pull data from multiple data sources including, but not limited to: Intacct accounting software, Mercer payroll/employee software, medical cost and metric data tables, and QNXT/Trizetto claims payment software. CareOregon uses both SAS and Tableau to generate detailed reporting and analysis by region, by category of service and by rate cell. These technology tools allow CareOregon to drill down in a detailed fashion to better understand drivers of medical cost and related trends. CareOregon is also nearing completion of implementing two new and robust software programs to support population health management (GSI) and data analytics and business intelligence (Arcadia). In the near future, CareOregon will acquire a "Prometheus-like software" to better pinpoint opportunities to eliminate potentially wasteful spending and identify provider contracting opportunities.

CareOregon has a strong accounting and analytic team who will use multiple data sources to provide stakeholders with a broad range of information – from monthly financial statements and cost allocations to strategic management reporting and data analysis. In addition, CareOregon has a financial planning team who will prepare detailed annual budgets, interim forecasts and management dashboards. CPCCO uses CareOregon's financial planning capabilities to closely monitor actual to budgeted outcomes for medical costs and operating metrics. CareOregon is committed to hiring, retaining and engaging high-performing employees who will bring expert levels of knowledge, experience and skill sets to accomplish required financial reporting and planning objectives.

CPCCO has a strong working relationship with its independent consulting actuaries (Wakely Consulting). Working with our actuaries, CPCCO is able to prioritize the accurate and complete reporting of its medical costs from year-end estimation of IBNR balances (by category of service, as well as by ACA vs. non-ACA) through the proper classification of paid claims activity (by category of service and by rate cell) submitted in the annual Exhibit L. CPCCO highly values its relationship with Wakely, knowing that engaging actuarial oversight on key medical cost accruals and allocations is an important CCO activity. Please note that CareOregon is also in the early stages of hiring in-house actuaries to join the CareOregon accounting and analytical teams, thereby enhancing our available actuarial resources.

12.G.3. What strategies will the Applicant utilize related to Value-Based Payment arrangements to achieve a sustainable expenditure growth?

CPCCO uses a value based payment arrangement called the County Community Risk Model to incentivize providers to manage members' costs. The Community Risk Model sets year over year cost targets to meet or beat the sustainable growth rate, with a portion of any savings realized then shared with the participating providers. Conversely, if the total costs exceed the cost target, providers are required to help cover a portion of the loss. This risk arrangement has been in place since 2015 and has helped motivate providers and other community partners to think differently about how they collaborate to manage members' care. CPCCO intends to continue this model and spread it to more providers to achieve the sustainable growth rate.

In addition, CPCCO supports cost containment through improved quality and cost consciousness measures built into their monthly Per Member Per Month (PMPM) payments through the Primary Care Payment Model (PCPM). Multiple measures are reported and monitored that support both the state CCO measures and Medicare Star measures and are intended to incent more efficient delivery of care. The new cost consciousness measure tracks Ambulatory Care Sensitive Conditions that can be treated more cost effectively and appropriately in the primary care setting versus the expensive hospital setting. These PCPM payments are significant to the providers and are effective at controlling costs while improving quality by varying the PMPM payment based on achievement of the measures.

12.G.4. What strategies will the Applicant utilize to contain costs, while ensuring quality care is provided to Members?

CPCCO has developed several strategies to contain costs over the next five-year period, while maintaining and improving high levels of quality care. While we will continue to develop strategies based on emerging data, the following have been identified for initial implementation:

- Increase emphasis on substance use disorder (SUD) Treatment. The trend has been that patients with SUD are increasingly needing inpatient care. Treatment of SUD is linked to cost savings, and clearly to improved quality outcomes.
- Build a new opioid treatment program in Seaside, Oregon in partnership with CODA. This was developed based on analysis of NEMT data showing high costs for daily rides to Portland and Salem for methadone treatment. Adding an opioid treatment program in Seaside that can also offer methadone will help mitigate NEMT costs, opioid related ED and inpatient costs, and improve patient health both because of the treatment and because they will not spend 4-6 hours daily traveling to get medication. The availability of a local methadone dispensary will also increase the numbers of members in recovery.

- Improve care coordination through continued use of county-specific Regional Care Teams. These inter-disciplinary teams address social determinants of health and barriers. This in turn decreases emergency department utilization and inpatient hospitalization, which decreases cost and improves quality.
- Address low value care as we use specialty referral, MRI and opioid dashboard data to develop strategies to improve cost and quality simultaneously, blending with clinical evidence and best practice such as Choosing Wisely (see 12.1.A).
- Control pharmacy costs through two main mechanisms: formulary management and development of clinical programs that will both increase quality and reduce costs. This has been successful: in 2018, CPCCO was able to maintain a year over year -1.5% pharmacy cost trend through these initiatives.

CPCCO has recently implemented several strategies that have resulted in significant cost reductions. These programs will be continued into the future. Examples of programs with significant cost impact include: maximizing Hepatitis C treatment for qualified patients; develop and distribute treatment pathways for asthma, COPD, and diabetes highlighting low-cost alternatives to commonly used medications; and leveraging risk-sharing partnerships to encourage utilization of low-cost medications when appropriate. Additionally, CPCCO recognized that escalating trends in infusion medications were caused by an A/B hospital designation which allows rural hospitals to acquire drugs at 340(B) prices and charge us many times more than the acquisition cost. We have successfully re-contracted these rates with one hospital and will continue to engage our other two hospitals to reduce pharmacy costs in the region.

In the next five years, CPCCO will build on the above strategies, expand SUD and mental health services, and utilize data internally and with our clinics to expand cost and utilization strategies that work to bend the cost curve and improve quality.

12.G.5. Has the Applicant achieved per-Member expenditure growth target of 3.4% per year in the past? Please specify time periods.

CPCCO is still working to finalize the 2018 Exhibit L and supplemental filings; we are cautiously optimistic that have achieved a global plan-wide medical cost PMPM trend of 3.4%, or less, when measured from DOS 2017 to DOS 2018 (excluding quality pool distributions). Several subtrends are impressive: plan-wide physical health medical cost PMPM trends from 2017 to 2018 were less than 1%, and in the non-ACA population, there was a significant PMPM cost decrease in physical health medical costs (-3%).

In prior years, CPCCO has not achieved the 3.4% global cost growth trend target due to a variety of non-controllable factors such as the ACA durational effect (rising risk scores and PMPM medical costs), delayed redeterminations, fluctuating birth rates, and benefit expansions by the State including the integration of NEMT and dental member services.

CPCCO has ongoing factors that may impact meeting the target in the future. (1) As rural A/B hospitals expand local access to complex disease treatment options, there can be cost increases as members receive treatments at more expensive, but local, A/B hospitals rather than traveling to the less-expensive Portland metro DRG hospitals. (2) Our smaller risk pool means that, in any one year, a large number of random and/or a super-catastrophic number of medical claim costs will have an outsized (but temporary) effect on the trend, even though our reinsurance policy helps to financially mitigate the net cost.

CPCCO is committed to reaching and maintaining a consistent sustainable rate of growth of 3.4% for medical costs. We have made, and will continue to make, significant investments that improve health care access while maintaining sustainable growth in costs:

- increase primary care and behavioral health integration
- improve local access to substance abuse disorder treatment options
- improve local access to mental health treatment providers
- improve access to primary care services and member engagement
- implement value-based contracting, particularly for hospital spending
- pinpoint cost-saving opportunities and reduce potentially wasteful or low-value medical spending by acquiring "Prometheus-like" software
- expand our healthcare analytics ability, allowing us to maximize the financial outcomes of our member and provider cost-mitigation strategies

Our ongoing work to better control medical costs, and more importantly, our efforts to improve our members' ability to access healthcare services, will have a substantial positive long-term effect on mitigating future medical cost trends.

12.H. Potential Establishment of Program-wide Reinsurance Program in Future Years

OHA seeks to establish a statewide reinsurance program to better control costs related to high-cost medical conditions, treatments, and patients.

12.H.1. What type of reinsurance policy does the Applicant plan on holding for 2020? Please include the specifics. (e.g. attachment points, coinsurance, etc.)

CPCCO's future reinsurance policy is expected to be similar to that currently in place for CY2019 (January through December). CPCCO delegates the financial risk for physical and behavioral health to CareOregon, thereby aggregating its member population in a larger risk pool at CareOregon. This administrative efficiency allows us to comfortably carry an attachment point of $400,000 and coinsurance of 90%. Eligible expenses are based on physical health FFS claims paid, and specifically exclude subcapitation and/or APM amounts (e.g. PCPM). Our policy is also subject to "lasers," in which identified high cost members can be subject to higher attachment points ranging from $600,000 to $1M. Please note that we have separate reinsurance policies for our Medicaid and Medicare populations.

12.H.2. What is the Applicant's reasoning for selecting the reinsurance policy described above?

Reinsurance coverage is a risk mitigation strategy to protect CPCCO's and its parent company CareOregon's financial reserves from catastrophic cost events. We carefully analyze coverage options, premium costs and estimated recoveries to evaluate projected net costs. Projected net costs are then considered in tandem with the organization's ability/desire for risk tolerance.

12.H.3. What aspects of its reinsurance policy are the most important to the Applicant?

The most important aspects of the reinsurance policy for CPCCO/CareOregon are attachment points (risk mitigation), net reinsurance costs (financial sustainability) and the quality of the reinsurer's customer service.

12.H.4. Does existing or previous reinsurance contract allow specific conditions or patients to be excluded, exempted, or lasered out from being covered?

Yes. It is very common to laser members with hemophilia and transplant candidates. Rare chronic diseases are also lasered due to emerging breakthrough therapies.

12.H.5. Is Applicant able to leave or modify existing reinsurance arrangements at any time or is Applicant committed to existing arrangements for a set period of time? If so, for how long is Applicant committed to existing arrangements? Are there early cancellation penalties?

Policies are constructed to be in effect for each calendar year. Premium costs and estimated recoveries are based on YTD (12-months) activity. It is likely that if the organization was required to terminate a policy before the 12-month coverage period, the financial outcome would be that CPCCO incurs higher PMPM costs than necessary. Our current policy through our current reinsurer does not have early cancellation penalties, but that does not mean that a future policy would not. It is possible that CareOregon may purchase a future reinsurance policy that includes early termination penalties. If the Oregon Legislature or OHA is considering new rules for CCOs regarding reinsurance policies, we respectfully request that these changes (1) occur on January 1 of the effective year to coincide with calendar year terms, and (2) give CCOs as much advance notice as possible so that we can properly plan for any changes to reinsurance.

12.I. CCO Solvency Standards and OHA Tools to Regulate and Mitigate Insolvency Risk
OHA seeks to ensure continued financial viability of the CCO program as a whole so as to ensure OHP Members are protected from potential access barriers that could come with a CCO insolvency event. In addition, OHA may implement new solvency regulation tools that are similar to those utilized by DCBS in its regulation of commercial carriers that would allow OHA to prevent or meliorate insolvency events.

12.I.1. Please describe Applicant's past sources of capital.

In the past, CPCCO has received its capital from three different sources. When CPCCO was formed in 2012, CareOregon contributed capital so it could meet the minimum capital requirements. In 2015, CPCCO, CareOregon, GOBHI (CPCCO's original delegate for behavioral health risk), and providers across the service area entered into a county-level collaborative risk share arrangement where a portion of gains generated by CareOregon and GOBHI in managing the delegated risk were shared with CPCCO and the providers. Lastly, CPCCO generated its own capital by managing within its budget for NEMT and administration.

12.I.2. Please describe Applicant's possible future sources of capital.

If needed, CPCCO would look to CareOregon to provide any needed capital, as it has done in the past, either through a contribution or through the gainshare arrangement that already exists.

12.I.3. What strategies will the Applicant use to ensure solvency thresholds are maintained?

Since CPCCO holds very little insurance risk, it is not difficult to ensure solvency thresholds are maintained. CPCCO delegates s all risk for physical and behavioral health to CareOregon, and CPCCO delegates dental risk to its DCO partners. Only NEMT and CCO administration expenses are borne by CPCCO. CPCCO's staff and Board monthly monitor the solvency of CareOregon to ensure it is sufficiently capitalized and CareOregon holds itself to industry standard risk based capital levels.

12.I.4. Does Applicant have a parent company, Affiliate, or capital partner from which Applicant may expect additional capital in the event Applicant becomes undercapitalized? If so, please describe those activities

Yes, CareOregon is the sole member ("parent") of CPCCO and could provide additional capital in the event CPCCO is undercapitalized. In the past, CareOregon contributed capital to CPCCO. In addition, CPCCO could earn risk share dollars through the county community risk share arrangement with CareOregon.

12.J. Encounter Data Validation Study

12.J.1. Please describe Applicant's capacity to perform regular Provider audits and claims review to ensure the timeliness, correctness, and accuracy of Encounter Data.

CPCCO is committed to ensuring the timeliness, correctness and accuracy of encounter data and we have several strategies in place to support this. We work with a vendor partner to perform pre-payment clinical reviews for certain payment thresholds and cost outliers for inpatient services. We have both employed and contracted certified coding specialists performing pre-payment and post-payment clinical reviews for professional and facility claim types. We also have both employed and contracted certified coding specialists to perform pre-payment and post-payment clinical reviews for professional claim types. Our Internal Audit Department conducts focused audits to ensure the timeliness, correctness and accuracy of encounter data. Encounter data is validated, formatted and clean data is submitted to OHA via 837 and NCPDP file format within the regulatorily required timeframe. CPCCO has never been subject to the 1% withhold for timeliness of encounter data submission.

12.J.2. Does Applicant currently perform any activities to validate Claims data at the chart level that the claims data accurately reflects the services provided? If yes, please describe those activities.

Yes. (1) We currently perform pre-payment reviews against medical records for certain services; the medical record is required with the claim submission. (2) We work with a vendor partner to perform post-payment DRG audits. (3) We target certain provider types to perform regular post payment audits in which the medical record is requested and then reviewed regarding the services billed, medical necessity and level of care.

12. K. Cost and Finance Reference Documents

- ***Exhibit L Financial Reporting***
- ***Exhibit L Financial Reporting Supplemental SE***
- ***2020 Minimum Medical Loss Ratio Rebate Calculation Report Instructions***
- ***2020 Minimum Medical Loss Ratio Template***

12.L. Exhibits to this Attachment 11

- ***Oregon CY20 Procurement Rate Methodology***
- ***CCO 2.0 Procurement Rate Methodology Appendix I***
- ***RFA Pro Forma Reference Document***
- ***UCAA Supplemental Financial Analysis***
- ***CCO RFA Enrollment Forecast***

The following Documents are to be redacted in their entirety:

Attachment 12, Section F.6

RFA4690-CPCCO-Att12-Form13H with Support CPC BE
RFA4690-CPCCO-Att12-Form13H with Support CPC MAX
RFA4690-CPCCO-Att12-Form13H with Support CPC MIN
RFA4690-CPCCO-Att12-UCAA-Supplemental Financial Analysis CPC

Attachment 8.C.1

RFA4690-CPCCO-Att8-VBP Data Template

Applicant Company Name: Columbia Pacific CCO, LLC NAIC No.

