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: Jackson County CCO, LLC, d.b.a, Jackson Care Connect

Address: 33 N Central Avenue, Suite 320

Medford, OR 97501

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

Contact Name: Jennifer Lind   **Phone:** 503.416.3683   **Email:** lindj@careoregon.org

Oregon Business Registry Number: 857453-97, d.b.a. 876396-97

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:** Chief Legal Officer   **Date:** 4.19.19

(Authorized to Bind Applicant)

State of ___OR___)

) ss:

County of Multnomah

Signed and sworn to before me on ___19 Apr___ (date) by ___Erin Fair-Taylor___ (Affiant's name).

_____

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 Jackson County CCO, LLC, d.b.a, Jackson Care Connect ("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 7 - Provider Participation and Operations Questionnaire

7.1. Governance and Organizational Relationships
7.1.a. Governance (recommended page limit 1 page)
7.1.a.(1) The proposed Governance Structure, consistent with ORS 414.625.
The JCC Board of Directors has had a stable governance structure since its inception in 2012. Our governance board is composed of stakeholders including community leaders with experience as clinicians, health administrators, social service providers, and CCO members. The Board of Directors has chartered 5 committees: Community Advisory Council (CAC), Clinical Advisory Panel (CAP), Finance, Governance / Compliance, and Network / Quality. Two CAC members serve on the Board of Directors. The CAC has direct responsibility for prioritizing CHIP related projects and allocating funds designated by the Board of Directors. Our efficient business model leverages the community board and staff to build strong relationships with service providers and members. These relationships allow us to provide technical assistance and capacity building support for local organizations who would not otherwise be exposed to quality improvement principles.

1.a.(2) The proposed Community Advisory Council (CAC) in each of the proposed Service Areas and how the CAC was selected consistent with ORS 414.625.
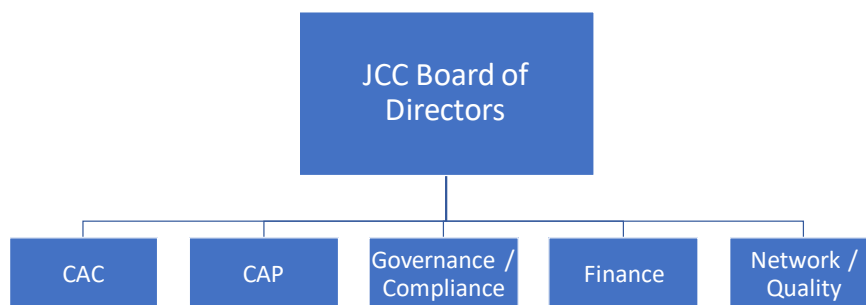
The JCC CAC includes community representatives, one county administrator, and consumers. More than half of the CAC members are consumers. CAC members and JCC staff are responsible for recruitment efforts. CAC recruitment efforts prioritize matching the demographic composition of JCC membership whenever possible. New CAC members are nominated by the CAC, reviewed by the Governance Committee (as the committee responsible for nominating new Board members and maintaining Board composition) and approved by the JCC Board of Directors. CAC meetings are held monthly and are open to the public.

1.a.(3) The relationship of the Governance Structure with the CAC, including how the Applicant will ensure transparency and accountability for the governing body's consideration of recommendations from the CAC.
JCC actively seeks to ensure cross-representation and communication between the JCC governing bodies and the CAC. This cross-representation, along with reporting mechanisms, creates a structure ensuring the JCC Board of Directors seriously considers CAC recommendations in a manner which supports transparency and accountability. Two CAC members sit on the JCC Board of Directors. This has several benefits. It builds leadership and empowerment amongst CAC members and allows CAC members to be mentored by fellow Board of Director members. It also provides for an

immediate, in-person lens of member experiences added to Board of Directors discussions and decisions. One CAC member also sits on JCC Governance Committee, providing similar benefits.

As an active committee of the JCC Board, the CAC participates in governing decisions on projects, member communications, and community investments related to Social Determinants of Health (SDOH) and Health Equity (HE). From this perspective, the CAC: makes budget recommendations to Board of Directors for SDOH interventions; reviews and approves CHIP grants for SDOH-HE work; is involved in sponsorship investments, and makes recommendations to JCC Board of Directors and staff on projects, strategic priorities, and member communications. Because of its key role in providing member and community input, the JCC Board of Directors refers issues to the CAC for further exploration and consideration of member experience. Similarly, the CAC Board members can flag issues for the Board of Directors to consider that may have member impact.

JCC achieves transparency and accountability in decision making by including CAC members in the Governing Board of Directors. To support their empowerment, JCC provides training and support to CAC members about role as advocates and member representatives in areas such as public speaking, meeting facilitation, community organizing, overall healthcare system, and human resources training. In addition, JCC sends CAC members to conferences to encourage growth and leadership. Overall, JCC strives to create a culture that provides comfort and support to CAC members for asking questions and speaking up as an advocate for members.

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

The JCC Board is committed to meeting the needs of our most vulnerable members, including those with severe and persistent mental illness. Our Clinical Advisory Panel (CAP), which is part of our Governance structure, includes one Board of Directors member and oversees clinical initiatives. The CAP integrates clinical leaders in our community from primary care, mental health, addiction services, hospitals, and oral health. These leaders have deep knowledge of serving individuals with severe and persistent mental illness and individuals receiving long term care (LTC) services, and regularly incorporate that experience in the clinical discussions and recommendations. In addition, we have representation on the JCC Governing Board from the County Mental Health and Veterans Administration programs working with individuals who are experiencing homelessness, behavioral health diagnoses and/or Medicaid-funded LTC services. Lastly, we have active CAC members on the CAC who receive LTC services and bring a member perspective to the coordination of these programs.

The work of board members and staff have resulted in development of a primary care clinic specifically committed to individuals with multiple behavioral health diagnoses, supported housing for individuals with mental health diagnoses (including those discharged from the state hospital), cross discipline care coordination teams led by social workers, and in increase in mental health utilization and penetration rates.

JCC currently coordinates care for those on CCO-G ("mental health only"), and it serves CareOregon Advantage Dual SNP members and those with other Medicare primary coverage who enroll in JCC 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 LTC services, or

who have special mental health care needs to ensure full and equitable participation in the JCC governance structure.

7.1.b. Clinical Advisory Panel (recommended page limit ½ page)
An Applicant is encouraged but not required to establish a Clinical Advisory Panel as a means of assuring best clinical practices across the CCO's entire network of Providers and facilities.
7.1.b.(1). If a Clinical Advisory Panel is established, describe the role of the Clinical Advisory Panel and its relationship to the CCO governance and organizational structure.
JCC has a Clinical Advisory Panel (CAP) that serves as an active committee to the governing board. It meets every month to discuss clinical guidelines, quality metrics, and value data across clinics. The CAP consists of Chief Medical Officers / Medical Directors for all 5 of the major primary care systems, leadership from the two hospitals, Clinical Directors from the main substance use and mental health service providers, and two Dental Directors. It is chaired by a practicing pediatrician and two (2) Board of Directors members participate. The CAP wants to have even more direct engagement with JCC decision making and we are excited to expand its role. Critically, JCC looks to cross pollinate between the CAP, Finance Committee, Network and Quality, and the CAC by holding joint meetings of these committees.

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

7.1.c. Agreements with Type B Area Agencies on Aging and DHS local offices for APD (APD) (recommended page limit ½ page)
While DHS Medicaid-funded LTC services are legislatively excluded in HB 3650 from CCO responsibility and will be paid for directly by the Department of Human Services, CCOs will still be responsible for providing physical and Behavioral Health services for individuals receiving DHS Medicaid-funded LTC services and will be responsible for coordinating with the DHS Medicaid-funded LTC system. To implement and formalize coordination and ensure relationships exist between CCOs and the local DHS Medicaid-funded LTC Providers, CCOs will be required to work with the local Type B AAA or DHS' APD local office to develop a Memorandum of Understanding (MOU) or contract, detailing their system coordination agreements regarding Members receiving DHS Medicaid-funded LTC services.
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.
JCC has an active MOU with the Rogue Valley Council of Governments Area Agency on Aging and Aging and People with Disabilities, which has been in place since 2014.