Jackson County CCO, LLC, d.b.a. Jackson Care Connect FEIN: 45-5532847

45-5499608

Uniform Certificate of Authority Application (UCAA)

BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Columbia Pacific CCO, LLC	Jackson County CCO, LLC, d.b.a, Jackson Care Connect
315 SW 5th Avenue	33 N Central Avenue
Portland, OR 97204	Medford, OR 97501
503.488.2822	855.722.7208

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE. ALL FIELDS MUST HAVE A RESPONSE. INCOMPLETE FORMS COULD DELAY THE APPLICATION PROCESS or REUSLT IN REJECTION OF THE APPLICATION.

1. Affiant's Full Name (Initials Not Acceptable): First: Erin Middle: Denise Last: Fair

2. a. Are you a citizen of the United States?

   Yes [X] No [ ]

   b. Are you a citizen of any other country?

   Yes [ ] No [X]

   If yes, what country? _____

3. Affiant's occupation or profession: Healthcare Administration

4. Affiant's business address: 315 SW 5th Avenue, Portland, OR 97204

   Business telephone: 503.416.1797 Business Email: faire@careoregon.org

5. Education and training:

College/University	City/State	Dates Attended (MM/YY)	Degree Obtained
University of Florida	Gainesville, FL	08/96 - 05/00	BA

Graduate Studies	College/University	City/State	Dates Attended (MM/YY)	Degree Obtained
Tulane University School of Public Health		New Orleans, LA	08/03 - 08/05	MPH

Other Training: Name	City/State	Dates Attended (MM/YY)	Degree/Certification Obtained
University of Oregon	Eugene, OR	08/05 - 05/08	JD

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

©2019 National Association of Insurance Commissioners

Applicant Company Name: Columbia Pacific CCO, LLC
Jackson County CCO, LLC, d.b.a, Jackson Care Connect

NAIC No.
FEIN: 45-5532847
45-5499608

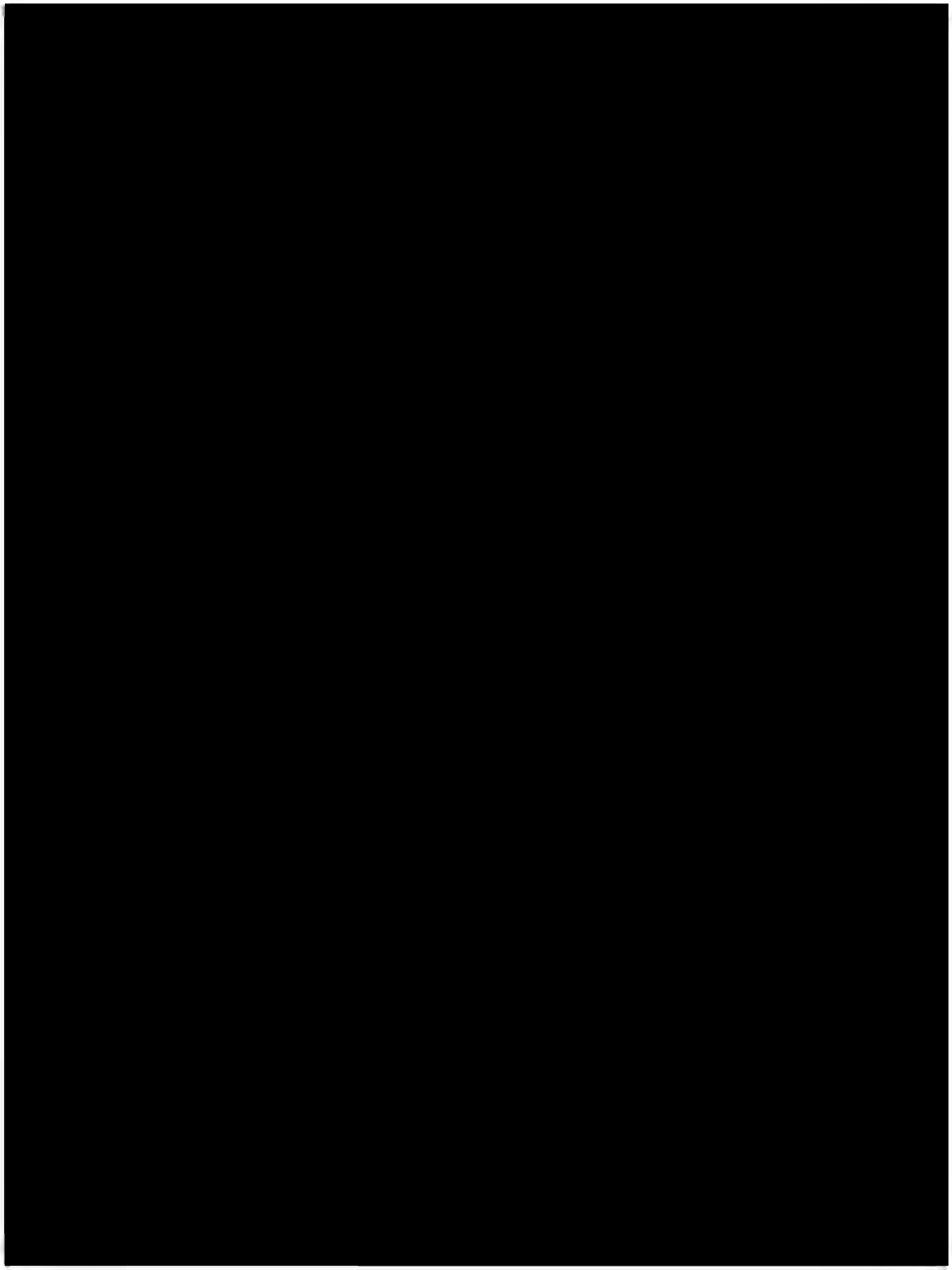
6. List of memberships in professional societies and associations:

Name of Society/Association	Contact Name	Address of Society/Association	Telephone Number of Society/Association
American Health Lawyers Assn		1620 Eye Street NW, 6th fl, Washington, DC 20006	202.833.1100

7. Present or proposed position with the Applicant Company: Chief Legal Officer

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

[redacted]



9. [redacted]

10. [redacted]

and was
spring

©2019 National Association of Insurance Commissioners

12. [redacted]

©2019 National Association of Insurance Commissioners

13. [redacted]

14. [redacted]

15. [redacted]

©2019 National Association of Insurance Commissioners

Applicant Company Name: Columbia Pacific CCO, LLC NAIC No. _____
Jackson County CCO, LLC, d.b.a, Jackson Care Connect FEIN: 45-5532847
45-5499608

[redacted]

Dated and signed this 22nd day of April 20 29 at _____. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

X I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

_____
(Signature of Affiant)

State of: OR County of: Multnomah

The foregoing instrument was acknowledged before me this 22 day of Apr, 20 19 by Erin Fair Taylor and:

☒ who is personally known to me, or

☐ who produced the following identification: _____.

[SEAL]

Lorinda S. Koller
Notary Public

Lorinda S. Koller
Printed Notary Name

2-22-20
My Commission Expires

OFFICIAL STAMP
LORINDA SUE KOLLER
NOTARY PUBLIC-OREGON
COMMISSION NO. 947695
MY COMMISSION EXPIRES FEBRUARY 22, 2020

©2019 National Association of Insurance Commissioners

Applicant Company Name: Columbia Pacific CCO, LLC
Jackson County CCO, LLC, d.b.a, Jackson Care Connect

NAIC No.
FEIN:

BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Columbia Pacific CCO, LLC	Jackson County CCO, LLC, d.b.a. Jackson Care Connect
315 SW 5th Avenue	33 N Central Avenue
Portland, OR 97204	Medford, OR 97501

[redacted]

©2019 National Association of Insurance Commissioners

Applicant Company Name: Columbia Pacific CCO, LLC
Jackson County CCO, LLC, d.b.a, Jackson Care Connect

NAIC No. _____
FEIN: _____

[redacted]

Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this 22nd day of April, 20 19 at 315 SW 5th Avenue, Portland, OR, I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

X I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

_____
(Signature of Affiant)

State of: OR County of: Multnomah

The foregoing instrument was acknowledged before me this 22 day of Apr, 20 19 by Erin Fair Taylor and:

☒ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

OFFICIAL STAMP
LORINDA SUE KOLLER
NOTARY PUBLIC-OREGON
COMMISSION NO. 947695
MY COMMISSION EXPIRES FEBRUARY 22, 2020

Lorinda S. Koller
Notary Public

Lorinda S. Koller
Printed Notary Name

2-22-20
My Commission Expires

Applicant Company Name: Columbia Pacific CCO, LLC
Jackson County CCO, LLC, d.b.a., Jackson Care Connect

NAIC No. _____
FEIN: _____

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS

(All states except California, Minnesota and Oklahoma)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of CPCCO and JCC **[company name]**("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both)("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact _____ **[company's designated person, position, or department, address and phone]**.

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act."

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

Erin Denise Fair, 8724 SW 45th Avenue, Portland, OR 97219
(Printed Full Name and Residence Address)

(Signature)

4.22.19
(Date)

State of: OR County of: Multnomah

The foregoing instrument was acknowledged before me this 22nd day of April, 20 19 by Erin Fair Taylor, and:

☑ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

OFFICIAL STAMP
LORINDA SUE KOLLER
NOTARY PUBLIC-OREGON
COMMISSION NO. 947695
MY COMMISSION EXPIRES FEBRUARY 22, 2020

Lorinda S. Koller
Notary Public

Lorinda S. Koller
Printed Notary Name

2-22-20
My Commission Expires

Attachment 13 — Attestations

Applicant Name: Columbia Pacific CCO, LLC

Authorizing Signature: _____

Printed Name: Mimi Haley

Instructions: For each attestation, Applicant will check "yes," or "no." A "yes" answer is normal, and an explanation will be furnished if Applicant's response is "no". Applicant must respond to all attestations. If an attestation has more than one question and Applicant's answer is "no" to any question, check "no" and provide an explanation.

These attestations must be signed by a representative of Applicant.

Unless a particular item is expressly effective at the time of Application, each attestation is effective starting at the time of Readiness Review and continuing throughout the term of the Contract. Each section of attestations refers to a questionnaire in an Attachment, which may furnish background and related questions.

A. General Questions Attestations (Attachment 6)

1. Contract

a. Is Applicant willing to enter into a Contract for 2020 in the form of Appendix B?

☒ Yes ☐ No

If "no" please provide explanation: _____

b. Is Applicant willing to satisfy Readiness Review standards by September 30, 2019?

☒ Yes ☐ No

If "no" please provide explanation: _____

2. Subcontracts

a. Is Applicant willing to hold written agreements with Subcontractors that clearly describe the scope of work?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to provide to OHA an inventory of all work described in this Contract that is delegated or subcontracted and identify the entity performing the work?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to provide to OHA unredacted copies of written agreements with Subcontractors?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

3. Third Party Liability and Personal Injury Lien

a. Is Applicant willing to identify and require its Subcontractors and Providers to identify and promptly report the presence of a Member's Third Party Liability?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to document all efforts to pursue financial recoveries from third party insurers?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to report and require its Subcontractors to report all financial recoveries from third party insurers?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to provide and require its Affiliated entities and Subcontractors to provide to OHA all information related to TPL eligibility to assist in the pursuit of financial recovery?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

4. Oversight and Governance

a. Is Applicant willing to provide its organizational structure, identifying any relationships with subsidiaries and entities with an ownership or Control stake?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

B. Provider Participation and Operations Attestations (Attachment 7)

1. General Questions

a. Will Applicant have an individual accountable for each of the operational functions described below?

- Contract administration
- Outcomes and evaluation
- Performance measurement
- Health management and Care Coordination activities
- System coordination and shared accountability between DHS Medicaid-funded LTC system and CCO
- Behavioral Health (mental health and addictions) coordination and system management
- Communications management to Providers and Members
- Provider relations and network management, including credentialing
- Health information technology and medical records
- Privacy officer
- Compliance officer
- Quality Performance Improvement
- Leadership contact for single point of accountability for the development and implementation of the Health Equity Plan
- Traditional Health Workers Liaison

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Will Applicant participate in the Learning Collaboratives required by ORS 442.210?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Will Applicant collect, maintain and analyze race, ethnicity, and preferred spoken and written languages data for all Members on an ongoing basis in accordance with standards jointly established by OHA and DHS in order to identify and track the elimination of health inequities?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Will Applicant (i) authorize the provision of a drug requested by the Primary Care Physician (PCP) or Referral Provider, if the approved prescriber certifies medical necessity for the drug such as: the formulary's equivalent has been ineffective in the treatment or the formulary's drug causes or is reasonably expected to cause adverse or harmful reactions to the Member and (ii) reimburse Providers for dispensing a 72-hour supply of a drug that requires Prior Authorization?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

e. Will Applicant comply with all applicable Provider requirements of Medicaid law under 42 CFR Part 438, including Provider certification requirements, anti-discrimination requirements, Provider participation and consultation requirements, the prohibition on interference with Provider advice, limits on Provider indemnification, rules governing payments to Providers, and limits on physician incentive plans?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

f. Will Applicant ensure that all Provider, facility, and supplier contracts or agreements contain the required contract provisions that are described in the Contract?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

g. Will Applicant have executed Provider, facility, and supplier contracts in place to demonstrate adequate access and availability of Covered Services throughout the requested Service Area?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

h. Will Applicant have all Provider contracts or agreements available to OHA in unredacted form?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

i. Will Applicant's contracts for administrative and management services contain the OHA required Contract provisions?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

j. Will Applicant establish, maintain, and monitor the performance of a comprehensive network of Providers to ensure sufficient access to Medicaid Covered Services, including comprehensive behavioral and oral health services, as well as supplemental services offered by the CCO in accordance with written policies, procedures, and standards for participation established by the CCO? Participation status will be revalidated at appropriate intervals as required by OHA regulations and guidelines.

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

k. Will Applicant have executed written agreements with Providers (first tier, downstream, or related entity instruments) structured in compliance with OHA regulations and guidelines?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

l. Will Applicant have executed written agreements with Local Mental Health Authorities throughout its Service Area, structured in compliance with OHA regulations and guidelines?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

m. Will Applicant develop a comprehensive Behavioral Health plan in collaboration with the Local Mental Health Authority and other Community partners?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

n. Will Applicant coordinate and collaborate on the development of the Community health improvement plan (CHP) under ORS 414.627 with the Local Mental Health Authority's comprehensive local plan for the delivery of mental health services (ORS 430.630)?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

o. Will Applicant, through its contracted Participating Provider Network, along with other specialists outside the network, Community resources or social services within the CCO's Service Area, provide ongoing primary care, Behavioral Health care, oral health care, and specialty care as needed and will guarantee the continuity of care and the integration of services as described below?

- Prompt, convenient, and appropriate access to Covered Services by Members 24 hours a day, 7 days a week;
- The coordination of the individual care needs of Members in accordance with policies and procedures as established by the Applicant;
- Member involvement in decisions regarding treatment, proper education on treatment options, and the coordination of follow-up care;
- Effectively addressing and overcoming barriers to Member compliance with prescribed treatments and regimens; and
- Addressing diverse patient populations in a linguistically diverse and culturally competent manner.

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

p. Will Applicant establish policies, procedures, and standards that:

- Ensure and facilitate the availability, convenient, and timely access to all Medicaid Covered Services as well as any supplemental services offered by the CCO;
- Ensure access to medically necessary care and the development of medically necessary individualized care plans for Members;
- Promptly and efficiently coordinate and facilitate access to clinical information by all Providers involved in delivering the individualized care plan of the Member while following Timely Access to Services standards;
- Communicate and enforce compliance by Providers with medical necessity determinations; and
- Do not discriminate against Medicaid Members, including providing services to individuals with disabilities in the most integrated Community setting appropriate to the needs of those individuals.

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

q. Will Applicant have verified that contracted Providers included in the CCO Facility Table are Medicaid certified and the Applicant certifies that it will only contract with Medicaid certified Providers in the future?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

r. Will Applicant provide all services covered by Medicaid and comply with OHA coverage determinations?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

s. Will Applicant have an Medicare plan to serve Fully Dual Eligibles either through contractual arrangement or owned by Applicant or Applicant parent company to create integrated Medicare-Medicaid opportunities during the contract period? [Plan can be a Dual Special Needs Plan or MA plan that offers low premiums and integrated Part D medications options].

☒ Yes ☐ No

If "no" please provide explanation:

t. Will Applicant, Applicant staff and its Affiliated companies, subsidiaries or Subcontractors (first tier, downstream, and related entities), and Subcontractor staff be bound by 2 CFR 376 and attest that they are not excluded by the Department of Health and Human Services Office of the Inspector General or by the General Services Administration? Please note that this attestation includes any member of the board of directors, key management or executive staff or major stockholder of the Applicant and its Affiliated companies, subsidiaries or Subcontractors (first tier, downstream, and related entities).

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

u. Is it true that neither the state nor federal government has brought any past or pending investigations, legal actions, administrative actions, or matters subject to arbitration involving the Applicant (and Applicant's parent corporation, subsidiaries, or entities with an ownership stake, if applicable) or its Subcontractors, including key management or executive staff, or major shareholders over the past three years on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

2. Network Adequacy

a. Is Applicant willing to monitor and evaluate the adequacy of its Provider Network?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to remedy any deficiencies in its Provider Network within a specified timeframe when deficiencies are identified?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to report on its Provider Network in a format and frequency specified by OHA?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to collect data to validate that its Members are able to access care within time and distance requirements?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

e. Is Applicant willing to collect data to validate that its Members are able to make appointments within the required timeframes?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

f. Is Applicant willing to collect data to validate that its Members are able to access care within the required timeframes?

☒ Yes ☐ No

g. Is Applicant willing to arrange for Covered Services to be provided by Non-Participating Providers if the services are not timely available within Applicant's Provider Network?

☒ Yes ☐ No

3. Fraud, Waste and Abuse Compliance

a. Is Applicant willing to designate a Compliance Officer to oversee activities related to the prevention and detection of Fraud, Waste and Abuse?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to send two representatives, including the Applicant's designated Compliance Officer and another member of the senior executive team to attend a mandatory Compliance Conference on May 30, 2019?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

C. Value-Based Payment (VBP) Attestations (Attachment 8)

1. Have you reviewed the VBP Policy Requirements set forth in the VBP Questionnaire?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

2. Have you reviewed the VBP reference documents linked to the VBP Questionnaire?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

3. Can you implement and report on VBP as defined by VBP Questionnaire and the Health Care Payment Learning and Action Network's (LAN's) "Alternative Payment Model Framework White Paper Refreshed 2017" (https://hcp-lan.org/apm-refresh-white-paper/) and the OHA Value-Based Payment Roadmap Categorization Guidance for Coordinated Care Organizations?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

4. Will you begin CCO 2.0 – January 2020 – with at least 20% of your projected annual payments to your Providers under contracts that include a Value-Based Payment component as defined by the Health Care Payment Learning and Action Network's (LAN's) "Alternative Payment Model Framework White Paper Refreshed 2017" (https://hcp-lan.org/apm-refresh-white-paper/), Pay for Performance category 2C or higher and the OHA Value-Based Payment Roadmap Categorization Guidance for Coordinated Care Organizations?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

5. Do you permit OHA to publish your VBP data such as the actual VBP percent of spending that is LAN category 2C or higher and spending that is LAN category 3B or higher, as well as data pertaining to your care delivery areas, Patient-Centered Primary Care Home (PCPCH) payments, and other information about VBPs required by this RFA? (OHA does not intend to publish specific payments amounts from an Applicant to a specific rovider.)

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

6. Do you agree to develop mitigation plans for adverse effects VBPs may have on health inequities, health disparities, or any adverse health-related outcomes for any specific population (including racial, ethnic and culturally-based communities; LGBTQ people; persons with disabilities; people with limited English proficiency; and immigrants or refugees and Members with complex health care needs, as well as populations at the intersections of these groups) and to report on these plans to OHA annually?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

7. Do you agree to the requirements for VBP targets, care delivery areas and PCPCH clinics for years 2020 through 2024, as set forth in the VBP Questionnaire?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

8. Do you agree to the requirements for VBP data reporting for years 2020 through 2024, as set forth in the VBP Questionnaire?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

9. Should OHA contract with one or more other CCOs serving Members in the same geographical area, will you participate in OHA-facilitated discussions to select performance measures to be incorporated into each CCO's VBP Provider contracts for common Provider types and specialties?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

10. If, after the discussion described in the previous question, OHA informs you of the Provider types and specialties for which the performance measures apply, will you incorporate all selected measures into applicable Provider contracts?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

D. Health Information Technology (HIT) Attestations (Attachment 9)

1. HIT Roadmap

a. Does Applicant agree to participate in an interview/demonstration and deliver an HIT Roadmap with any refinements/adjustments agreed to with OHA during Readiness Review, for OHA approval?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Does Applicant agree to provide an annual HIT Roadmap update for OHA approval to include status/progress on CCO-identified milestones, and any adjustments to the HIT Roadmap; as well as participate in an annual interview with OHA?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

2. HIT Partnership

a. Does Applicant agree to participate in the HIT Commons beginning 2020, including agreeing to do all of the following:

- Maintaining an active, signed HIT Commons MOU and adhering to its terms,
- Paying annual HIT Commons assessments, and
- Serving, if elected, on the HIT Commons Governance Board or one of its committees?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Does Applicant agree to participate in OHA's HIT Advisory Group, (HITAG), at least once annually?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

3. Support for EHR Adoption

a. Will Applicant support EHR adoption for its contracted physical health Providers?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Will Applicant support EHR adoption for its contracted Behavioral Health Providers?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Will Applicant support EHR adoption for its contracted oral health Providers?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. During Year 1, will Applicant report on the baseline of EHR adoption among its contracted physical health Providers, set Improvement Targets, and provide supporting detail about its implementation approach?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

e. During Year 1, will Applicant report on the baseline of EHR adoption among its contracted Behavioral Health Providers, set Improvement Targets, and provide supporting detail about its implementation approach?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

f. During Year 1, will Applicant report on the baseline of EHR adoption among its contracted oral health Providers, set Improvement Targets, and provide supporting detail about its implementation approach?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

g. Will Applicant report to the state annually on which EHR(s) each of its contracted physical health Providers is using, by means of definitions and data sources agreed upon during Readiness Review? Will reports include product and vendor name, version, and, if applicable, certification year the ONC Certification (CHPL) number for Certified EHR Technology? See https://chpl.healthit.gov/ and https://www.healthit.gov/topic/certification-ehrs/2015-edition for more information about Certified EHR Technology.

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

h. Will Applicant report to the state annually on which EHR(s) each of its contracted Behavioral Health Providers are using, by means of definitions and data sources agreed upon during Readiness Review? Will reports include product and vendor name, version, and, if applicable, certification year the ONC Certification (CHPL) number for Certified EHR Technology? See https://chpl.healthit.gov/ and https://www.healthit.gov/topic/certification-ehrs/2015-edition for more information about Certified EHR Technology.

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

i. Will Applicant report to the state annually on which EHR(s) each of its contracted oral health Providers is using, by means of definitions and data sources agreed upon during Readiness Review? Will reports include product and vendor name, version, and, if applicable, certification year the ONC Certification (CHPL) number for Certified EHR Technology? See https://chpl.healthit.gov/ and https://www.healthit.gov/topic/certification-ehrs/2015-edition for more information about Certified EHR Technology.

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

4. Support for HIE

a. Will Applicant ensure access to timely Hospital event notifications for its contracted physical health Providers? If there are costs associated with ensuring access to timely Hospital event notifications for contracted Providers, will the Applicant be responsible for those costs?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Will Applicant ensure access to timely Hospital event notifications for its contracted Behavioral Health Providers? If there are costs associated with ensuring access to timely Hospital event notifications for contracted Providers, will the Applicant will be responsible for those costs?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Will Applicant ensure access to timely Hospital event notifications for its contracted oral health Providers? If there are costs associated with ensuring access to timely Hospital event notifications for contracted Providers, will the Applicant will be responsible for those costs.

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Will Applicant use Hospital event notifications within the CCO, for example to support Care Coordination and/or population health efforts?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

e. Will Applicant support access to health information exchange that enables sharing patient information for Care Coordination for its contracted physical health Providers?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

f. Will Applicant support access to health information exchange that enables sharing patient information for Care Coordination for its contracted Behavioral Health Providers?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

g. Will Applicant support access to health information exchange that enables sharing patient information for Care Coordination for its contracted oral health Providers?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

h. During Year 1, will Applicant report on the baseline of HIE access and use among its contracted physical health Providers (inclusive of Hospital event notifications and HIE for Care Coordination), set Improvement Targets, and provide supporting detail about its implementation approach?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

i. During Year 1, will Applicant report on the baseline of HIE access and use among its contracted Behavioral Health Providers (inclusive of Hospital event notifications and HIE for Care Coordination), set Improvement Targets, and provide supporting detail about its implementation approach?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

j. During Year 1, will Applicant report on the baseline of HIE access and use among its contracted oral health Providers (inclusive of Hospital event notifications and HIE for Care Coordination), set Improvement Targets, and provide supporting detail about its implementation approach?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

k. Will Applicant report to the state annually on which HIE tool(s) each of its contracted physical health Providers is using, using definitions and data sources agreed upon during Readiness Review?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

l. Will Applicant report to the state annually on which HIE tool(s) each of its contracted Behavioral Health Providers is using, using definitions and data sources agreed upon during Readiness Review?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

m. Will Applicant report to the state annually on which HIE tool(s) each of its contracted oral health Providers is using, using definitions and data sources agreed upon during Readiness Review?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

5. Health IT for VBP and Population Management.

a. For the initial VBP arrangements, will Applicant have by the start of Year 1 the HIT needed to administer the arrangements (as described in its supporting detail)?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. For the planned VBP arrangements for Years 2 through 5, does Applicant have a roadmap to obtain the HIT needed to administer the arrangements (as described in its supporting detail)?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. By the start of Year 1, will the Applicant provide contracted Providers with VBP arrangements with timely (e.g., at least quarterly) information on measures used in the VBP arrangement(s) applicable to the Providers?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. By the start of Year 1, will the Applicant provide contracted Providers with VBP arrangements with accurate and consistent information on patient attribution?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

e. By the start of Year 1, will the Applicant identify for contracted Providers with VBP arrangements specific patients who need intervention through the year, so they can take action before the year end?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

f. By the start of Year 1, will the Applicant have the capability to risk stratify and identify and report upon Member characteristics, including but not limited to past diagnoses and services, that can inform the targeting of interventions to improve outcomes?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

g. By the start of each subsequent year for Years 2 through 5, will the Applicant CCO provide risk stratification and Member characteristics to your contracted Providers with VBP arrangements for the population(s) included in the arrangement(s) in place for each year?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

E. Social Determinants of Health and Health Equity (SDOH-HE) Attestations (Attachment 10)

1. Social Determinants of Health and Health Equity Spending, Priorities, and Partnership

a. Is Applicant willing to direct a portion of its annual net income or reserves, as required by Oregon State Statute and defined by OHA in rule, to addressing health disparities and SDOH-HE?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to enter into written agreements with SDOH-HE partners that describe the following: any relationship or financial interest that may exist between the SDOH-HE partner and the CCO, how funds will be distributed, the scope of work including the domain of SDOH-HE addressed and the targeted population, whether CCO will refer Members to the SDOH-HE partner, the geographic area to be covered, how outcomes will be evaluated and measured, and how the CCO will collect and report data related to outcomes?

☒ Yes ☐ No

If "no" please provide explanation: _____

c. When identifying priorities for required SDOH-HE spending, is Applicant willing to designate, define and document a role for the CAC in directing, tracking and reviewing spending?

☒ Yes ☐ No

If "no" please provide explanation: _____

d. Is Applicant willing to align its SDOH-HE spending priorities with the priorities identified in the Community Health Improvement Plan and its Transformation and Quality Strategy, and to include at least one statewide priority (e.g. housing-related services and supports, including Supported Housing) in addition to its Community priorities?

☒ Yes ☐ No

If "no" please provide explanation: _____

2. Health-related Services

a. Is Applicant willing to align HRS Community benefit initiatives with Community priorities from the CCO's Community Health Improvement Plan?

☒ Yes ☐ No

If "no" please provide explanation: _____

b. Is Applicant willing to align HRS Community benefit initiatives with a designated statewide priority should OHA require it?

☒ Yes ☐ No

If "no" please provide explanation: _____

c. Is Applicant willing to designate, define and document a role for the CAC when determining how Health-Related Services Community benefit initiatives decisions are made?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

3. Community Advisory Council membership and role

a. Is the Applicant willing to provide to OHA an organizational chart that includes the Community Advisory Council, and notes relationships between entities, including the CAC and the Board, how information flows between the bodies, the CAC and Board connection to various committees, and CAC representation on the board?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

4. Health Equity Assessment and Health Equity Plan

a. Is Applicant willing to develop and implement a Health Equity Plan according to OHA guidance, which includes a plan to provide cultural responsiveness and implicit bias education and training across the Applicant's organization and Provider Network? See Sample Contract and Cultural Responsiveness Training Plan Guidance Document.

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to include in its Health Equity Plan at least one initiative using HIT to support patient engagement?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to adopt potential health equity plan changes, including requirements, focus areas and components, based on OHA plan review feedback and, when applicable, based on guidance provided by the Oregon Health Policy Board's Health Equity Committee?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to designate a single point of accountability within the organization, who has budgetary decision-making authority and health equity expertise, for the development and implementation of the Health Equity Plan?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

e. Is Applicant willing to faithfully execute the finalized Health Equity Plan?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

f. Is Applicant willing to a) ask vendors for cultural and linguistic accessibility when discussing bringing on new HIT tools for patient engagement and b) when possible, seek out HIT tools for patient engagement that are culturally and linguistically accessible?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

5. Traditional Health Workers (THW) Utilization and Integration

a. Is Applicant willing to develop and fully implement a Traditional Health Workers Integration and Utilization Plan?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to work in collaboration with the THW Commission to implement the Commission's best practices for THW integration and utilization?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to fully implement the best practices developed in collaboration with the THW Commission?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to develop and implement a payment strategy for THWs that is informed by the recommendations from the Payment Model Committee of the THW Commission?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

e. Is Applicant willing to designate an individual within the organization as a THW Liaison as of the Effective Date of the Contract?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

f. Is Applicant willing to engage THWs during the development of the CHA and CHP?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

g. For services that are not captured on encounter claims, is Applicant willing to track and document Member interactions with THWs?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

6. Community Health Assessment and Community Health Improvement Plan

a. Is Applicant willing to partner with local public health authorities, non-profit Hospitals, any CCO that shares a portion of its Service Area, and any Tribes that are developing a CHA/CHP to develop shared CHA and CHP priorities?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to align CHP priorities with at least two State Health Improvement Plan (SHIP) priorities and implement statewide SHIP strategies based on local need?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to submit its Community Health Assessment and Community Health Improvement Plan to OHA?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to develop and fully implement a community engagement plan?