Leadership of the MOU signatory agencies meet at least twice during the year to review the processes defined in the MOU. In the meetings, attendees identify challenges, opportunities, and strategies to strengthen the partnership. In addition, twice monthly meetings where JCC and APD staff engage in multidisciplinary rounds on specific members has supported the development of a robust referral process, shared care planning, and identification of barriers (for example, delay in obtaining durable medical equipment) which can then be elevated and addressed. The value of these meetings has been demonstrated over time, and as a result, the meetings now include additional participants, such as representatives from our mental health service provider and primary care case managers. All parties are committed to maintaining the MOU and further evolving the programmatic work.

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 page limit 1 page)
To implement and formalize coordination, CCOs will be required to work with local mental health authorities and Community Mental Health Programs to develop a Memorandum of Understanding (MOU) or contract, detailing their system coordination agreements regarding Members receiving mental health services.

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.
JCC and Jackson County Mental Health (JCMH), the CMHP/LMHA, have an executed MOU included in this application. More critically, JCC has had a contract in place with JCMH since 2012. While the contract has shifted from a full delegation agreement to a provider contract, the strong partnership and commitment has remained. The current contract includes crisis and safety net services as well as outpatient treatment, Assertive Community Treatment, Wraparound, Early Assessment and Support Alliance (EASA), and mental health court. Our MOU for collaboration on the CHIP and the local Behavioral Health Plan is in process and no barriers are foreseen.

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).
N/A

7.1.d(3). Describe how the Applicant has established and will maintain relationships with social and support services in the Service Area.
JCC has a deep history of working with social and support services across our county. These relationships are built to both serve the specific needs of JCC members *and* build capacity within the social support system. We are deeply enmeshed in our county's social support system both directly and through our provider network. These are not merely contractual relationships, as they include frequent collaboration between staff. As a result, the relationships are maintained though tight collaboration and deliberate resourcing.

Some key social support services JCC works with include:
- DHS Branch Office to ensure children in DHS custody receive behavioral health assessments in a timely way
- Law Enforcement and Corrections to problem solve issues and ensure continuity of care for those members involved in community justice
- Continuum of Care to address homelessness for our community and members
- Reclaiming Lives, a recovery café that provides long-term sobriety and personal growth support while building community
- Age Friendly Innovators, which provides home safety assessments, improvements and installation of safety equipment for older adults on limited incomes and disabled adults
- Head Start's Southern Oregon Child and Family Council, which provides health literacy training for parents, with an emphasis on families experiencing poverty or homelessness, who have special needs, or who are dual language learners
- NOWIA Unete, Center for Farm Worker Advocacy, which provides educational classes for youth with an emphasis on traditional Latino culture

- Jackson Elementary School's Ready for Kinder Home Visiting program, which works to eliminate disparities in equity school readiness for vulnerable young children
- Compass House, a peer run drop in center based on the Clubhouse model that provides social supports to individuals with mental health diagnoses

7.2. Member Engagement and Activation (recommended page limit 1½ pages)
Members should be actively engaged partners in the design and implementation of their treatment and care plans through ongoing consultations regarding cultural preferences and goals for health maintenance and improvement. Member choices should be reflected in the selection of their Providers and in the development of Treatment Plans while ensuring Member dignity and culture will be respected.
7.2.a. Describe the ways in which Members (and their families and support networks, where appropriate) are meaningfully engaged as partners in the care they receive as well as in organizational Quality Improvement activities.

JCC believes that improved health outcomes and health equity can only be achieved when members are actively engaged as partners in the care they receive and in improving organizational quality. We will ensure that opportunities for member engagement will occur throughout a member's experience with the health care system and that engagement activities meet members wherever they happen to be. Our care coordination team and cross-organizational programs all incorporate member input into the care plan whenever possible.

New Members. Member engagement starts with the Welcome Packet which encourages members to be active participants in their care. Members are informed of the JCC member incentive program which incentivizes healthy activities such as seeing the doctor, getting regular HbA1c testing for diabetics, getting an annual wellness check, and being up to date on immunizations.

In the Care Setting. Members are reached directly through decision support tools used in most clinics to engage the patient in their own health care accountability. Members work with providers in the design and implementation of their treatment and care plans, which will 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

In the Community. JCC enacts several location-specific efforts to engage members in their healthcare. We have an entire program, Starting Strong, committed to engaging pregnant members and parents of young children in primary care and dental providers. We also conduct numerous outreach events to inform members about their OHP benefits and help them engage in needed primary care or social services. We are developing materials requested by the CAC that will assist members in preparing for medical visits and help them be educated consumers.

JCC 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 quantitative patient satisfaction surveys, grievance reporting, and direct interactions with providers and CCO staff.

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:
JCC believes that empowered and engaged individuals have the best health outcomes. As a result, we work with our network to have member-centric care and always include members directly in our care coordination.

Member engagement begins with communication strategies that account for the social determinants of health. We use CareOregon to develop member communications that include mailings with care reminder postcards and letters, outbound calls, text messaging, member newsletters, member apps, member portals, and social media. These communications describe covered benefits and services and provide information on how members can utilize their Oregon Health Plan benefits.

JCC also plans to expand *Oregon Health Plan & You (OHP & You)*, an 8-part series of workshops that provide an in-depth look at the benefits covered by Jackson Care Connect CCO. Workshops are designed to benefit members and potential members by empowering and informing assisters, Traditional Health Workers (THWs), and other professionals who help our members navigate healthcare.

Engage Members in culturally and linguistically appropriate ways
JCC is committed to being responsive to member needs including engaging in culturally and linguistically appropriate ways. We are proud to have a strength in serving Spanish speaking members directly with our bicultural and bilingual staff. To ensure inclusion of Spanish speaking members, we offer interpretation at CAC meetings and member outreach events. Staff participate in community events that are held in Spanish to provide information about OHP benefits and engage members in their healthcare. Our translation of documents is reviewed by staff who are familiar with the specific cultural regions of Central America with significant representation in Jackson County. And, we publish educational articles in a Spanish language monthly publication.

We also have numerous members with linguistic or cultural backgrounds who are not Spanish speaking. For this reason, we use data to understand the broad base of our membership. Based on that data we can build a relationship through our required communication and our presence and participation at community events. We continue that work with targeted communications designed to motivate and engage members to participate in our plan and in their health.

We build engagement programs based on what we know about our members through demographic data, needs assessments and feedback from members and customers. For example, we recognize that prioritizing preventive care is difficult for our members in their busy lives. To support them in actively participating in wellness care, we offer incentive programs (such as gift cards) to certain members who engage in preventive care appropriate for their age and conditions.

Through our language access work, JCC arranges for the provision of oral language assistance from contracted certified and qualified language interpreters to meet the need of Limited English Proficiency (LEP) members. These services are provided face-to-face, telephonically, and on-line and at no charge to eligible physical JCC enrollees, and are accessible in physical, behavioral and oral health settings. We review our demographic data for language need and do active outreach to ensure that members are aware of the language services that are available to them.

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

JCC provides information on our approach to providing care coordination through our welcome letter, member handbook, member-focused educational materials, and through our member call center representatives. Additionally, once members are assigned to JCC, new member onboarding begins with activities such as welcome calls and member-centric orientation to OHP benefits and supports. If a member needs care coordination, a care manager reaches out to the member and describes the care coordination process and how to connect to their care team, including THWs when appropriate.

JCC will provide all new members with materials that outline how to engage in dental services. We have created an easy-to-read brochure that summarizes dental benefits and how to access care. Members' JCC ID cards currently include the assigned dental plan and phone number. In the future, we will also include the member's dental home on their ID card wherever possible. The JCC websites feature a dental page that provides succinct information on oral health benefits and services. The member portal contains and will continue to contain information on our dental plan partners and dental benefits. Our well-trained customer service representatives will provide proactive information on all aspects of members' health care.

JCC will conduct annual member incentive programs that include a dental sealant incentive. This program will offer qualifying members a $15 gift card if they receive dental sealants at a dental visit during the year. All eligible families will receive information regarding dental sealants and preventive dental services. 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

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

JCC will actively reach 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. We will continue to strengthen our wellness offerings through the local YMCA that provide discounted memberships for members who frequent the YMCA at least 8 times a month. This not only encourages those members to be physically active, but also provides them with child care supports, social networks, healthy eating education, and family supports. We have script pads printed for our primary care clinics that allow a provider to write a prescription for exercise or healthy food, and then provide programmatic supports for the members who act on those recommendations. Lastly, we support the development of healthy living programs within primary care and social service organizations.

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

All new members receive a welcome letter and a member handbook that explains member rights and responsibilities in detail. This information is also available on JCC's website. In addition, all member communications follow best practices and meet contractual requirements in terms of health literacy, plain language, alternative formats, and more.

Meaningfully engage the CAC to monitor and measure patient engagement and activation.
JCC will continue to benefit from the CAC's work around member engagement. This work 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 the health issue at the community level. The CAC also reviews the JCC CAHPS survey and makes recommendations to address areas of improvement.

7.3. Transforming Models of Care (recommended page limit 1 page)
Transformation relies on ensuring that Members have access to high quality care: "right care, right place, right time". This will be accomplished by the CCO through a Provider Network capable of meeting Health System Transformation (HST) objectives. The Applicant is transforming the health and health care delivery system in its Service Area and communities – taking into consideration the information developed in the Community health assessment – by building relationships that develop and strengthen network and Provider participation, and Community linkages with the Provider Network.

7.3.a. Patient-Centered Primary Care Homes
Integral to transformation is the Patient-Centered Primary Care Home (PCPCH), as currently defined by Oregon's statewide standards in OAR. These standards advance the Triple Aim goals of better health, better care, lower costs by focusing on effective wellness and prevention, coordination of care, active management and support of individuals with Special Health Care Needs, a patient and Family-centered approach to all aspects of care, and an emphasis on whole-person care in order to address a patient's physical, oral and Behavioral Health care needs.
7.3.a.(1) Describe Applicant's PCPCH delivery system.

JCC and CareOregon have long been champions of the PCPCH model as a key strategy to achieve the Quadruple Aim of health care transformation. JCC currently has 26,095 members assigned to PCPCH certified clinics ranging from tier 1 to tier 5, which is 86.4% of our members. Our 5 largest primary care clinics are all PCPCH and active participants in our APM that supports the PCPCH functions. The majority of these clinics are also participating in our Behavioral Health Integration payment model that we offer PCPCH clinics because we believe a primary care team best supports members when integrated with behavioral health.

JCC staff help to build PCPCH capacity by providing a Practice Transformation Learning Series, which focuses on the Building Blocks of Primary Care Transformation. Through this Learning Collaborative, many of the elements of the PCPCH are presented to provider groups. To ensure this training is as impactful as possible, we adjust the curriculum to meet current clinic needs. The series will occur in ten two-hour sessions concluding on December 17th, 2019. We will have attendees from JCC's four largest primary care network partners: Rogue Community Health, Asante Physician Partners, Providence Medical Group and La Clinica. Future support for PCPCH development will also be personalized to the needs of the network.

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.
JCC will meet the goals and expectations of care coordination with the PCPCH for members receiving long term care (LTC) services through an individualized, strengths-based, person-centered approach to all care coordination efforts. As outlined in our existing MOU we have regularly scheduled meetings with our APD branch office to facilitate coordination of PCPCH and LTC care services. Because these members meet the criteria for special health care needs, a health risk screening will be conducted within 30 days of enrollment or as quickly as the member's health

requires. Working collaboratively with both the member and provider, JCC will help members identify their natural systems of support, articulate their goals for treatment and recovery, and identify gaps in care. 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. Issues, goals and interventions will be documented in the member's individualized care plan and shared with the PCPCH and LTC provider. Care plans will be developed by the assigned care coordinator and/or care team based on information gathered from the health risk screening. Care plans include goals with required estimated due dates for completing the goals. Including the member in the development of the care plan and goals will increase the likelihood that the goals will be met.

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.

As our two largest primary care clinics, JCC has built strong partnerships with the two FQHCs in the county: La Clinica and Rogue Community Health. In addition to providing PCPCH services, both of our FQHC partners manage the extensive network of school-based health clinics in Jackson County. We feel directly invested in their success as strong PCPCH clinics. To encourage the use of safety net providers that qualify as PCPCH, we prioritize capacity building efforts for these two clinic systems. JCC will provide coaching and community-level learning opportunities through our recurrent 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.

JCC will add support for safety net providers in transformation efforts, patient-centered care, and achievement of PCPCH status. This support will include:

- LEAN greenbelt training and certification opportunities at least 3 times a year, funded by CareOregon.
- Partnership with Oregon Primary Care Association to provide seamless technical assistance to mutual CareOregon and OPCA members clinics to maximize impact and efficiency of patient-centered care initiatives and mutual areas of work including:
    - Sharing of performance, utilization, cost, and patient experience data with CHCs
    - Enhancing CHC's understanding of total cost of care data and their role in impacting cost at the level of primary care
    - Implementing strategies to help CHCs demonstrate their patient and population complexity by designing and offering coding training opportunities and targeted clinic coaching
    - Aligning efforts to develop and design cost and utilization metrics across OHA's APCM program and JCC/CareOregon's PCPM offerings
- Collaboration with the Oregon ECHO network to provide and upskill primary care clinicians and clinical support staff in rural and urban areas in elements of patient-centered care.

JCC will incentivize FQHCs in providing high quality and patient-centered care through our APM programs. Only clinics recognized as PCPCHs will be eligible to participate in these APMs. 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 model. In addition, JCC will partner with CareOregon to create a four-tiered approach toward our network that facilitates our members' 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.
N/A. JCC will use the PCPCH model.

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

7.4. Network Adequacy (recommended page limit 3 pages)
Applicant's network of Providers must be adequate to serve Members' health care and service needs, meet access to care standards, including time and distance standards and wait time to appointment, and allow for appropriate choice for Members, and include Traditional Health Workers including Community Health Workers, Personal Health Navigators and certified, qualified interpreters.
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 JCC's network adequacy monitoring and reporting. CareOregon applies the CMS time/distance network adequacy standards when analyzing the JCC provider network. The Quest Analytics Adequacy software is used to validate network adequacy following CMS time and distance standards to regularly assess JCC's network adequacy, demonstrating that 97.6% of members (or more) 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
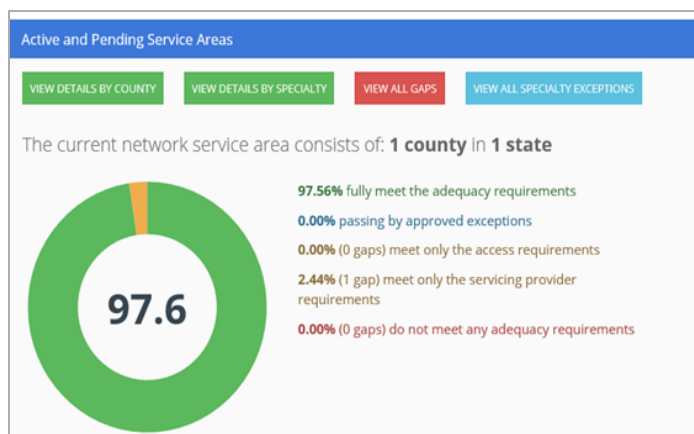
non-contracted/available providers in a specific area (based on NPI and using "marketplace tool") as possible contracting opportunities.

The Network Adequacy Steering Committee (NASC) provides structured oversight and accountability to ensure JCC is compliant with network adequacy regulations as specified by the Oregon Health Authority and the Center for Medicare and Medicaid Services. The committee is comprised of management from Provider Services, Contracting, Information Services and Legal/Regulatory.

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 will routinely monitor wait times to appointments for primary care, specialty care, oral health, and behavioral health services. Monitoring will be prioritized for those services that have historic access concerns based on JCC's request, member feedback, or concerns identified through routine monitoring. Call center performance and accessibility is also monitored utilizing standard metrics such as percentage of calls answered within 30 seconds and percentage of calls abandoned. On a monthly basis, CareOregon conducts a capacity analysis that includes both provider to enrollee ratios and 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 the 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.

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.
JCC 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 no providers in a needed specialty in the geographical area or a provider's refusal to contract with CareOregon, 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 will be submitted on a quarterly basis during the last quarter of the month or as needed more frequently for material network changes.