☒ Yes ☐ No

If "no" please provide explanation:

F. Behavioral Health Attestations (Attachment 11)

1. Behavioral Health Benefit

a. Will Applicant report performance measures and implement Evidence-Based outcome measures, as developed by the OHA Metrics and Scoring Committee, and as specified in the Contract?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Will Applicant work collaboratively with OHA and its partners to implement all of the requirements in Exhibit M of the Contract?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Will Applicant be fully responsible for the Behavioral Health benefit for Members beginning in CY 2020?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Will Applicant manage the Global Budget (as defined in ORS 414.025) in a fully integrated manner? Fully integrated manner means that Applicant will not sub-capitate any Provider or entity for Behavioral Health services separately from physical health services nor will Applicant enter into any Value-Based Payment arrangements under which Behavioral Health spending is tracked separately from physical health services.

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

e. Will Applicant report on the information and data specified in the Performance Expectations section as specified in the Contract and submit an annual report to OAH for review and approval?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

f. Will Applicant have sufficient resources, including technological, financial, Provider and workforce, to integrate the Behavioral Health benefit with oral and physical health care benefits?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

g. Will Applicant ensure the provision of cost-effective, comprehensive, person-centered, Culturally Responsive, and integrated Community-based Behavioral Health services for Members?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

h. Will Applicant provide oversight, Care Coordination, transition planning and management of the Behavioral Health needs of Members to ensure Culturally Responsive and linguistically appropriate Behavioral Health services are provided in a way that Members are served in a most natural and integrated environment possible and that minimizes the use of institutional care?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

i. Will Applicant follow Intensive Care Coordination standards as identified in OAR 410-141-3160/70?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

j. Will Applicant ensure Members have access to Referral and screening at multiple health system or health care entry points?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

k. Will Applicant use a standardized Assessment tool, to adapt the intensity and frequency of Behavioral Health services to the Behavioral Health needs of the Member?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

l. Will Applicant work collaboratively to improve services for adult Members with SPMI as a priority population? Will Applicant make significant commitments and undertake significant efforts to continue to improve treatment and services so that adults with SPMI can live and prosper in integrated Community settings?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

m. Will Applicant ensure Members have timely access to all services under the Behavioral Health benefit in accordance with access to service standards as developed in Appendix C, the Administrative Rules Concept Document, under OHPB #17?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

n. Will Applicant have an adequate Provider Network to ensure Members have timely access to Behavioral Health services and effective treatment in accordance with the Delivery System and Provider Capacity section of the Contract?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

o. Will Applicant establish written policies and procedures for Prior Authorizations, in compliance with the Mental Health Parity and Addiction Equity Act of 2008, and be responsible for any inquiries or concerns and not delegate responsibility to Providers?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

p. Will Applicant establish written policies and procedures for the Behavioral Health benefit and provide the written policies and procedures to OHA by the beginning of CY 2020?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

q. Will Applicant require mental health and substance use disorder programs be licensed or certified by OHA to enter the Provider Network?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

r. Will Applicant require Providers to screen Members for adequacy of supports for the Family in the home (e.g., housing adequacy, nutrition/food, diaper needs, transportation needs, safety needs and home visiting)?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

s. Will Applicant ensure Applicant's staff and Providers are trained in recovery principles, motivational interviewing, integration, and Foundations of Trauma Informed Care (https://traumainformedoregon.org/tic-intro-training-modules/)?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

t. Will Applicant ensure Providers are trained in Trauma Informed approaches and provide regular periodic oversight and technical assistance to Providers?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

u. Will Applicant require Providers, in developing Individual Service and Support Plans for Members, to assess for Adverse Childhood Experiences (ACEs) and trauma in a Culturally Responsive and Trauma Informed framework and approach?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

v. Will Applicant ensure Behavioral Health services are Culturally Responsive and Trauma Informed?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

w. Will Applicant assume responsibility for the entire Behavioral Health residential benefit by the beginning of CY 2022?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

x. Will Applicant include OHA approved Behavioral Health homes (BHHs) in Applicant's network as the BHHs qualify in Applicant's Region?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

y. Will Applicant assist Behavioral Health organizations within the delivery system to establish BHHs?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

z. Will Applicant utilize BHHs in their network for Members to the greatest extent possible?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

aa. Will Applicant provide a full psychological evaluation and child psychiatric consultation for children being referred to the highest levels of care (day treatment, subacute or PRTS)?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

2. MOU with Community Mental Health Program (CMHP)

a. Will Applicant enter into a written memorandum of understanding (MOU) with the local Community Mental Health Program (CMHP) in Applicant's Region by beginning of CY 2020, in accordance with ORS 414.153?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Will Applicant develop a comprehensive Behavioral Health plan for Applicant's Region in collaboration with the Local Mental Health Authority and other Community partners (e.g., education/schools, Hospitals, corrections, police, first responders, Child Welfare, DHS, public health, Peers, families, housing authorities, housing Providers, courts)?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Will Applicant coordinate and collaborate on the development of the Community health improvement plan (CHP) under ORS 414.627 with the local Community Mental Health Program (CMHP) for the delivery of mental health services under ORS 430.630

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

3. Provisions of Covered Services – Behavioral Health

a. Will Applicant provide services as necessary to achieve compliance with the mental health parity requirements of 42 CFR§ 438, subpart K and ensure that any quantitative treatment limitations (QTLs), or non-quantitative treatment limitations (NQTLs) placed on Medically Necessary Covered Services are no more restrictive than those applied to fee-for-service medically necessary covered benefits, as described in 42 CFR 438.210(a)(5)(i)?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Will Applicant assume accountability for Members that are civilly committed and are referred to and enter Oregon State Hospital; be financially responsible for the services for Members on waitlist for Oregon State Hospital after the second year of the Vontract, with timeline to be determined by OHA; and be financially responsible for services for Members admitted to Oregon State Hospital after the second year of the Vontract, with timeline to be determined by OHA?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Will Applicant reimburse for covered Behavioral Health services rendered in a primary care setting by a qualified Behavioral Health Provider, and reimburse for covered physical health services in Behavioral Health care settings, by a qualified medical Provider?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Will Applicant ensure Members receive services from Non-Participating Providers for Behavioral Health services if those services are not available from Participating Providers or if a Member is not able to access services within the timely access to care standards? Will Applicant remain responsible for coordinating Behavioral Health services with Non-Participating Providers and reimbursing for services?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

e. Will Applicant ensure continuity of care throughout episodes of care and provide Intensive Care Coordination and general Care Coordination as specified in the Contract?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

4. Covered Services Component – Behavioral Health

a. Will Applicant establish written policies and procedures for an emergency response system, including post-stabilization care services and Urgent Services for all Members on a 24-hour, 7-day-a-week basis consistent with OAR 410-141-3140 and 42 CFR 438.114? Will the emergency response system provide an immediate, initial or limited duration response for emergency situations or potential Behavioral Health emergency situations that may include Behavioral Health conditions?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Will Applicant ensure access to Mobile Crisis Services for all Members in accordance with OAR 309-019-0105, OAR 309-019-0150, 309-019-0242, and 309-019-0300 to 309-019-0320 to promote stabilization in a Community setting rather than arrest, presentation to an Emergency Department, or admission to an Acute psychiatric care facility?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Will Applicant establish written policies and procedures for a Quality Improvement plan for the emergency response system?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Will Applicant collaboratively work with OHA and CMHPs to develop and implement plans to better meet the needs of Members in Community integrated settings and to reduce recidivism to Emergency Departments for Behavioral Health reasons?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

e. Will Applicant work with Hospitals to provide data on Emergency Department (ED) utilization for Behavioral Health reasons and length of time in the ED? Will Applicant develop remediation plans with EDs with significant numbers of ED stays longer than 23 hour?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

f. Will Applicant establish a policy and procedure for developing a management plan for contacting and offering services to each Member who has two or more readmissions to an ED in a six-month period?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

g. Will Applicant make a reasonable effort to provide Covered Services on a voluntary basis and consistent with current Declaration for Mental Health Treatment as provided at: http://www.oregon.gov/oha/amh/forms/declaration.pdf in lieu of involuntary treatment?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

h. Will Applicant establish written policies and procedures describing the appropriate use of Emergency Psychiatric Holds consistent with ORS 426 and alternatives to involuntary psychiatric care when a less restrictive voluntary service will not meet the Medically Appropriate needs of the Member and the behavior of the Member meets legal standards for the use of an Emergency Psychiatric Hold?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

i. Will Applicant assure that any involuntary treatment provided under the Contract is provided in accordance with administrative rule and statute, and coordinate with the CMHP Director in assuring that all statutory requirements are met? Will Applicant also work with the CMHP Director in assigning a civilly committed Member to any placement and participate in circuit court hearings related to planned placements, if applicable?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

j. If Applicant identifies a Member, over age 18 with no significant nursing care needs due to a general medical condition, Acute medical condition or physical disorder, is appropriate for Long Term Psychiatric Care (State Facility level of care), will Applicant request a LTPC determination from the OHA LTPC reviewer?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

k. If Applicant identifies a Member, age 18 to age 64, with no significant nursing care needs due to a general medical condition, Acute medical condition or physical disorder of an enduring nature, is appropriate for LTPC, will Applicant request a LTPC determination from the applicable HSD Adult Mental Health Services Unit, as described in Procedure for LTPC Determinations for Members 18 to 64, available on the Contract Reports Web Site?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

l. If Applicant identifies a Member, age 65 and over, or age 18 to age 64 with significant nursing care needs due to a general medical condition, Acute medical condition or physical disorder of an enduring nature, is appropriate for LTPC, will Applicant request a LTPC determination from the State hospital-NTS, Outreach and Consultation Service (OCS) Team as described in Procedure for LTPC Determinations for Member Requiring Neuropsychiatric Treatment, available on the Contract Reports Web Site?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

m. For the Member age 18 and over, will Applicant work with the Member to assure timely discharge and transition from LTPC to the most appropriate, independent and integrated Community-based setting possible consistent with Member choice?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

n. Will Applicant authorize and reimburse Care Coordination services, in particular for Members who receive ICC, that are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are provided to Members receiving care through licensed Community treatment programs? Will Applicant authorize and reimburse for ICC services, in accordance with standards identified in OAR 410-141-3160-70?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

o. Will Applicant ensure that any involuntary treatment provided under the Contract is provided in accordance with administrative rule and statute and coordinate with the CMHP Director in assuring that all statutory requirements are met? Will Applicant work with the CMHP Director in assigning a civilly committed Member to any placement and participate in circuit court hearings related to planned placements, if applicable?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

p. Will Applicant provide Acute Inpatient Hospital Psychiatric Care for Members who do not meet the criteria for LTPC?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

q. Will Applicant ensure that all Members discharged from Acute Care Psychiatric Hospitals are provided a Warm Handoff to a Community case manager, Peer bridger, or other Community provider prior to discharge, and that all such Warm Handoffs are documented?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

r. Will Applicant ensure that all Members discharged from Acute Care Psychiatric Hospitals have linkages to timely, appropriate behavioral and primary health care in the Community prior to discharge and that all such linkages are documented, in accordance with OAR provisions 309-032-0850 through 309-032-0870?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

s. Will Applicant ensure all adult Members receive a follow-up visit with a Community Behavioral Health Provider within seven (7) days of their discharge from an Acute Care Psychiatric Hospital?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

t. Will Applicant reduce readmissions of adult Members with SPMI to Acute Care Psychiatric Hospitals?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

u. Will Applicant coordinate with system Community partners to ensure Members who are homeless and who have had two or more readmissions to an Acute Care Psychiatric Hospital in a six-month period are connected to a housing agency or mental health agency to ensure these Members are linked to housing in an integrated Community setting, Supported Housing to the extent possible, consistent with the individual's treatment goals, clinical needs and the individual's informed choice?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

v. Will Applicant ensure coordination and appropriate Referral to Intensive Care Coordination to ensure that Member's rights are met and there is post-discharge support? If Member is connected to ICC coordinator, will Applicant ensure coordination with this person as directed in OAR 410-141-3160-3170?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

w. Will Applicant work with OHA and the CMHPs to ensure that Members who are discharged from Acute Care Psychiatric Hospitals are discharged to housing that meets the individuals' immediate need for housing and work with Acute Care Psychiatric Hospitals in the development of each individual's housing assessment?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

x. Will Applicant establish a policy and procedure for developing a management plan for contacting and offering services to each Member who has two (2) or more readmissions to an Acute Care Psychiatric Hospital in a six-month period?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

y. Will Applicant work with OHA, other state agencies, and other state funded or operated entities to identify areas where treatment and services for adult Members with SPMI can be improved?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

z. Will Applicant coordinate services for each adult Member with SPMI who needs assistance with Covered or Non-covered Services?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

aa. Will Applicant provide oversight, Care Coordination, transition planning and management for Members receiving Behavioral Health services, including Mental Health Rehabilitative Services and Personal Care Services, in licensed and non-licensed home and Community-based settings, ensuring that individuals who no longer need placement in such settings are transitioned to a Community placement in the most integrated Community setting appropriate for that person?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

bb. Will Applicant provide Utilization Review and utilization management, for Members receiving Behavioral Health Services, including Mental Health Rehabilitative Services and Personal Care Services, in licensed and non-licensed home and Community-based settings, ensuring that individuals who no longer need placement in such setting transition to the most integrated Community setting, Supported Housing to the extent possible, consistent with the individual's treatment goals, clinical needs, and the individual's informed choice?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

cc. Will Applicant encourage utilization of Peer-Delivered Services (PDS) and ensure that Members are informed of their benefit to access and receive PDS from a Peer Support Specialist, Peer Wellness Specialist, Family Support Specialist, or Youth Support Specialist as applicable to the Member's diagnosis and needs?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

dd. Will Applicant ensure that Members with SPMI receive Intensive Care Coordination (ICC) support in finding appropriate housing and receive coordination in addressing Member's housing needs?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

ee. Will Applicant ensure Members with SPMI are assessed to determine eligibility for ACT?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

ff. Will Applicant ensure ACT services are provided for all adult Members with SPMI who are referred to and eligible for ACT services in accordance with OAR 309-019-0105 and 309-019-0225 through 309-019-0255?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

gg. Will Applicant ensure additional ACT capacity is created to serve adult Members with SPMI as services are needed?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

hh. Will Applicant, when ten (10) or more of Applicant's adult Members with SPMI in Applicant's Service Area are on a waitlist to receive ACT for more than thirty (30) days, without limiting other Applicant solutions, create additional capacity by either increasing existing ACT team capacity to a size that is still consistent with Fidelity standards or by adding additional ACT teams?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