The initial contracting process for PCPs requires a minimum of 100 patients per FTE clinical when a provider first joins CareOregon. 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.

JCC 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 will also monitor time to next available appointment. Existing contracted capacity analysis demonstrates network adequacy meeting CMS time and distance standards. 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?

JCC ensures contracts with nearly all providers (primary care, specialist, acute) within Jackson County through PrimeCare (the IPA) and Asante Physicians Partnership. Contracts are regularly reviewed and updated to ensure any negative impacts of network deficiencies are mitigated. Through CareOregon, we also have access to a broad state-wide network of providers for which our members can utilize non-emergent medical transportation (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. It is particularly challenging to provide access to 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 30 days, regardless of payer. Remedies to address deficiencies include:

Expanding Specialist Capacity
JCC 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, JCC 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 JCC. 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.

We have an Access Coordinator (AC) position dedicated to streamlining specialty referrals on behalf of JCC 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.

Telehealth

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

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.

JCC 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 (86% of JCC members are assigned to a 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 appointment and aggregating those results across the network to ensure we meet timeliness standards. We will also support work between PCPs and specialty providers to implement closed loop referral systems and referral tracking to support access for members.

JCC 2018 Average Wait Times

New Patient to establish care

...Scheduled within an average of **17 days**

Existing Patient appointments

...Scheduled within an average of **5 days**

Urgent/Emergent Appointments

...Scheduled the **same day**

Additionally, tools like PreManage are used by Population Health, the integrated care coordination team, and other CCO staff and teams to provide a real time view into how and where our members are accessing care. Any identified opportunities for care coordination and member support are followed up by these teams.

Our ENCC and UM teams also monitor access through their interactions with our members.

JCC has tracking and monitoring systems in place that ensure members have access to high quality, timely behavioral health services. JCC will require providers to report on access monthly 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, 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. Internally, JCC 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.

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.
JCC receives an annual DSN report from their delegated dental plan partners. We then geomap general practice providers and specialists alongside membership to ensure sufficient oral health access. Provider type is included on the DSN and this is 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 are 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 are required to travel to a general dentist or specialist from their home locale. This data is particularly helpful in more rural areas of the region as an additional measure of members' ability to access care within reasonable time and travel distances.

JCC will monitor available dental capacity weekly and require validation of provider FTE prior to any increase in dental plan capacity limits. In addition, we will conduct annual oversight of the dental plan partners and ensure each dental plan is conducting routine timely access reporting of their provider network. We 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 JCC network is currently able to provide and sustain capacity, at a level that can absorb fluctuations in network composition and/or membership. JCC will develop a contingency plan to bridge any gaps created by sudden fluctuations, which may include paying for services for providers that are not yet contracted or adjusting authorization requirements to ensure continued access. JCC also works closely with its CAC, CAP, Board of Directors, and providers to identify and close gaps in culturally responsive care providers across physical, behavioral, and oral health to ensure that we are addressing both clinical and cultural barriers to care.

Please refer to Attachment 16 for further details.

7.4.b. Requested Documents
Completion of the DSN Provider Report (does not count towards page limitations)
Please see DSN Provider 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 Non-Emergent Medical Transportation).
CareOregon manages the Grievance & Appeal system on behalf of JCC as part of its administrative services agreement. 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. JCC leadership and Board of Directors 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. JCC 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 then work collaboratively with the provider to assess barriers to access for members.

The Medical Management department monitors grievances and appeals related to access issues, looking for trends and addressing individual complaints one by one. QA staff members track member complaints of all types. They monitor the complaints and identify patterns and trends. 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 types of complaints from members. Our Quality Assurance department monitors all access complaints and trends are reviewed regularly. If there is a trend with access to a specific specialty, Provider Services is notified to pursue resolution. Resolution can include but is not limited to contracting with additional providers, the use of single case agreements, and allowing services to be performed by non-contracted providers.

Due to the consistent work towards creating a stable network we have minimal access complaints in relation to the membership size of JCC.

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 JCC dental staff will track, trend, and analyze dental specific grievances and appeals data quarterly. Grievance and appeals dashboards, along with 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 on 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 can be utilized if network adequacy or provider access and wait times are not resolved.

The JCC 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 makes sure that any recommendations are followed up to ensure they were successful in addressing the identified issue.

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 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 subcontractor and delegate audit protocols.

7.6. Coordination, Transition and Care Management (recommended page limit 5 pages)
7.6.a. Care Coordination:
7.6.a.(1) Describe how the Applicant will support the flow of information between providers, including DHS Medicaid-funded LTC care Providers, mental health crisis services, and home and Community-based services, covered under the State's 1915(i) State Plan Amendment (SPA) for Members with severe and persistent mental illness, as well as Medicare Advantage plans serving Fully Dual Eligible Members, in order to avoid duplication of services, medication errors and missed opportunities to provide effective preventive and primary care.

As outlined in Attachment 9, JCC is supporting various HIT strategies to facilitate flow of information between providers. This includes helping PCPCH clinics, mental health providers, and substance use treatment providers adopt and optimize their EHRs. We are also utilizing Reliance (our community HIE), PreManage, OPDMP, and cross organizational case conferences for complex members.

In addition to this, JCC 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 home and community-based services (HCBS). Our care coordination team model 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, JCC uses GSI HealthCoordinator, 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 Triage Coordinator collates inpatient discharges and reviews emergency department utilization reports. The Health Care Coordinator accepts incoming referrals directly from PCPCHs, other providers, community partners, and members.
- **Weekly Interdisciplinary Care Team (ICT) Huddle**. Complex cases are reviewed at the weekly ICT. Care Coordinators bring forward cases that require a multidisciplinary approach. 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 are invited to join or call in to this weekly meeting when their patients are being discussed.
- **Case Conferences**. Case conferences are held twice a month as a forum to discuss extremely complex cases that require Medical Director support as well as support from multiple external partners. Case conferences include a Medical Director from our Utilization Management team, an internal pharmacist who can review medications, the care coordination 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.
- **Cross System Review Committee.** JCC care coordination staff attend and co-chair a cross system review committee to discuss SPMI members that are in the highest levels of care such as Oregon State Hospital and secure residential treatment programs. This meeting

includes representation from the CHOICE program, Involuntary Commitment Team, ACT and crisis services, and ColumbiaCare Services, the largest provider of services to SPMI.

JCC care coordination team 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, 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 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. Since 2017, JCC has convened community partners regularly to advance implementation of the PreManage platform. Leaders from 13 network partners (including both local hospitals and AllCare) have been engaged and are committed to meeting quarterly as part of a Cross-System Care Coordination Steering Committee. Through these efforts, we have developed best practices for care recommendations and mapped the roles and responsibilities of all participating partners before, during, and after an emergency department visit.

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.

JCC staff are dedicated to working with our provider network and other community partners, including those that provide social and support services, to help providers engage with JCC's care coordination team and directly with each other. JCC has played a leadership role in Jackson County by convening stakeholders and facilitating cross-organizational discussions. The JCC **Population Health Portfolio 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 care coordination team supervisor provide routine outreach to these partners to educate them on accessing these services. Some examples include:

- Funding of the mental health crisis program at Jackson County Mental Health (JCMH) and creation of strong referral pathways from across the community (including providers, sheriff and police departments, and school-based health clinics)
- Funding for mental health treatment court at JCMH that connects offenders to appropriate treatment and social services
- Co-creation of a community para-medicine program that trains paramedics on identifying and addressing behavioral and social needs
- Referral pads placed in PCPCH settings for providers to refer JCC members to social support programs
- Support of traditional health workers and integrated behavioral health staff in the provider network to facilitate appropriate connection to social and support services for JCC members

- Participation in the Accountable Health Communities grant to facilitate broad social determinants of health screening across the county and navigation to available resources

JCC also believes in building relationships across clinical and social services, as we believe they make the strongest referral pathways. To this end, we participate and/or convene in the following collaborations:
- Cross-System Care Coordination Steering Committee
- Southern Oregon Regional Success (SORS) – Collective impact
- Local Alcohol and Drug Planning Commission
- Public Safety Coordinating Council
- Jefferson Regional Health Association
- Continuum of Care
- Southern Oregon Health Equity Coalition
- Learning Collaboratives
- MH and SUD Provider Network meetings

Through networking opportunities like these, providers can develop relationships with other services that frequently interact with members in order 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.
JCC membership data shows that over 8% of members have limited English proficiency. JCC expects that all providers use a culturally and linguistically appropriate approach when communicating with and educating members. One of the tools to assist providers in providing culturally and linguistically appropriate services is interpretation services. As described elsewhere in this application, JCC contracts with multiple interpreter vendors. A central objective of the JCC Equity Action workplan is partnerships with contracted language service vendors to increase awareness among providers on the value of interpretation services to members' experience of care. Trainings will be provided to clinic providers and staff to increase meaningful and effective use of interpretation services, disseminate best practices, and outline resources available.

In addition to this partnership, the JCC Health Equity Operations Specialist offers health equity trainings to support partners in their equity, diversity and inclusion (EDI) goals. This ongoing technical assistance helps elevate the importance of an equity lens in the provision of services to our members and community; it will also provide the basis for developing a tool for providers that will summarize best practices for assisting in the culturally and linguistically appropriate education of members. This tool will include information about the care coordination team, care plans and how they are created in a person-centered way, and how to access care coordination. The tool will also outline the responsibilities of providers and members in ensuring effective communication, be compliant with health literacy standards, and be available in multiple formats.

JCC already has a strong partnership in place with a Spanish language magazine, *Caminos*, that is widely read by our Latino community, and we will run at least one article on patients' rights to have quality interpretation services for care coordination services available at no cost. We will encourage providers to have copies of this publication in their office.

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.
JCC 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. JCC 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 who are using services across multiple systems, with particular attention to disparities. We will leverage the interoperability of our 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. This will enable all providers using PreManage (Rogue Community Health, La Clinica, Providence, ColumbiaCare Services, Jackson County Mental Health, and Asante Physician Partners) to identify members who fall into this cohort in real-time.

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 care coordination team model. Once a member enters care coordination with the care coordination team, a care plan is created in collaboration with the member and the member's PCPCH. For special populations, such as adults and youth with disabilities, care coordinators work with the appropriate case managers from disability programs or brokerages. These staff are invited to participate in the individual care team meetings for their clients and ensure aligned care plans are in place. In addition, our providers for SPMI adults meet routinely with the I/DD program staff to ensure coordination of care. For children and youth, care coordination includes the youth and family, behaviorists, therapists, specialty providers, the schools or early intervention and other community agencies in addition to the PCPCH. Our care coordination team 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 the PCPCH, other providers, social support organizations, member and their supports.

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.
The JCC service area has a high prevalence of SPMI when compared to other CCOs around the state (11% according to OHA data). This subgroup requires a high level of care coordination due to

its inherent complexity. The goal of such coordination is to improve the health and functioning of people with SPMI, particularly because they are at high risk for "falling through the cracks" as they are often involved with multiple agencies and individuals helping to address their care needs. Further, the coordination is necessary to reduce duplication of services and overutilization of emergency departments, acute psychiatric hospitals, residential treatment facilities, and the Oregon State Hospital (OSH).

As JCC has already fully integrated the administration and risk of the behavioral and physical health benefits, we have behavioral health staff embedded within our care coordination team. Within JCC's care coordination team, 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 HCBS. 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.

JCC has been collaborating with the local CHOICE contractor, Jackson County Mental Health (JCMH), for several years. We will continue holding weekly meetings with JCMH representatives of CHOICE, ACT and crisis services, as well as our main treatment provider for adults, ColumbiaCare Services. Depending on the circumstances, this meeting can also include ad hoc representation from the local acute care system, private practice network, and other social services agencies who may be involved. This will continue to be a functional cross system meeting to review members who are currently in or have the potential for needing the Oregon State Hospital or other residential levels of care. It is intended to ensure that the community services are in place to keep members in the least restrictive setting possible, as well as helping with successful transition to and from these higher levels.

JCC has built highly functioning relationships with APD staff that are centered around coordinating care for members with APD benefits. JCC will continue to host meetings every two weeks with caseworkers from Rogue Valley Council of Governments (APD/AAA), and others involved in the member's care to review care plans for members in DHS Medicaid-funded LTC.

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.
JCC 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.

JCC has developed its care coordination program to be comprehensive and span the entire care continuum, as opposed to traditional programs like telephonic disease management or catastrophic case management for acute health care episodes. We believe, and the evidence supports, that care coordination with a population health approach both benefits members in most acute need and averts the progression of disease and disability among those at risk of worsening health. An

important distinction of the care coordination team model is the use of specially trained, multidisciplinary teams that 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 care coordination team 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.

JCC and CareOregon have invested in predictive analytics capabilities that enable segmenting the member population. This provides insight into how each member is using the healthcare system and allows us to create precise care coordination workflows and interventions for each member segment. Not all needs or referrals are equal, and this process allows us to direct the care coordinator to work most efficiently based on the member segment data. Each cohort has a specific set of interventions and/or clinical programs designed to address its members' unique needs. This system allows us to take a proactive approach to finding members who need support and steer them to the appropriate support at the right time to most meaningfully impact their health.

JCC recognizes the value of Traditional Health Workers (THW) for our members. THWs are 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 members' active engagement. Our Early Childhood Navigator, Starting Strong Program Specialist and care coordination team staff connect members to appropriate community-based supports. These supports often include THWs, such as community health workers embedded within Federally Qualified Health Centers, peer support specialists associated with behavioral health organizations, bilingual/bicultural promotoras through home visiting programs, and doulas for perinatal support. JCC will integrate THWs within health systems such as La Clinica, Rogue Community Health, Asante Physicians Partners, and Providence. However, we also recognize that if only the large health systems have THWs, there is limited access for other members who don't use those systems. Thus, JCC is exploring the potential to expand to additional sites or through additional delivery models. (See more in Attachment 10.)

JCC is also leveraging innovative payment models to advance care coordination. We have a Behavioral Health Integration APM program that supports care coordinators (often THWs) in primary care. In 2018, JCC added a Cost of Care Incentive Payment to the primary care APM program. The Cost of Care components measure 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.

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. These include the analytics mentioned earlier, geo-access mapping and applying a health equity lens to identify opportunities to improve care coordination through culturally specific programs focusing on populations with high rates of disparities, including pregnant women with substance use disorders, colorectal cancer screening rates among Latino men, members with

behavioral health diagnoses (especially those with SPMI or addiction diagnosis), and rural communities.

The Starting Strong Program Specialist serves as a navigator at JCCs Starting Strong store location where Accountable Health Community (AHC) screenings are administered to identify pregnant or parenting members who would benefit from up to 12 months of navigation support. This process also allows JCC to gather member-reported data on social determinants of health that is not otherwise captured in our claims data. This is a rich source of information that informs how we allocate resources and invest in services to address gaps experienced by our most marginalized and vulnerable populations.

7.6.a.(8) Assignment of responsibility and accountability: The Applicant must demonstrate that each Member has a Primary Care Provider or primary care team that is responsible for coordination of care and transitions. 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.
JCC's standard requires that all members are assigned to a primary care provider (PCP) within 30 days of enrollment, with preference to certified PCPCH. As a result, approximately 86% of our members are assigned to PCPCH certified clinics with demonstrated care coordination expertise to help connect their patients to health and social support services. While not a stand-alone metric, our APMs and quality metrics require providers to have high rates of engaged patients. As PCPCH providers evolve their care coordination abilities, JCC will support them 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 JCC, new members receive a welcome packet within the first 30 days of enrollment 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 integrated care coordination team. The coordinator helps the member engage with appropriate physical, behavioral and oral health providers and other support services. 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.

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 (ICC). Eligible members for ICC are sent a special letter explaining their right to ICC services and how to access them as soon as they are enrolled. The care coordination team Triage Coordinator reviews all ICC eligible members monthly for an active care plan. If the member does not have a care plan, then care coordination 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.(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.
In addition to continuing to develop a culturally and linguistically diverse workforce and utilizing interpretation services whenever necessary, JCC will work to improve our PCP assignment process

to align patients with particular cultural and linguistic needs with clinics serving those needs, if available. JCC expects its network providers to provide equitable, understandable, and respectful care to members and, as noted elsewhere in this application, provides technical assistance to providers through its Health Equity Operations Specialists to elevate the importance of considering the equity lens in the assessment of member needs. For instance, JCC has addressed colorectal cancer screening among Latino men by training providers on increasing screening rates by using engagement techniques that specifically address this group's perceptions about this particular type of screening.