If Applicant lacks qualified Providers to provide ACT services, will Applicant consult with OHA and develop a plan to develop additional qualified Providers? Will lack of capacity not be a reason to allow individuals who are determined to be eligible for ACT to remain on the waitlist? Will no individual on a waitlist for ACT services be without such services for more than 30 days?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

ii. Will Applicant ensure all denials of ACT services for all adult Members with SPMI are: based on established, evidence-based medical necessity criteria; reviewed, recorded and compiled in a manner that allows denials to be accurately reported out as appropriate or inappropriate; and follow the Notice of Adverse Benefit Determination process for all denials as described in the Contract?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

jj. Will Applicant be responsible for finding or creating a team to serve Members who have appropriately received a denial for a particular ACT team but who meet ACT eligibility standards?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

kk. Will Applicant be responsible for engaging with all eligible Members who decline to participate in ACT in an attempt to identify and overcome barriers to the Member's participation?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

ll. Will Applicant require that a Provider or care coordinator meets with the Member to discuss ACT services and provide information to support the Member in making an informed decision regarding participation? Will this include a description of ACT services and how to access them, an explanation of the role of the ACT team and how supports can be individualized based on the Member's self-identified needs, and ways that ACT can enhance a Member's care and support independent Community living?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

mm. Will Applicant provide alternative evidence-based intensive services if Member continues to decline participation in ACT, which must include coordination with an ICC?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

nn. Will Applicant report the number of individuals referred to ACT, number of individuals admitted to ACT programs, number of denials for the ACT benefit, number of denials to ACT programs, and number of individuals on waitlist by month?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

oo. Will Applicant ensure a Member discharged from OSH who is appropriate for ACT shall receive ACT or an evidence-based alternative?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

pp. Will Applicant document efforts to provide ACT to individuals who initially refuse ACT services, and document all efforts to accommodate their concerns?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

qq. Will Applicant offer alternative evidence-based intensive services for individuals discharged from OSH who refuse ACT services?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

rr. Will Applicant ensure a Member discharged from OSH who is determined not to meet the level of care for ACT shall be discharged with services appropriate to meet their needs?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

ss. Will Applicant coordinate with system partners as needed regarding Oregon State Hospital discharges for all adult Members with SPMI in accordance with OAR 309-091-0000 through 0050?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

tt. Will Applicant ensure access to Supported Employment Services for all adult Members eligible for these services, in accordance with OAR 309-019-0275 through 309-019-0295? ("Supported Employment Services" means the same as "Individual Placement and Support (IPS) Supported Employment Services" as defined in OAR 309-019-0225.)

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

uu. Will Applicant work with local law enforcement and jail staff to develop strategies to reduce contacts between Members and law enforcement due to Behavioral Health reasons, including reduction in arrests, jail admissions, lengths of stay in jails and recidivism?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

vv. Will Applicant work with SRTFs to expeditiously move civilly committed adult Members with SPMI who no longer need placement in an SRTF to a Community placement in the most integrated setting, Supported Housing to the extent possible, consistent with the individual's treatment goals, clinical needs, and the individual's informed choice?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

ww. Will Applicant provide Substance Use Disorder (SUD) services to Members, which include outpatient, intensive outpatient, medication assisted treatment including Opiate Substitution Services, residential and detoxification treatment services consistent with OAR Chapter 309, Divisions 18, 19 and 22, and OAR Chapter 415 Divisions 20, and 50?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

xx. Will Applicant comply with Substance Use Disorder (SUD) waiver program designed to improve access to high quality, clinically appropriate treatment for opioid use disorder and other SUDs, upon approval by Centers for Medicare and Medicaid Services (CMS)?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

yy. Will Applicant inform all Members using Culturally Responsive and linguistically appropriate means that Substance Use Disorder outpatient, intensive outpatient, residential, detoxification and medication assisted treatment services, including opiate substitution treatment, are Covered Services consistent with OAR 410-141-3300?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

zz. Will Applicant participate with OHA in a review of OHA provided data about the impact of these criteria on service quality, cost, outcome, and access?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

5. Children and Youth

a. Will Applicant develop and implement cost-effective comprehensive, person-centered, individualized, and integrated Community-based Child and Youth Behavioral Health services for Members, using System of Care (SOC) principles?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Will Applicant utilize evidence-based Behavioral Health interventions for the needs of children 0-5, and their caregivers, with indications of Adverse Childhood Experiences (ACEs) and high complexity?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Will Applicant provide Intensive Care Coordination (ICC) that is Family and youth-driven, strengths based and Culturally Responsive and linguistically appropriate and abide by ICC standards as set forth in Appendix C, Administrative Rules Concept under OHPB #24 and in accordance with the ICC section in the Contract? Will Applicant abide by ICC standards as forth in Appendix C, Administrative Rules Concept, under OHPB #24, and in accordance with the ICC section in the Contract?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Will Applicant provide services to children, young adults and families of sufficient frequency, duration, location, and type that are convenient to the youth and Family? Will Services alleviate crisis while allowing for the development of natural supports, skill development, normative activities and therapeutic resolution to Behavioral Health disorders and environmental conditions that may impact the remediation of a Behavioral Health disorder?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

e. Will Applicant adopt policies and guidelines for admission into Psychiatric Residential Treatment Services (PRTS), Psychiatric Day Treatment Services (PDTS) and/or Intensive Outpatient Services and Supports?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

f. Will Applicant ensure the availability of service, supports or alternatives 24 hours a day/7 days a week to remediate a Behavioral Health crisis in a non-emergency department setting?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

g. Will Applicant encourage utilization of Peer-Delivered Services (PDS) and ensure that Members are informed of their benefit to access and receive PDS from a Peer Support Specialist, Peer Wellness Specialist, Family Support Specialist, or Youth Support Specialist as applicable to the Member's diagnosis and needs?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

h. If Applicant identifies a Member is appropriate for LTPC Referral, will Applicant request a LTPC determination from the applicable HSD Child and Adolescent Mental Health Specialist, as described in Procedure for LTPC Determinations for Members 17 and Under, available on the Contract Reports Web Site?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

i. Will Applicant arrange for the provision of non-health related services, supports and activities that can be expected to improve a Behavioral Health condition?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

j. Will Applicant coordinate admissions to and discharges from Acute Inpatient Hospital Psychiatric Care and Sub-Acute Care for Members 17 and under, including Members in the care and custody of DHS Child Welfare or OYA? For a Member 17 and under, placed by DHS Child Welfare through a Voluntary Placement Agreement (CF 0499), will Applicant also coordinate with such Member's parent or legal guardian?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

k. Will Applicant ensure a CANS Oregon is administered to a Member who is a child or youth and the data is entered into OHA approved data system according to the eligibility and timeline criteria in the Contract?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

l. Will Applicant have funding and resources to implement, to fidelity, Wraparound Services?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

m. Will Applicant enroll all eligible youth in Wraparound and place no youth on a waitlist?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

n. Will Applicant screen all eligible youth with a Wraparound Review Committee in accordance with Wraparound Services as described in the OHA System of Care Wraparound Initiative (SOCWI) guidance document found at the link below and in Wraparound Service OARs? http://www.oregon.gov/oha/hsd/amh/pages/index.aspx.

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

o. Will Applicant establish and maintain a functional System of Care in its Service Area in accordance with the Best Practice Guide located at https://www.pdx.edu/ccf/best-practice-guide including a Practice Level Workgroup, Advisory Committee and Executive Council with a goal of youth and Family voice representation to be 51 percent?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

p. Will Applicant have a functional SOC governance structure by the beginning of CY 2020 that consists of a practice level work group, advisory council, and executive council?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

q. By end of CY 2020, will Applicant have written Charters and new Member handbooks for Practice Level Work group, Advisory Council and Executive Council?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

G. Cost and Financial Attestations (Attachment 12)

1. Rates

Does Applicant accept the CY 2020 Rate Methodology appended to Attachment 12?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

2. Evaluate CCO performance to inform CCO-specific profit margin

a. Does Applicant agree to performance and efficiency evaluation being used to set profit margins in CCO capitation rates?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Does Applicant agree to accept the CCO 2.0 capitation rate methodology as described in the Oregon CY20 Procurement Rate Methodology document and also accept the performance evaluation methodology and its use in setting CCO-specific profit margins?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Does Applicant agree to report additional data as needed to inform the performance evaluation process, including data on utilization of Health-Related Services?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to have OHA use efficiency analysis to support managed care efficiency adjustments that may result in adjustments to the base data used in capitation rate development to further incentivize reductions in Waste in the system?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

3. Qualified Directed Payments to Providers

a. Is Applicant willing to make OHA-directed payments to certain Hospitals within five Business Days after receipt of a monthly report prepared and distributed by OHA?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to report to OHA promptly if it determines payments to Hospitals will be significantly delayed?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to exclude the portion of OHA-directed payments for provider tax repayment when negotiating alternative or Value-Based Payment reimbursement arrangements?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to provide input and feedback to OHA on the selection of measures of quality and value for OHA-directed payments to Providers?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

4. Quality Pool Operations and Reporting

a. Does Applicant agree to having a portion of capitation withheld from monthly Capitation Payment and awarded to the Applicant based on performance on metrics based on the Quality Incentive Pool program?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Does Applicant agree to report to OHA separately on expenditures incurred based on Quality Pool revenue earned?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Does Applicant agree to report on the methodology it uses to distribute Quality Pool earnings to Providers, including SDOH-HE partners and public health partners?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Does Applicant have a plan to evaluate contributions made by SDOH-HE and public health partners toward the achievement of Quality Pool metrics?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

5. Transparency in Pharmacy Benefit Management Contracts

a. Will Applicant select and contract with the Oregon Prescription Drug Program to provide Pharmacy Benefit Management services? If yes, please skip to section 5. If not, please answer parts b-f of this question.

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Will Applicant use a pharmacy benefit manager that will provide pharmacy cost passthrough at 100% and pass back 100% of rebates received to Applicant?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Will Applicant separately report to OHA any and all administrative fees paid to its PBM?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Will Applicant require reporting from PBM that provides paid amounts for pharmacy costs at a claim level?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

e. Will Applicant obtain market check and audits of their PBMs by a third party on an annual basis, and share the results of the market check with the OHA?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

f. Will Applicant require its PBM to remain competitive with enforceable contract terms and conditions driven by the findings of the annual market check and report auditing?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

6. Alignment Preferred Drug Lists (PDLs) and Prior Authorization Criteria

a. Will Applicant partner with OHA on the goal of increasing the alignment of CCO preferred drug lists (PDL) with the Fee-For-Service PDL set every year by OHA?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Will Applicant align its PDL in any and all categories of drugs as recommended by the P&T committee and as required by OHA?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Will Applicant post online in a publicly accessible manner the Applicant's specific PDL with coverage and Prior Authorization criteria in a format designated by OHA and update the posting concurrently or before any changes to the PDL or coverage/PA criteria become effective?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

7. Financial Reporting Tools and Requirements

a. Is Applicant willing to partake of all financial, legal and technological requirements of the National Association of Insurance Commissioners (NAIC) in whatever capacity necessary to file its financial information with OHA under NAIC standards?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Will Applicant report its required financial information to OHA on the NAIC's Health Quarterly and Annual Statement blank ("Orange Blank") through the NAIC website as described in this RFA, under NAIC standards and instructions?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Will Applicant report its financial information to OHA using Statutory Accounting Principles (SAP), subject to possible exemption from SAP for 2020 as described in this RFA?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Will Applicant file the financial reports described in this RFA, including Contract Exhibit L and supplemental schedules with the instructions referenced in this RFA?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

e. Is Applicant willing to resubmit its pro forma financial statements for three years starting in 2020, modified to reflect the Enrollment expected assuming other CCOs that may operate in Applicant's Service Area?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

f. Does Applicant commit to preparing and filing a Risk Based Capital (RBC) report each year based on NAIC requirements and instructions?

☒ Yes ☐ No

If "no" please provide explanation: _____

g. Is Applicant willing to submit quarterly financial reports including a quarterly estimation of RBC levels to ensure financial protections are in place during the year?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

h. Is Applicant willing to have its RBC threshold evaluated quarterly using a proxy calculation?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

i. If Applicant's estimated RBC falls below the minimum required percentage based on the quarterly estimation, is Applicant willing to submit a year-to-date financial filing and full RBC evaluation?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

8. Accountability to Oregon's Sustainable Growth Targets

a. Does Applicant commit to achieving a sustainable growth in expenditures each calendar year (normalized by membership) that matches or is below the Oregon 1115 Medicaid demonstration project waiver growth target of 3.4%?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Does Applicant similarly commit to making a good faith effort towards achievement of future modifications to the growth target in the waiver?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Does Applicant agree that OHA may publicly report on CCO performance relative to the sustainable growth rate targets (normalized for differences in membership)?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Does Applicant agree that OHA may institute a Corrective Action Plan, that may include financial penalties, if a CCO does not achieve the expenditure growth targets based on the current 1115 Medicaid waiver?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

9. Potential Establishment of Program-wide Reinsurance Program in Future Years

a. Will Applicant participate in any program-wide reinsurance program that is established in years after 2020 consistent with statutory and regulatory provisions that are enacted?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Will Applicant use private reinsurance contracts on only an annual basis so as to ensure ability to participate in state-run program if one is launched at the start of a calendar year?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Does Applicant agree that implementation of program-wide reinsurance program will reduce capitation rates in years implemented as a result of claims being paid through reinsurance instead of with capitation funds?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

10. CCO Solvency Standards and OHA Tools to Regulate and Mitigate Insolvency Risk

a. Is Applicant willing to have its financial solvency risk measured by Risk Based Capital (RBC) starting in 2021?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to achieve a calculated RBC threshold of 200% by end of Q3 of 2021 and thereafter to maintain a minimum RBC threshold of 200%?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to report to OHA promptly if it determines that its calculated RBC value is or is expected to be below 200%?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to report to OHA promptly if it determines that its actual financial performance departs materially from the pro forma financial statements submitted with this Application?

☒ Yes ☐ No

If "no" please provide explanation: _____

e. Will Applicant maintain the required restricted reserve account per Contract?

☒ Yes ☐ No

If "no" please provide explanation: _____

11. Encounter Data Validation Study

a. Is Applicant willing to perform regular chart reviews and audits of its encounter claims to ensure the Encounter Data accurately reflects the services provided?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to engage in activities to improve the quality and accuracy of Encounter Data submissions?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

H. Member Transition Plan (Attachment 16)

1. Is Applicant willing to faithfully execute its Member Transition Plan as described in Attachment 16?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

Attachment 14 — Assurances

Applicant Name: Columbia Pacific CCO, LLC

Authorizing Signature: _____

Printed Name: Mimi Haley, Executive Director

Instructions: Assurances focus on the Applicant's compliance with federal Medicaid law and related Oregon rules. For each assurance, Applicant will check "yes," or "no." A "yes" answer is normal, and an explanation will be furnished if Applicant's response is "no". Applicant must respond to all assurances. If an assurance has more than one question and Applicant's answer is "no" to any question, check "no" and provide an explanation.

These assurances must be signed by a representative of Applicant.

Each assurance is effective starting at the time of Readiness Review and continuing throughout the term of the Contract.