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

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

For members transitioning out of the hospital, JCC contracts with Mercy Flights Community Paramedic Transitions Program. Mercy Flights receives a PreManage alert when a JCC member is hospitalized; prior to discharge, a Mercy Flights community paramedic engages 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, Mercy Flights 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 JCC pharmacist, and scheduling and transport to primary, specialty (including mental health) and dental care services as appropriate. Mercy Flights care coordinators document care plans in PreManage and work closely with JCC's care coordination team to ensure continuity.

Beginning in April 2019, Mercy Flights will receive PreManage real-time auto notifications when a JCC member included in the PreManage rising risk cohort admits to the emergency department (ED). Mercy Flights will then outreach to the member in the ED and provide ongoing care coordination support for up to 60 days. The supports include:
- Initial needs assessment, which includes an assessment of barriers related to social determinants of health, identification of immediate care coordination needs, recommendations for follow-up, and referral to services
- Referral for medication review by pharmacist when indicated
- Self-management tools using standardized chronic disease protocols for conditions such as CHF, COPD, diabetes, wound care, and substance use disorder to increase member engagement and to ensure member has access to appropriate supplies and services
- Collaborative ED care recommendations with assigned primary care teams as appropriate
- Ongoing member supporting in achieving self-identified goals

Other Treatment Facilities/Settings

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

- Primary care provider
- Commitment investigator/monitor
- Skilled nursing facility
- LMHA
- CHOICE contractor of guardian
- Mercy Flights/ acute care discharge planner
- Member and any other individual identified by member as a support
- Other providers involved in the member's care (psychiatric provider, ACT team, MH therapist, case manager or treatment team)

Behavioral Health

For Oregon State Hospital (OSH) discharges, the JCC OSH Care Coordinator facilitates discharge and transition into the most appropriate, independent, and integrated community-based setting and to ensure treatment teams are established for continuity of medication and treatment. This is done in close collaboration with the CHOICE coordinator at Jackson County Mental Health. The JCC OSH Care Coordinator will also ensure that member needs are met, service providers (medical, behavioral health, and oral health) are identified, referrals are made, and that members have access to ACT services. If an ACT-eligible member refuses to engage with ACT services, another evidence-based intensive service will be identified. The JCC care coordination team, with behavioral health and Medical Director input, will review and sign off on all incoming LTC/Oregon State Hospital referrals for care coordination.

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.

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.

JCC has a strong relationship with the Rogue Valley Council of Governments, which runs our APD/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 integrated care coordination team 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, JCC's care coordination team and the appropriate agency share information and identify needs to support the transition, including the appropriate setting for further care. If needed, the JCC care coordination team will facilitate an interdisciplinary care coordination 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.
JCC uses the combination of PreManage and GSI HealthCoordinator (GSI) care coordination platform to track member transitions between care settings and to seamlessly share care plans, send and receive secure messages, and promote post-discharge follow-up. PreManage provides real-time notification of discharge and 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). JCC care coordination staff 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 allows information sharing and data aggregation across multiple systems and providers, including electronic health records and PreManage, allowing for real-time alerts of care transitions. Providers can choose to document care plans and case conference documentation into their EHRs or receive them via GSI or PreManage.

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

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, JCC's care coordination team 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. Because JCC has fully integrated the behavioral health benefit with physical health, the care coordination team includes behavioral health care coordinators who are responsible for ensuring the ICP also addresses any SPMI (or other behavioral health) conditions. 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; it also prioritizes what is important to the individual to ensure delivery of services in a manner reflecting personal preferences and ensuring health and well-being.

JCC Triage Coordinators are responsible for monitoring ICPs. They will pull monthly reports of members with special health care needs and route care plans for review to the assigned JCC care coordination team. 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 in order to complete the process within 30 days. For members in LTC services, they receive the same screening with a targeted goal of completion within 30 days. This screening asks members 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, JCC utilizes 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. Eligible members for ICC are sent a special letter explaining their right to ICC services and how to access them. The JCC care coordination Triage Coordinator reviews all ICC eligible members monthly for an active care plan. If the member does not have a care plan, a JCC care coordination 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.

- 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 JCC 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.

- JCC 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 utilization data that tracks members who move into a high utilization cohort or who move from a lower risk cohort into a rising or high-risk cohort. One of our Triage Coordinators 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 above in 7.a.1, JCC works closely with Rogue Valley Council of Governments and 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. Members of our

care coordination team attend the DHS Medicaid-funded LTC care provider 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.

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.

JCC's care coordination team 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 plan; the plan reflects what is important to the individual to ensure delivery of services in a manner reflecting personal preferences and ensuring health and well-being.

JCC Triage Coordinators are responsible for monitoring members who may have ICC needs. They will pull monthly reports of members meeting criteria (using OHA PERC codes) and route care plans for review to the assigned 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, at minimum, on a semi-annual basis or more frequently as requested or indicated by a change in patient status.

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, CareOregon's 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.

JCC works closely and collaboratively with dental partners and providers to coordinate members' oral health needs. JCC 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 patients are central to that collaboration. JCC also works collaboratively with several community services providers, including health centers, schools, and other community locations to provide preventive oral health services. An onsite dental hygienist provides preventive dental services at our Starting Strong program which serves pregnant women and young children. 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 JCC 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 ensures that 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 that JCC 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.
JCC's care coordination team is fully integrated and consists of multidisciplinary professionals including care coordinators with expertise in nursing, behavioral health, oral health (Dental Access Coordinators and a Dental Care Coordinator), and system navigation. The JCC care coordination team will accept referrals from oral health to physical and/or behavioral health care. The JCC care coordination team 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 the member's unmet physical or behavioral health needs. In addition, JCC 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. JCC also has a dental care coordinator who supports navigational and low acuity requests for care coordination across the spectrum 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.
JCC's care coordination team is a fully integrated and multidisciplinary team that includes a dental care coordinator. Members with complex needs or other identified risk factors are supported by the care team, which establishes a comprehensive care plan, including oral health. When members indicate dental needs on their initial health screening, a care plan issue is created. The care coordinator then further assesses the needs and works with the dental providers and partners to establish an appropriate dental home for the member that will best meet their needs, based on the overall acuity or complexity of the member's situation. Dental specific care coordination and/or dental care management is available for all members who need assistance or support meeting their oral health needs, regardless of how, when, or where those needs were identified. Conversely, unmet physical or behavioral health care needs identified in the dental setting are also managed by the JCC care coordination team 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.

JCC actively pursues integrated delivery systems, which include co-located primary and dental care health homes. Members will be co-assigned to a primary care clinic with a co-located dental clinic, to the greatest extent possible. This allows for alignment of primary care and dental care assignment and makes accessing oral health services much easier for members. Other medical-dental provider partnerships will be developed 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 are and will continue to be employed by JCC. These mobile sites will bring oral health services to locations where members are, which increases ease of access. Current mobile services include onsite oral health services at the Starting Strong program in Medford and school-based services. In addition, JCC partners with community agencies and health centers that will provide mobile oral health prevention services during various activities throughout the year.

JCC is actively promoting, training, and supporting 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 such as oral health assessment and fluoride varnish application in the primary care setting. Oral health interventions for children ages 0-5 are another key integration metric and will further promote setting-appropriate oral health services and engagement for members.

Lastly JCC will include a dental utilization metric in their contracts for dental services. This metric will set annual improvement targets to promote member engagement in dental services. This metric has led to increased engagement and utilization of services by members and is a starting point for more robust alternative payment mechanisms for engagement and outcomes specific to oral health.

7.6.b.(2). Hospital and Specialty Services
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 time of enrollment. The screening asks members key questions regarding their health, social determinants of health, 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. This coordination can occur through many methods including telephone, electronic communication, or via an Interdisciplinary Care Team meeting for members with complex needs. The comprehensive and advanced use of PreManage is now widespread in the region and quickly identifies high risk patients with real-time notifications of utilization of hospitals, ED, and now starting to include skilled nursing facilities (SNF). Care coordination occurs across multiple systems include the PCPCH, behavioral health, SNF, and hospital. The use of the collective platform 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.