1. **Emergency and Urgent Care Services.** Will Applicant have written policies and procedures, and oversight and monitoring systems to ensure that emergency and urgent services are available for all Members on a 24-hour, 7-days-a-week basis? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? (See 42 CFR 438.114 and OAR 410-141-3140]

   ☒ Yes ☐ No

   If "no" please provide explanation: _____

2. **Continuity of Care.** Will Applicant implement written policies and procedures that ensure a system for the coordination of care and the arrangement, tracking and documentation of all Referrals and Prior Authorizations to other Providers? Will Applicant follow Intensive Care Coordination (ICC)/ENCC standards and Care Coordination standards, including transition meetings, as directed in OAR 410-141-3170? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.208 and OAR 410-141-3160]

   ☒ Yes ☐ No

   If "no" please provide explanation: _____

3. Will Applicant implement written policies and procedures that ensure maintenance of a record keeping system that includes maintaining the privacy and security of records as required by the Health Insurance Portability and Accountability Act (HIPAA), 42 USC § 1320-d et seq., and the federal regulations implementing the Act, and complete Clinical Records that document the care received by Members from the Applicant's Primary Care and Referral Providers? Will Applicants communicate these policies and procedures to Participating Providers, regularly monitor Participating Providers' compliance with these policies and procedures and take any Corrective Action necessary to ensure Participating Provider compliance? Will Applicants document all monitoring and Corrective Action activities? Will such policies and procedures will ensure that records are secured, safeguarded and stored in accordance with applicable Law? [See 45 CFR Parts 160 – 164, 42 CFR 438.242, ORS 414.679 and OAR 410-141-3180]

   ☒ Yes ☐ No

   If "no" please provide explanation: _____

4. Will Applicant have an ongoing quality performance improvement program for the services it furnishes to its Members? Will the program include an internal Quality Improvement program based on written policies, standards and procedures that are designed to achieve through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas and that are expected to have a favorable effect on health outcomes and Member satisfaction? The improvement program will track outcomes by race, ethnicity and language. The Applicant will communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance. [See OAR 410-141-0200]

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

5. Will Applicant make Coordinated Care Services accessible to enrolled Members? Will Applicant not discriminate between Members and non-Members as it relates to benefits to which they are both entitled including reassessment or additional screening as needed to identify exceptional needs in accordance with OAR 410-141-3160 through 410-141-3170? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance.? [See 42 CFR 438.206 to 438.210; and OAR 410-141-3220]

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

6. Will Applicant have written procedures approved in writing by OHA for accepting, processing, and responding to all complaints and Appeals from Members or their Representatives that are consistent with Exhibit I of the Appendix B "Sample Contract"? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.228, 438.400 – 438.424]

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

7. Will Applicant develop and distribute OHA-approved informational materials to Potential Members that meet the language and alternative format requirements of Potential Members? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.10; OAR 410-141-3280]

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

8. Will Applicant have an on-going process of Member education and information sharing that includes appropriate orientation to the Applicant provided in the Member handbook or via health education, about the availability of intensive Care CoordinationCare Coordination for Members who are aged, blind and/or disabled, or are part of a prioritized population, and appropriate use of emergency facilities and urgent care? Will Applicant will communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.10; and OAR 410-141-3300]

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

9. Will Applicant have written policies and procedures to ensure Members are treated with the same dignity and respect as other patients who receive services from the Applicant that are consistent with Appendix B, Core Contract? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.100, ORS 414.635 and OAR 410-141-3320]

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

10. Will Applicant provide Intensive Care Coordination (otherwise known as Exceptional Needs Care Coordination or ENCC) to Members who are Aged, Blind or Disabled; Members with high health needs or multiple chronic conditions; Members receiving Medicaid-funded long-term care or long-term services and supports or receiving Home and Community-Based Services (HCBS) under the state's 1915(i), 1915(j), or 1915(k) State Plan Amendments or the 1915(c) HCBS waivers, or Behavioral Health priority populations in accordance with OAR 410-141-3170? Will Applicant ensure that Prioritized Populations, who sometimes have difficulty with engagement, are fully informed of the benefits of Care Coordination? Will Applicant ensure that their organization will be Trauma Informed by January 1, 2020? Will Applicant utilize evidence-based outcome measures? Will Applicant ensure that Members who meet criteria for ENCC receive contact and service delivery as required in OAR 410-141-3170? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.208]

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

11. Will Applicant maintain an efficient and accurate billing and payment process based on written policies, standards, and procedures that are in accordance with accepted professional standards, OHP Administrative Rules and OHA Provider Guides? Will Applicant and its Providers or Subcontractors will not hold Members responsible for debt incurred by the Applicant or by Providers if the entity becomes insolvent? Will Applicant have monitoring systems in operation and review the operations of these systems on a regular basis. The Applicant will communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 447.46]

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

12. Will Applicant participate as a trading partner of the OHA in order to timely and accurately conduct electronic transactions in accordance with the HIPAA electronic transactions and security standards? Has Applicant executed necessary trading partner agreements and conducted business-to-business testing that are in accordance with accepted professional standards, OHP Administrative Rules and OHA Provider Guides? Will Applicant have monitoring systems in operation and review the operations of these systems on a regular basis? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 45 CFR Part 162; OAR 943-120-0100 to 943-120-0200]

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

13. Will Applicant maintain an efficient and accurate system for capturing Encounter Data, timely reporting the Encounter Data to OHA, and regularly validating the accuracy, truthfulness and completeness of that Encounter Data based on written policies, standards, and procedures that are in accordance with accepted professional standards, CCO and OHP Administrative Rules and OHA Provider Guides? Will Applicant have monitoring systems in operation and review the operations of these systems on a regular basis? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.242; and the Contract]

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

14. Will Applicant maintain an efficient and accurate process that can be used to validate Member Enrollment and Disenrollment based on written policies, standards, and procedures that are in accordance with accepted professional standards, OHP Administrative Rules and OHA Provider Guides? Will Applicant have monitoring systems in operation and review the operations of these systems on a regular basis? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.242 and 438.604; and Contract]

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

15. Assurances of Compliance with Medicaid Regulations

Item 15 of this Attachment 14 has ten assurances of Compliance with Medicaid Regulations. These Assurances address specific Medicaid regulatory requirements that must be met in order for the Applicant to be eligible to contract as a CCO. For purposes of this section and the federal Medicaid regulations in 42 CFR Part 438, a CCO falls within the definition of a "managed care organization" in 42 CFR 438.2. This section asks the Applicant to provide a brief narrative of how the Applicant meets each applicable Assurance. The Applicant must provide supporting materials available to the OHA upon request.

Please describe in a brief narrative how Applicant meets the standards and complies with the Medicaid requirements cited in the Medicaid Assurances in Item 15:

a. Medicaid Assurance #1 – 42 CFR § 438.206 Availability of services.

b. Medicaid Assurance #2 – 42 CFR § 438.207 Assurances of adequate capacity and services.

c. Medicaid Assurance #3 – 42 CFR § 438.208 Coordination and continuity of care.

d. Medicaid Assurance #4 – 42 CFR § 438.210 Coverage and authorization of services.

e. Medicaid Assurance #5 – 42 CFR § 438.214 Provider selection.

f. Medicaid Assurance #6 – 42 CFR § 438.224 Confidentiality.

g. Medicaid Assurance #7 – 42 CFR § 438.228 Grievance and Appeal systems.

h. Medicaid Assurance #8 – 42 CFR § 438.230 Subcontractual relationships and delegation.

i. Medicaid Assurance #9 – 42 CFR § 438.236 Practice guidelines.

j. Medicaid Assurance #10 – 42 CFR § 438.242 Health information systems.

Please see attached document for the narrative responses to Question 15.

Attachment 14 – Assurances
Responses to Question 15

15. Assurances of Compliance with Medicaid Regulations
Please describe in a brief narrative how Applicant meets the standards and complies with the Medicaid requirements cited in the Medicaid Assurances in Item 15:

a. Medicaid Assurance #1 – 42 CFR § 438.206 Availability of services.

CPCCO meets all of the required provisions in 42 CFR § 438.206 in the following ways:

- **Delivery Network**
    1. CPCCO maintains and provides ongoing monitoring of a network of providers sufficient to provide access to all enrolled members for the full spectrum of Covered Services under the CCO Contract, including those with limited English proficiency or physical or mental disabilities. This is demonstrated through the attached DSN report in Attachment 7 of this Application.
    2. CPCCO provides female enrollees with direct access to women's health specialists in the network for routine and preventive services, regardless of whether the PCP is a women's health specialist.
    3. Members may access a second opinion from in-network providers and CPCCO will arrange for members to obtain second opinions outside of the network, if necessary, at no cost.
    4. CPCCO will provide out-of-network services if and when the existing network is unable to provide necessary Covered Services.
    5. CPCCO works with out-of-network providers to ensure that there is little to no cost to members, and in any event, the cost is no greater than if the service were provided in-network.
    6. CareOregon credentials all network providers on CPCCO's behalf.
    7. CPCCO can demonstrate sufficient family planning access.
- **Furnishing of Services**
    1. Timely access – CPCCO provides ongoing monitoring of its network to ensure that the network meets or exceeds state standards for timely access to care and services, including those services that may be needed urgently. CPCCO also ensures that network hours of operation are no less than hours of operation offered to any other coverage types. Those services that may be medically necessary 24 hours a day, 7 days a week are available to all CPCCO members. We perform routine audits and oversight of providers, and include compliance requirements in provider agreements to ensure compliance. In the event that we identify compliance concerns with a provider, we take immediate action to correct that deficiency.
    2. Access and cultural considerations – As articulated in the body of this Application, CPCCO invests heavily in terms of dollars, resources, time, and focus on developing and prioritizing partnerships, programs, and learning opportunities to promote the delivery of services in a culturally responsive manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.
    3. Accessibility considerations – Part of CPCCO's routine monitoring and contract provisions include oversight to ensure that network providers provide physical access, reasonable accommodations and accessible equipment for members with physical and/or mental disabilities.

b. Medicaid Assurance #2 – 42 CFR § 438.207 Assurances of adequate capacity and services.

CPCCO demonstrates is capacity to serve the entire eligible OHP population in Clatsop, Columbia and Tillamook counties, in accordance with the state's standards for access to care, through the attached DSN report, and its routine monitoring activities.

- **Nature of supporting documentation** – CPCCO has documented a broad range of preventive, primary care, specialty services that are adequate for the entire OHP eligible population in its service area that is sufficient in number, mix and geographic distribution.
- **Timing of documentation** – CPCCO has included its DSN and supporting documentation along with this application, and is prepared to do so annually (as it has annually since its inception), as well as any time there has been a significant change in operations that would affect the adequacy of capacity and services, including changes to services, benefits, service area, payments or network, or enrollment of a new population.

c. Medicaid Assurance #3 – 42 CFR § 438.208 Coordination and continuity of care.

- **Care Coordination**
  - CPCCO ensures that every member is assigned to a PCP, with preference for assignment to PCPs who are PCPCH certified.
  - Depending on the specific needs or circumstances, CPCCO provides telephonic or in-person coordination services between settings of care, including discharge planning, coordination of benefits, Open Card benefits, and services provided in community-based settings.
  - CPCCO makes its best effort to conduct health risk screenings of each new member within the first 90 days of enrollment, including follow-up attempts to conduct screening if the initial attempt is unsuccessful.
  - Within what is allowable under HIPAA, 42 CFR Part 2, or other regulations, CPCCO shares any assessment information regarding members' needs to prevent duplication of efforts. Similarly, CPCCO promotes HIE efforts to ensure that providers may also share health information, as allowable.
- **Additional Services for Enrollees with Special Health Care Needs**
  - CPCCO conducts comprehensive assessment of those members that the state identifies as needing LTSS or having special health care needs in order to identify special conditions. Typically, these members are enrolled with CPCCO's Regional Care Team, which provides comprehensive care coordination services and works directly with the member's primary care home to ensure the full array of services needed are readily available and coordinated.
  - The RCT or other care coordination staff on CPCCO's team produce treatment plans that detail the specific needs and goals of the member and/or the member's caregivers. All of CPCCO's care coordination staff are trained in person-centered planning and trauma-informed care. All plans are reviewed and revised at least annually.
  - All of CPCCO's members may access specialists directly. CPCCO's systems do not require referrals to access specialty appointments.

d. Medicaid Assurance #4 – 42 CFR § 438.210 Coverage and authorization of services.

- **Coverage** – CPCCO ensures that Covered Services rendered are sufficient in amount, duration or scope to achieve the purpose for which the services are rendered. CPCCO's policies and practices ensure that amount, duration, or scope of a required service are not denied or reduced solely because of diagnosis, type of illness or condition.

- **Limits** – CPCCO does not place any limitations on family planning services. CPCCO's utilization management team assesses any other limitations placed on services based on:
    - regulations;
    - medical necessity; and/or
    - utilization control when:
        - the services can reasonably achieve their purpose;
        - the services are reflective of the member's specific need for services and supports
- **Medical Necessity** – CPCCO defines medical necessity in a manner that adheres to the prioritized list and associated guideline notes. It is no more restrictive, and in many cases, less restrictive than the state program is for Open Card members.
- **Authorization of Services** – CPCCO has and follows written policies and procedures for its prior authorization obligations. Its team regularly reviews prior authorization work for interrater reliability so that the application of its criteria is applied consistently. Requesting providers are consulted regularly when there are questions about services or information specific to the member or the member's health record. All decisions to deny all or part of any prior authorization is made by licensed clinicians who have the appropriate expertise to address the member's medical, behavioral, oral health, or other services and supports needs.
- **Notice of adverse benefit determination**. CPCCO notifies the requesting provider and gives the member written notice of any decision to deny all or part of prior authorization request.
- **Timeframe for decisions**. CPCCO adheres to all required timeframes for turning around prior authorization requests, whether standard or expedited.

e. Medicaid Assurance #5 – 42 CFR § 438.214 Provider selection.

- **Credentialing & Recredentialing** – CareOregon, on behalf of CPCCO, has written policies and procedures that adhere to state requirements for credentialing and recredentialing. CareOregon follows its documented process consistently.
- **Nondiscrimination** – CareOregon does not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. CareOregon similarly does not discriminate against providers, based on their license type, when credentialing or contracting with those providers for services included in their scope of practice, pursuant to Oregon state law.
- **Excluded Providers** – CareOregon checks all providers against exclusion lists and it does not employ or contract with any providers who are found on those lists.

f. Medicaid Assurance #6 – 42 CFR § 438.224 Confidentiality.

- CPCCO ensures that its staff and all business associates, subcontractors, and network providers use or disclose individually identifiable health information in accordance with privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable. CPCCO similarly adheres to privacy requirements described in 42 CFR part 2.

g. Medicaid Assurance #7 – 42 CFR § 438.228 Grievance and Appeal systems.

- CPCCO receives, processes, follows up, and reports on grievances and appeals in accordance with the requirements in the CCO Contract. CPCCO also cooperates with the OHA on any review of the grievance and appeal system.

h. Medicaid Assurance #8 – 42 CFR § 438.230 Subcontractual relationships and delegation.