JCC's agreements with hospital and specialty care providers prioritize access to care for our members by allowing the initial consult without prior authorization to remove barriers to access. Ongoing care can be requested by the specialist. All authorization information is available to

PCPCH and PCPs so they can stay informed of services their patients are receiving. Urgent/emergent admissions do not require prior authorization. For pre-planned admissions, PCPCH or PCPs submit requests for inpatient services. These requests are reviewed for medical necessity and compliance with OHP guidelines for coverage. Each request is reviewed on its own merit 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 JCC care coordination team 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. JCC maintains very close relationships with our community based organizations. We work collaboratively with these geographic or culturally specific organizations to address member needs. The 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.

The coordination of care and sharing of information is essential to the successful transition of the member from differing levels of care. JCC expects hospital notification when members are admitted to facilities. This occurs via PreManage whenever possible and more detailed community health records are available in Reliance, our regional HIE. Lastly, we work with Mercy Flights, our local emergency medicine provider, to meet with members in our high risk or rising risk population cohorts prior to their discharge to create a transition plan and ensure proper medication reconciliation.

To facilitate the required communication across organizations, we convene a community stakeholder group to define expectations and roles related to PreManage notification and maintenance of care plans in the PreManage platform. Most network providers are utilizing PreManage to 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.

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.

JCC agreements with hospital, specialty care providers, and paramedicine providers address shared planning for successful transition of care. When JCC members are hospitalized within the JCC region, the JCC care coordination team will work collaboratively with the member's PCPCH and the facility discharge planners to assist the 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. Due to the comprehensive and advanced use of PreManage, many PCPCHs are notified in real time of discharge from hospital as well. The JCC 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 members transition are notified of care coordination efforts across multiple systems.

We have a contract with our paramedicine provider, Mercy Flights, to conduct more intensive transitions of care support for higher risk members. In order to maximize engagement with this level of care, Mercy Flight's community paramedicine program initiates with a visit from a Mercy Flights staff to identified members before they are discharged. This program is being jointly developed by Mercy Flight and JCC, and we continue to evolve it based on data and QI tools.

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 JCC, the PCPCH and the SNF are notified that a member has entered a SNF via PreManage. Transitional care for the member begins at the time of admission which ensures ample time for appropriate discharge planning. When the member is ready for discharge, the JCC care coordination team and SNF staff 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. DHS Medicaid-funded LTC services include, but are not limited to, in-home supports/services, Adult Foster Care, Residential Care Facilities, Assisted Living Facilities, DHS Medicaid-funded LTC Nursing Facility state plan, State Plan Personal Care for APD, Adult Day Services, Contract Nursing Program, administrative examinations and reports, non-medical transportation (except in some areas where contracted to transportation brokerages) and PACE state plan (including Medicare benefits).
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;
We will continue to work effectively with our AAA and APD partners to ensure our shared clients receive high quality, coordinated care. We achieve this through a robust referral system with twice monthly meetings during which referred clients are discussed and care plans collaboratively developed.

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;
JCC has worked with the Rogue Valley Council of Governments Area Agency on Aging and Aging and People with Disabilities through a formal MOU since 2014. We will follow the best practice of holding multi-disciplinary meetings twice monthly where members are staffed and care plans around transitions and/or care coordination are developed. The member's plan will be discussed regularly at these case conferences until their needs have been adequately addressed and/or their situation has stabilized.

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.
JCC believes in providing integrated services for our members whenever possible. We have provided start-up funding and ongoing support to integrated behavioral health clinicians in our

PCPCHs via our alternative payment methodology. We have community-based teams 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.

JCC utilizes a team approach to our multi-disciplinary intensive care coordination. 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. 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 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.

Through the work of our integrated care coordination team, our Mercy Flights community para-medicine hospital transitions program, and our MOU with the AAA/APD, JCC members with acute and highly complex needs can receive care in their homes, SNFs, or community-based settings. Our work with AAA/APD case managers also may include helping members to obtain in-home personal care 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;

Utilization Management (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. UM program activities include the evaluation of appropriateness of clinical services and treatment, and encourage the highest quality care, including using care coordination to engage APD, DHS, DD, specialty mental health, and physical health providers to gather additional information about the member and supports available through those networks. UM also includes a retrospective review of covered services already rendered or already

incurred costs, and 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 to 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 (inpatient), planned admissions require preauthorization. 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

JCC monitors over- and underutilization using a cost and utilization dashboard that details, by service category, the total cost and utilization over time. We follow several utilization measures (ED, primary care, specialty, mental health, etc.) and can further disaggregate this data into demographic or group slicers 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.
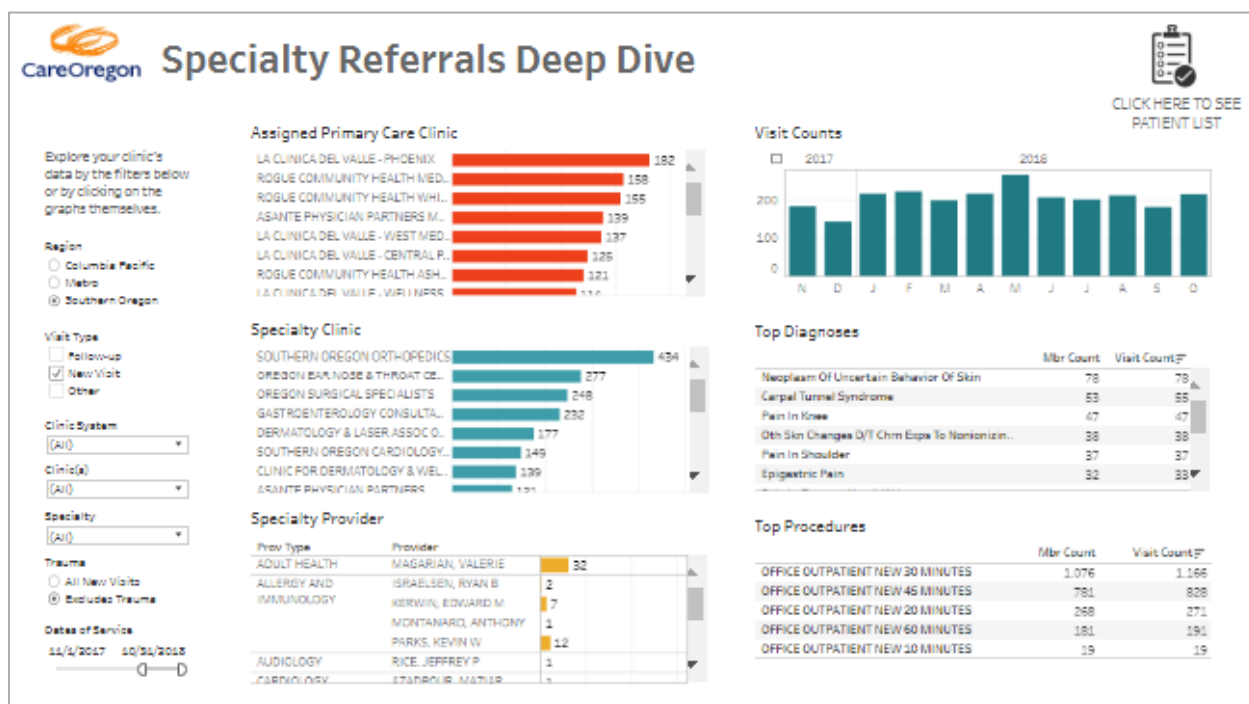
The above snapshot of our specialty dashboard highlights our ability to evaluate utilization and cost by CCO, clinic, and specialty provider over time with deep dive capabilities into member lists, top diagnosis, and top procedures for a given time period.

We also use the quality improvement data to understand over- and underutilization. For instance, by regularly reviewing data about the utilization of medication assisted treatment (MAT) for opioid use

disorder, we identified significant underutilization of this service. These data will be used to convene partners to develop innovative approaches in reducing opioid-related harms and finding better treatment models. After convening and discussing MAT data, we will begin to bring together multiple community partners and programs to create a Pathways to Treatment collaborative. This collaborative will identify high risk patients with SUD in the hospital and engage them to receive MAT, SUD treatment, SDOH supports, and eventual links to primary care with MAT treatment support.