- CPCCO recognizes that it maintains the ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the OHA.
- CPCCO ensures that all delegated activities are specified clearly in a contract and that contract requires that the delegated entity to perform its obligations in accordance with the CCO Contract requirements. All delegation agreements provide for revocation and other remedies or sanctions when/if the OHA determines that the delegated entity has not performed satisfactorily.
- All delegated entities must agree to comply with all applicable Medicaid laws, regulations and applicable subregulatory guidance and contract provisions. Further, all delegated entities must agree that the OHA, CMS, the HHS IG, the Comptroller General or other designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor or of the subcontractors' contractor that pertain to any aspect of services an activities performed under the CCO Contract with the OHA, and that the delegated entity will make these implements available, upon request, for 10 years from the final date of the contract period, or from the completion date of any audit.

i. Medicaid Assurance #9 – 42 CFR § 438.236 Practice guidelines.

- CPCCO works with its CAP and other clinical workgroups at CareOregon and with CareOregon clinical leadership to develop and disseminate practice guidelines which:
    - Are based on valid and reasonable clinical evidence or a consensus of providers in a particular field;
    - Consider the needs of the members;
    - Are adopted in consultation with contracting health care professionals; and
    - Are reviewed and updated periodically, as appropriate.

j. Medicaid Assurance #10 – 42 CFR § 438.242 Health information systems.

- Health information systems. CareOregon, on behalf of CPCCO, maintains health information systems that comply with all regulations in this regulation. The health information systems are audited and updated regularly as technology advances. All data exchanged with the OHA and with providers is done so in a compliant fashion, with standard claims, eligibility, enrollment, and encounter formats typical for the industry.
- Enrollee encounter data. CareOregon, on behalf of CPCCO collects and submits enrollee encounter data within the timeframes and at the level of detail required by CMS and the OHA, based on program administration, oversight, and program integrity needs.

Attachment 15 — Representations

Applicant Name: Columbia Pacific CCO, LLC (CPCCO)

Authorizing Signature: [signature]

Printed Name: Mimi Haley, Chief Executive Officer, CPCCO

Instructions: For each representation, Applicant will check "yes," or "no,". On representations, no particular answer is normal, and an explanation will be furnished in all cases. Applicant must respond to all representations.

These representations must be signed by a representative of Applicant.

Each representation is effective starting at the time of Readiness Review and continuing throughout the term of the Contract.

1. Will Applicant have an administrative or management contract with a contractor to manage/handle all staffing needs with regards to the operation of all or a portion of the CCO program?

☒ Yes ☐ No

Explanation: CPCCO will have a Management Services contract with CareOregon, Inc., the sole Member/parent of CPCCO to manage/handle all staffing needs with regard to all of the CCO program. This arrangement will be identical to the arrangement CPCCO has maintained with CareOregon since its inception.

2. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the systems or information technology to operate the CCO program for Applicant?

☒ Yes ☐ No

Explanation: CPCCO will have a Management Services contract with CareOregon, Inc., the sole Member/parent of CPCCO to perform all of the systems and information technology to operate the CCO program for CPCCO This arrangement will be identical to its 2012-2019 systems. CareOregon also supports IT for Health Share and JCC.

3. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the claims administration, processing and/or adjudication functions?

☒ Yes ☐ No

Explanation: CPCCO will have a Management Services contract with CareOregon, Inc., the sole Member/parent of CPCCO to perform nearly all of the claims administration, processing and adjudication functions. Dental claims will be administered directly by CPCCO's DCO partners for oral health services; all others will be administered by CareOregon.

4. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the Enrollment, Disenrollment and membership functions?

☒ Yes ☐ No

Explanation: CPCCO will have a Management Services contract with CareOregon, Inc., the sole Member/parent of CPCCO to perform all Enrollment, Disenrollment and membership functions. This arrangement will be identical to the arrangement CPCCO has had in its Management Services Agreement with CareOregon since its inception.

5. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the credentialing functions?

☒ Yes ☐ No

Explanation: CPCCO will have a Management Services contract with CareOregon, Inc., the sole Member/parent of CPCCO to perform all credentialing functions, except for dental care providers who provide dental benefits as delegated to CPCCO DCO partners; the DCOs will credential their network providers and CPCCO will conduct delegation oversight of their work.

6. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the utilization operations management?

☒ Yes ☐ No

Explanation: CPCCO will have a Management Services contract with CareOregon, Inc., the sole Member/parent of CPCCO to perform all utilization operations management, except for dental utilization management, which will be delegated to CPCCO's DCO partners. CPCCO will retain final adjudication of any grievances and appeals.

7. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the Quality Improvement operations?

☒ Yes ☐ No

Explanation: CPCCO will have a Management Services contract with CareOregon, Inc., the sole Member/parent of CPCCO to perform all Quality Improvement activities. This arrangement will be identical to the QI activities CareOregon has performed on behalf of CPCCO since its inception.

8. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of its call center operations?

☒ Yes ☐ No

Explanation: CPCCO will have a Management Services contract with CareOregon, Inc., the sole Member/parent of CPCCO to perform all call center operations. This arrangement will be identical to the call center operations CareOregon has performed on behalf of CPCCO since its inception.

9. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the financial services?

☒ Yes ☐ No

Explanation: CPCCO will have a Management Services contract with CareOregon, Inc., the sole Member/parent of CPCCO to perform all financial services. This arrangement will be identical to the financial services functions CareOregon has performed on behalf of CPCCO since its inception.

10. Will Applicant have an administrative or management contract with a contractor to delegate all or a portion of other services that are not listed?

☒ Yes ☐ No

Explanation: CPCCO will have a Management Services contract with CareOregon, Inc., to also perform Member communications (handbook, health education, outreach, etc.), care coordination, audit support, network contracting support and VBP development.

11. Will Applicant will have contracts with related entities, contractors and Subcontractors to perform, implement or operate any aspect of the CCO operations for the CCO Contract, other than as disclosed in response to representation 1-10 above?

☐ Yes ☒ No

Explanation:

12. Other then VBP arrangements with Providers, will Applicant sub-capitate any portion of its Capitation Payments to a risk-accepting entity (RAE) or to another health plan of any kind?

☒ Yes ☐ No

Explanation: All physical health, behavioral health, and NEMT services will be subcapitated to Applicant Affiliate, and sole Member/parent, CareOregon, Inc. Dental services will be subcapitated to Advantage Dental, Capital Dental, ODS, and Willamette Dental (together, "DCO partners").

13. Does Applicant have a 2019 CCO contract? Is Applicant a risk-accepting entity or Affiliate of a 2019 CCO? Does Applicant a management services agreement with a 2019 CCO? Is Applicant under common management with a 2019 CCO?

☒ Yes ☐ No

Explanation: CPCCO has a 2019 CCO Contract, it is an Affiliate of Jackson Care Connect, which has a 2019 CCO Contract. Both entities have CareOregon, Inc. as their parent company (sole Member), and CareOregon accepts risk for two-thirds of Health Share of Oregon's physical health risk, and one quarter of Health Share of Oregon's dental risk. Overall, CareOregon, administers OHP benefits for more than 250,000 enrollees.

Attachment 16 - Member Transition Plan

16.1. Background and Supporting Sources. No associated questions/answers
16.2. Plan Contents
16.2.a. Coordination between Transferring and Receiving CCOs.
OHA expects the Transferring and Receiving CCOs to work together and cooperate to achieve a successful transition for Members who change CCO during the Open Enrollment period.
This section should describe the Applicant's plan to coordinate with other CCOs as the Transferring and/or Receiving CCO. This include but is not limited to establishing working relationships and agreements between CCOs to facilitate data sharing and validation, Member Prior Authorization history, Provider matching and Assignment, continuity of care and customer support.

CareOregon, on CPCCO's behalf, will be able to leverage its experience to ensure high quality communication to members and to providers. As the OHA is aware, under the Health Share of Oregon umbrella, CareOregon absorbed more than 80,000 of the 100,000 members who transitioned to Health Share in early 2018. In the course of that transition, CareOregon's clinical team led the discussions within Health Share about how to ensure a safe and orderly transition of members. As such, the same clinical and operational team supporting CPCCO will be well-poised to identify and organize the data for those members who may be at highest risk of disruption in care due to transition and ensure that they experience a warm hand-off.

CPCCO does, however, remain concerned that since we have such a small overall enrolled population, any transition of members will be a significant proportion of members in any community. Furthermore, while continuity of care is critical to minimizing disruption, we are very concerned that any transition of members may result in adverse selection for the Transferring CCO. In other words, it is probable, given the CCOs' experience with the ACA Expansion, that only those members who are actively engaged in care will opt to stay with their original CCO and those who are not engaged in care may be the ones who are passively "transferred" to a new CCO. This is not just disruptive to members, providers, and communities, but it puts the overall business model of a CCO in a rural area at risk. That said, below is an outline of how CPCCO may approach a successful transition.

To ensure the safe and orderly transition of members, CPCCO will cooperate with a Transferring or Receiving CCO to achieve a successful transition for members during/after the open enrollment period. CPCCO recommends that OHA serve as a central repository of information about members who are transitioning between CCOs, facilitate the transfer of information from the Transferring CCO to the Receiving CCO, and share the information through a health information exchange. Until that is available, we encourage OHA to house SFTP sites to facilitate the transfer of member health information from one CCO to another. This arrangement has the benefit of ensuring CCOs are not inappropriately sharing protected health information (PHI). CareOregon supports the claims administration for over 250,000 OHP enrollees and therefore has the capability to produce member-level data in nearly any format necessary to support a transition.

In the event that CPCCO's current service area is a Choice Area, CPCCO will designate a team to work with the Transferring CCO's staff to ensure a smooth transition. This team would include operations staff, clinical leadership, care coordinators, information systems, compliance, communications and customer service. CPCCO staff would engage the Receiving CCO's leadership to negotiate and execute appropriate Data Use Agreements, confidentiality agreements, and data validation procedures to enable the secure exchange of information. Both teams would also

negotiate the format and method for exchanging information in a way that is efficient, complete, and compatible to both organizations' systems.

If CPCCO is the Receiving CCO. Since CPCCO is the only CCO currently operating in Clatsop, Columbia, and Tillamook Counties, and because we only anticipate one other potential Applicant in the service area, we do not anticipate being a Receiving CCO. However, because of the role OHA plays as an intermediary in providing enrollment files and client statuses, CPCCO will depend on the OHA or a Transferring CCO (if any) to assist in identifying those members who may need assistance over the transition period. We request or recommend that any Transferring CCO approach the transition as outlined in the following "If CPCCO is the Transferring CCO" section.

If CPCCO is the Transferring CCO. In the event that the OHA awards a contract to an additional applicant in Clatsop, Columbia and Tillamook Counties, CPCCO will stratify its members in the following way (Note: all of this is subject to change, if the OHA directs the transition to be different in any way, and/or upon mutual agreement of an alternative plan between the Transferring and Receiving CCOs' clinical leadership):

Tier 1 – Highest Risk Members, including those who:

- Are actively engaged in treatment protocols of any type (e.g. chemotherapy, transplant recipients, dialysis, Breast and Cervical Cancer Treatment Program members, ABA, etc.);
- Are inpatient at the time of transition;
- Have specific high-risk diagnoses (e.g. hemophilia, members receiving CareAssist assistance due to HIV/AIDS, ESRD, certain types of cancer, medically-fragile children, SPMI, etc.); or
- Are engaged in exceptional needs or intensive care coordination.

Tier 2 – Rising Risk Members, including those who:

- Have a recent visit to specific specialists (e.g., neurology, gastroenterology, orthopedics);
- Have specific chronic conditions or multiple co-morbidities (e.g., CHF, emphysema, MS, severe depression, SUD); and
- Are engaged in the health resilience program or other types of care coordination or peer support;
- Are receiving routine prenatal and postpartum care.

Tier 3 – Low Risk Members, including those who:

- Are engaged in care or have established with a PCP, but do not fall into Tiers 1 or 2.

Tier 4 – No Risk or Unknown, including those who:

- Have not engaged in any care or have no claims history for the past 24 months with us.

For Tiers 1-3, CPCCO will make lists available to the Receiving CCO with data elements described in 16.2.b below.

Since, by definition, CPCCO will not have any of this information for those in Tier 4, a list will not be generated for this group. It is possible that some members in this group have a prior

authorization in place for services not yet accessed or billed. If so, CPCCO will make that information available as well.

CPCCO will also make a single-point-of-contact available for the Receiving CCO to call to ask real-time questions regarding claims history or any other pertinent question that may not be included in the data extract, by Tier.

16.2.b. Transferring CCOs with Outgoing Members
This section of the Member Transition Plan is required if Applicant (1) has a 2019 CCO contract, (2) is a risk-accepting entity or Affiliate of a 2019 CCO, or (3) has a management services agreement with or is under common management with a 2019 CCO.
16.2.b.(1). Data Sharing
This section should describe the plan to compile and share electronic health information regarding the Member, their treatment and services. Include data elements to be shared, formatting and transmittal methods, and staffing/resource plans to facilitate data transfers to the Receiving CCO(s).
As noted above, CPCCO's parent company and administrative partner, CareOregon, was the largest recipient of new members in 2018 during the transition of OHP members in the Metro region. In addition, CareOregon is the state's largest OHP payer/administrator. As such, it has robust data systems able to produce data in nearly any format needed to support a successful transition.

During the Open Enrollment period (if not before), CareOregon staff would engage with OHA and the Receiving CCO to develop an operational and clinical plan for sharing data necessary to support the transition. It will be critical for OHA to participate in the early stages to help both CCOs understand the Open Enrollment process and when we will expect to receive the enrollment files that will contain the members assigned to each CCO and will be the "source of truth" for member information to be shared so that PHI is protected to the greatest extent possible.

Data Elements. As described above, all members to be transferred will be assigned to one of 4 Tiers (or risk strata). Data for these members, by Tier, will include:

Member Identifying Information	**Name, DMAP ID, Address, Case ID**
Tier or Risk Score	Including flags for specific populations, including: • Breast & Cervical Cancer Program • CareAssist • Medically fragile children • Members discharged from the Oregon State Hospital or other residential programs • Members receiving ENCC or ICC services • Members receiving Wraparound services • Members receiving Choice program services • Dialysis • Transplant recipients • Other priority populations identified by OHA or the Receiving CCO, clinical leadership, the CAP or the CAC
Historical Claims Information	• Physical health

	• Behavioral health • Oral health • NEMT
Prior Authorizations	• Clinical services • Pharmacy • NEMT (including scheduled rides)
Inpatient Data	Including a list of those patients who are inpatient at the time of transition and those who have been recently discharged
Provider Assignment & History	PCP, PDP, behavioral health care assignment Specialty care provider visits
Diagnoses	With particular attention to chronic conditions, recent inpatient stays, and specific diagnosis-related authorizations

Format and Transmittal. As described above, in its work supporting CPCCO and other CCOs like Jackson Care Connect and Health Share of Oregon and all of its plan and provider partners, CareOregon commonly exchanges large data feeds and files between Covered Entities and with the OHA. CareOregon can be flexible about the manner and format of that exchange. However, the preferred format for claims files would be in APAC-format for the last 12 months in a delimited flat file format with a data dictionary through an SFTP, or other HIPAA-compliant portal. We are also able to share flat Excel-type files via secure email and we are able to set up a secure ShareFile or SharePoint sites, as necessary.

Staffing. CareOregon has a well-resourced information systems and clinical leadership team who will be dedicated to coordinating with the OHA and a Receiving CCO to ensure that any transition takes place with member safety and wellbeing as the top priority. The team has extensive experience exchanging data and managing transitions like this. As stated above, CareOregon will make a single-point-of contact on the care coordination team available to the Receiving CCO so that member-specific questions or concerns may be resolved quickly. Finally, CPCCO's customer service and provider customer service teams will be trained to resolve questions that inevitably may arise in a transition situation.

16.2.b.(2). Provider Matching

This section should describe the methods for identifying Members' primary care and Behavioral Health home Providers and any specialty Providers, and transmitting that information to the Receiving CCO(s).

On CPCCO's behalf, CareOregon maintains PCP, PDP and behavioral health provider (if any) information in each member's claims file. Assignment to these providers will be included in any file extract. As described above, in addition to the historical claims information reasonably necessary to transition a member, any specialty relationship apparent in the claims history or prior authorization will be provided.

Further, through the CPCCO CAP and provider services teams, we will develop plans to validate provider assignment information and workflows to correct any incorrect assignment information so that any disruption in a member-provider relationship is mitigated.

16.2.b.(3). Continuity of Care

This section should describe plans to support Member continuity of care, including but not limited to Prior Authorizations, prescription medications, medical Case Management Services, and Transportation. This section

should include all Members regardless of health status with specific details to address those Members at risk as described in Section (1).
Please see 16.2.a above.

CPCCO will provide OHA and the Receiving CCO with all of the data elements listed above in 16.2.b.(1). CPCCO will work with the Receiving CCO to co-develop specific communications to go out to providers and pharmacies in the service area notifying them of the change and how to resolve any questions that could impact continuity of care.

Prior Authorizations. The OHA and the Receiving CCO will have all current prior authorization data from CPCCO at the time of the transition. In 2018, when Metro region members transitioned, the Receiving CCO agreed to honor existing PAs for a period of 180 days for behavioral health services and 90 days for all other services. We would look to the OHA to establish similar criteria for honoring PAs in place at the time of any transition.

Prescription Medications. Historical pharmacy claims data and authorizations in place at the time of the transition will be made available to the Receiving CCO and clinical staff at CPCCO will be available to answer any questions that may arise. Again, in 2018, CareOregon was able to get pharmacies who participated with the Transferring CCO to also participate with us (the Receiving CCO) so that disruption to members was minimal, however, that would be up to the Transferring CCO to arrange since they would be liable for those claims post-transfer.

Transportation. Historical NEMT and Ambulance data and all authorized/scheduled rides will be shared with the Receiving CCO. Since we do not know which brokerage the Receiving CCO may use, it is unclear exactly how we can help to minimize disruption of this service, but we will make our transportation coordination staff available to troubleshoot any issues that may arise.

The reason that we believe it is important to stratify members based on known risk is so that we can devote as much attention and resource into ensuring continuity of care for those who fall in "Tier 1" or the highest risk members in our framework. For those in lower risk Tiers, we will provide as much data and staff resource as possible to the Receiving CCO, to OHA, to providers, and to other CBOs so that care disruption is minimized.

16.2.c. Member/Provider Outreach for Transition Activities - This section should describe plans to work directly with outgoing Members and their Providers to perform Warm Handoff activities for high-need Members and other specific Member groups identified as requiring additional support during the transition. This includes, but is not limited to, helping Members and Providers understand the coverage in place and the plan for transition of care, monitoring the transition of care to identify and address issues during the transition process, and collaborating with stakeholders and the Receiving CCO to ensure a seamless transition of care for the Member.
Through CPCCO's Regional Care Teams (RCT), we will ensure face-to-face meetings with the patient, either in person or through the use of telehealth, and coordinate the transfer of responsibility for the patient's ongoing care and continuing treatment and services. Members who are at risk for adverse health outcomes will be proactively engaged through the RCT to ensure continuity of care. For members with SPMI or discharging from an acute care psychiatric hospital, CPCCO will follow the warm handoff process as required by OAR 30-032-0860.

We believe, ultimately, that helping members understand their coverage and how to use their benefit should be a core competence and priority of the Receiving CCO. We will provide the Receiving

CCO with as much data as we can to make that smooth. We would want to work with the Receiving CCO to have common messages to providers and members so that they know what is happening, why it is happening, where to go for questions, how to resolve problems, how to make changes in their enrollment (if necessary or desired), and whether there are specific protocols for higher-needs members.

To connect with providers, CPCCO will utilize its provider portal which every provider can access. From the portal, we post alerts, relevant news and information relating to all transition activities. We also conduct an in-person monthly meeting with our provider workgroups to ensure clarity of data, and that coordination, access and any complaints are addressed in a timely fashion. CareOregon's robust member services teams will act as first point of contact for any member questions. Outreach efforts will be made to provide a welcome, answer questions, review benefits, or take and respond to complaints.

16.2.d. Receiving CCOs with Incoming Members

16.2.d.(1). Data Sharing:

This section should describe the data reception plan for incoming Members, including but not limited to Receiving and storing data files, front-end validation, system entry, output validation, distribution.

Since CPCCO is the only CCO currently operating in Clatsop, Columbia, and Tillamook Counties, and because we only anticipate one other potential Applicant in the service area, we do not anticipate being a Receiving CCO. However, because of the role OHA plays as an intermediary in providing enrollment files and client statuses, CPCCO will depend on the OHA or a Transferring CCO (if any) to assist in identifying those members who may need assistance over the transition period. We request or recommend that any Transferring CCO approach the transition as outlined in the previous sections, but in reverse.

As previously stated, CareOregon has extensive experiencing receiving, storing, validating, coordinating, parsing, and distributing data to numerous Covered Entities through its work supporting CPCCO, Jackson Care Connect and Health Share of Oregon. CareOregon is able to send and receive large quantities of PHI via SFTP, secure ShareFile or SharePoint. Upon receipt of any enrollment file from the OHA, CareOregon would request from any Transferring CCO the data elements listed above in 16.2.b.(1), which would be validated against the enrollment file. The data would then be further validated using record control tools to ensure that the files are formatted accurately and completely, and then it would be ingested into the CareOregon data warehouse. At that point, our team of analysts and clinical leaders would begin to stratify the data, quantify, and assign to specific staff who will then need to use the data to engage in outreach, communication, care coordination, disease management, etc.

16.2.d.(2). Provider Matching

This section should describe the methods for identifying Members' primary care and Behavioral Health home Providers and any specialty Providers, and enrolling Members with their assigned Providers. This includes contingency plans for assigning Members to appropriate Providers if they cannot enroll with the Provider from the Transferring CCO.

To meet the needs of the transferring members, CPCCO will need to receive the same information described in Section 2.b. above from the Transferring CCO regarding a member's most recent assignment to a PCP, PDP, and behavioral health provider. As data are made available from OHA or Transferring CCO we can identify recently transferred members and look for prior assignments that align with our provider network. CPCCO contacts new and transferring members within 30

days of their enrollment via multiple methods such as phone calls and mailings. This process identifies health care and health related needs including provider relationships which are then used to update provider assignments based on member needs and requests.

For incoming members with complex needs, particularly those receiving Exceptional Needs Care Coordination, Intensive Care Coordination, Choice, Wraparound or other care management, CPCCO will arrange to staff the cases and, whenever possible, allow for a "warm handoff" between the transferring in CCO and CPCCO. For example, to ensure the continuity of treatment course and prevent disruptions in medication coverage, pharmacy staff from CPCCO partners will provide transition coverage of members' active medications that require prior authorization. In addition to meeting the minimum OAR 410-141-3061 transition of care requirements, continued access to these medications can be extended beyond transition phase when they are deemed medically appropriate and necessary. Additionally, care coordination teams assess for coordination needs such as provider access, social determinant of health issues, or coordination with multiple providers. A care plan is created, documented in the care management platform and shared with the PCP to address any issues uncovered, and the care team will work with the member and any providers to ensure a smooth transition.

Sometimes a member will not be able to enroll with the provider of their choice when transferring to a new CCO. Certainly, the member should receive counsel that potentially moving from one service area or network to another may come with this risk. CPCCO will be thoughtful about the member's specific needs to assure adherence to their treatment plan. The CCO will explore creative options when additional considerations may be needed.

16.2.d.(3). Continuity of Care:

This section should describe plans to support Member continuity of care, including but not limited to honoring Prior Authorizations, prescription medications, and Treatment Plans from the Transferring CCO, medical Case Management Services, and Transportation. This section should address the approach for all Members regardless of health status with specific details to address those persons described in Section (1). As the Receiving CCO, the plan should address how the Receiving CCO will ensure access to all medically necessary services for Members at risk of serious detriment to their physical and mental health, hospitalization, or institutionalization.

Continuity of Care. In our prior experience with CCO membership transfer, CareOregon worked with both contracted and non-contracted providers to ensure members' care was not disrupted while members searched for and established relationships with new providers within our network as needed; we will continue this process for new members who may come to the CCO as a result of any CCO 2.0 transition process. CPCCO will cover out-of-network providers' claims for Covered Services (as long as the provider is enrolled with DMAP) at non-par rates, so care should not be disrupted. In the meantime, the CPCCO provider services team will reach out to any out-of-network providers present in the service area, who may be serving any transferring members to offer a contract. If a member is engaged in services, we will offer both options of a contract or a single case agreement. If the provider is not interested or unwilling to enter into a contract arrangement, we will work with the member to find a contracted provider suited to meet the member's needs.

Prior Authorizations. As CareOregon did with the Metro region transition in 2018, CPCCO will honor all existing prior authorizations for services, pharmaceuticals and treatment plans for at least the first 90 days. CPCCO would remain open to honoring prior authorizations for longer, where clinically appropriate and in the best interest of the member to do so.

Prescription Medications. CPCCO will also work with pharmacy staff and local pharmacies in our network to ensure access to medication is not disrupted. CPCCO also employs a team of clinical pharmacists who can work with member's primary care team to meet the member's specific pharmacy needs, as they may relate to the member's care plan. We will also evaluate whether there are specific pharmacies where transferring members purchased their medications that are outside of our pharmacy network. If there are any gaps in the network, we will work with our PBM and those pharmacies to expand access so that members will not have difficulty accessing their medications in the immediate term. Finally, the CPCCO pharmacy team will analyze pharmacy data to identify those medications that are associated with members identified on Tiers 1 and 2 to ensure that we pay particular attention to any members who may benefit from outreach from the clinical pharmacy team, or members who may need additional assistance ensuring that they are able to access their medications in a timely manner.

Treatment Plans. CareOregon is currently implementing its new care coordination platform (GSI). We anticipate loading care plans and health screening information into this platform so that all staff who touch members have the information they need to fully care for each member. For incoming members with complex needs, particularly those receiving Exceptional Needs Care Coordination, Intensive Care Coordination, Choice, Wraparound or other care management, CPCCO will staff each case, enroll members with CPCCO's Regional Care Team (RCT), as appropriate, connect with other care providers and, whenever possible, allow for a warm handoff from the Transferring CCO.

Provider Outreach. CPCCO will co-develop, with the Transferring CCO, communications strategies to ensure that any provider whose patients may be impacted by this transition is aware of the transition and has the information necessary to continue to work with their patients. CareOregon, on behalf of its CCO partners, has a long history of being flexible and open with its network and honoring member choice of providers wherever possible.

Member Outreach. CPCCO will outreach to members, with particular attention to those in Tiers 1 and 2, to offer assistance, to help answer any questions they may have, to assuage any concerns they may have, and to help connect them to any services they may need – clinical or community-based. We will also make best efforts to conduct health risk assessments, whether by phone or by mail, so that we can capture as much data as we can, beyond what we are able to get from the Transferring CCO's data.

16.2.d.(4). Member/Provider Outreach for Transition Activities:
This section should describe plans to work directly with incoming Members and their Providers to perform Warm Handoff activities for high-need Members and other specific Member groups identified as requiring additional support during the transition. This includes, but is not limited to, helping Members and Providers understand the coverage in place and the plan for transition of care, monitoring the transition of care to identify and address issues during the transition process, and collaborating with stakeholders and the Transferring CCO to ensure a seamless transition of care for the Member.

For Members

Our member services teams will act as first point of contact for general member questions. Outreach efforts will provide a welcome, answer questions, review benefits, or take and respond to complaints. Systems are configured to send welcome packets and ID cards to all new members. In our prior experience of transitioning a large group of members we also welcomed them through specific phone messaging and scripts recognizing the change they were experiencing as well as

through a temporary new member welcome line to ensure we could accommodate the increase in call volume.

Members who are at risk for adverse health outcomes will be proactively engaged through care coordinators to ensure continuity of care. For example, for members with SPMI or discharging from an acute care psychiatric hospital, CPCCO will follow the warm handoff process as required by OAR 30-032-0860. Through our care coordination team, we will ensure face-to-face meetings with the patient, either in person or through the use of telehealth, and coordinate the transfer of responsibility for the patient's ongoing care and continuing treatment and services.

Every effort will be made to assign members to the same PCP they are currently engaged with, provided they are in the primary care network. We will also work to assure that those members are engaged with the same behavioral health provider and dental provider. Additionally, we will make outreach attempts to welcome the member to CPCCO fill in any gaps in the data regarding medical provider assignments and care needs. If a member is assessed as needing care coordination, that member is immediately triaged into care coordination.

Another way we will outreach to members in a more informal manner is working with our network of health care navigators and health plan assistors who educate members and community based organizations on navigation of the health care and other social service systems such as DHS, Social Security, and SNAP to deliver a wrap-around experience with other programs that work with OHP members. With this program, we meet members where they ordinarily gather, including churches, grocery stores, the library, waiting rooms in community organizations, and school. During a CCO transition, we would want to encourage members and their advocates to engage with CPCCO and their PCP as early and often as needed.

Finally, we will engage our CACs to generate ideas for how to best reach members, to collect stories about how transition activities may be going, and to identify areas we can improve upon to better communicate.

For Providers

We have a dedicated provider portal that every provider can access. From the portal we post alerts, relevant news and information relating to all transition activities. We also conduct an in-person monthly meeting with our CAP and provider workgroups to ensure clarity of data, and that coordination, access and any complaints are addressed in a timely fashion.

The transition plan will include understanding and analyzing members' existing, open authorizations for services. An analysis will be conducted on the services that will be delivered in a facility that is in the network and if the data is available in advance it will be loaded into the claims system where the member is assigned. When there are out of network services planned, CPCCO will reach out to those providers to either complete single case agreements for those services or initiate contracting with those providers. We will also have the availability to work with those providers on a non-contracted basis to assure access for members.

Every effort will be made to assign members to the same PCP they are currently engaged with, provided they are in the primary care network. We will also work to assure that those members are engaged with the same behavioral health provider and dental provider. CPCCO's ability to effectively match members with their providers will be dependent on the attribution and assignment

data that the OHA is able to provide in advance of the transition. We will work after the transition with our primary care, behavioral health, and oral health providers to use clinical assignment data, matched with new member rosters, to ensure safe and smooth member transitions within the CPCCO network after open enrollment.

We will engage our Clinical Advisory Panel to ensure that we are outreaching to providers in a broad-based and effective manner, and to help us identify where there may be confusion or opportunities to improve our communication and education strategies.