- Pathways to Treatment for Opioid Use Disorder:
    - Database created for OUD and medication assisted treatment (MAT) engagement (see chart below)
    - 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 acute setting (ED, hospital)
    - Addiction Consult team will be created with the support of community addiction providers, peer support specialists, and a social worker to engage the member when in the ED or hospital, assess and diagnose SUD, start MAT, and refer to treatment services
    - Bridge Clinic: JCC will support the expansion of a low threshold MAT prescribing and induction clinic at Jackson County HHS
    - Engage PCP providers in best practice learning and workflow adoption for MAT

Graph showing PCPH assignment of JCC members with opiate use disorder
and their engagement level in treatment services
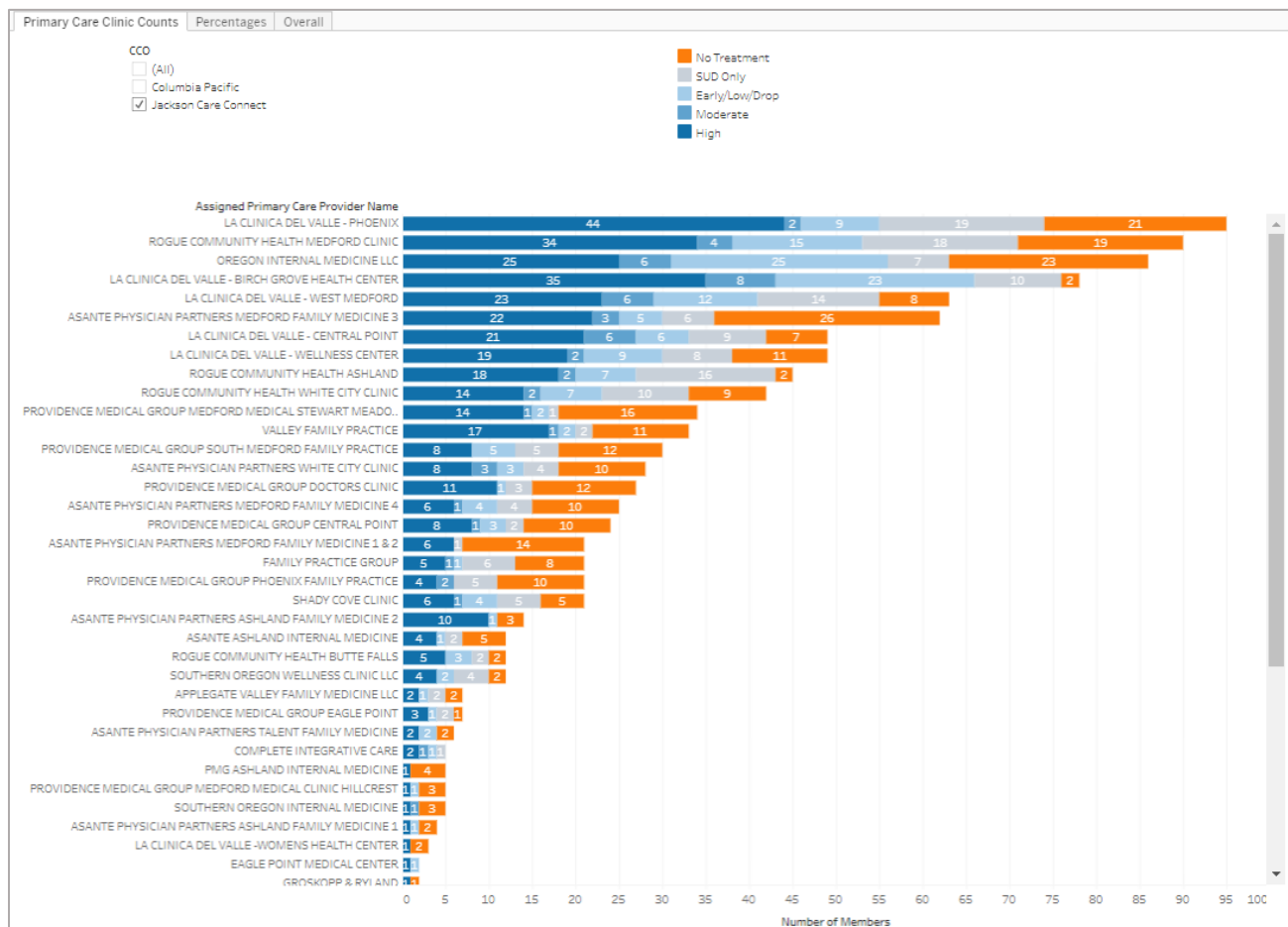
There are 2 main strategies JCC uses to monitor for over- or underutilization of JCC behavioral health outpatient services:

1) We require authorization for continued outpatient mental health episodes of care lasting longer than one year. This includes a clinical review of diagnostic justification/service plan and a summary of progress made in treatment to date. This allows JCC to monitor utilization and address over- and underutilization concerns with network providers on a member specific level.

2) We conduct post-payment audits on approximately four (4) providers per month to oversee compliance/documentation practices, perform encounter data validation, and monitor for overutilization. We base our selection of member records for audit on total members served and episodes of care that have the highest utilization.

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.
JCC has several mechanisms for quality measurement and reporting that we will continue to utilize and improve. JCC maintains a Transformation and Quality Strategy that complies with all

state and federal requirements. In partnership with our parent organization, CareOregon, we employ robust quality measurement and reporting programs including the collection and reporting of performance on health quality indicators including CCO Incentive Metrics and State Quality measures, as well as HEDIS and CAHPS measures. Through our board committees (CAP and Network & Quality), 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 help achieve the quadruple aim. JCC also measures and reports on our four Performance Improvement Projects (PIPs):

1) **Reduce number of ED visits, readmissions, and length of stay for JCC members**	2) **Increase number of JCC members screened for SDOH and reduce impact by providing resources and navigation support**
3) **Increase number of pregnant women and new moms engaged in prenatal and perinatal care and other health promoting activities**	4) **Statewide PIP: Improving Opioid Safety: Reducing Prescribing of High Morphine Equivalent Doses**

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)?
JCC's parent organization 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.
In our quality program, we prioritize the member experience and commitment to quality improvement principles. The JCC Board of Directors oversees the development and implementation of the strategic plan for JCC and is accountable for setting performance expectations for the CCO, which include ensuring an accountable and effective structure for quality and transformation. The board has a Network & Quality Committee that has an annual review schedule of external quality review, grievances, appeals, and delegation oversight activities. It also reviews performance data on utilization, access, metrics, and cost. The JCC Board of Directors undertakes strategic planning on a regular cycle, with annual retreats. The strategic direction incorporates feedback from all Board committees (including the CAC). As a result, our strategic direction incorporates the CHIP priorities and we have specific goals focused on equity, member experience, and access to quality services. Lastly, our staff and board hold a strong commitment to JCC's mission, vision, and values. Using these as guidelines for our strategic and programmatic planning ensures that we prioritize the serving our members' needs with quality in all respects.

To ensure that CareOregon is providing administrative services as outlined in the agreement with CareOregon, the JCC 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, and the behavioral health quality and compliance monitoring program. The JCC Medical Director sits on the CareOregon Quality Management Committee to provide alignment between JCC and CareOregon.

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

JCC uses the Clinical Advisory Panel and the Network & Quality Committee as mechanisms to share organization-level and CCO-level performance, unblinded, to cross-regional clinical partners. Within that forum, providers and regional quality leadership discuss with JCC areas of high and low performance and collaboratively work on areas for improvement We share similar data to the leadership of our network clinic systems 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 PC3 learning collaboratives with operational staff within our region who are leading quality improvement efforts.

We 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 organization know which patients are at highest risk and how to focus their 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)

CareOregon and its wholly owned CCOs utilize multiple methods and activities to provide guidance on identifying and reporting possible or suspected fraud, waste, and abuse (FWA). These items include the JCC 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.

The independent JCC and CareOregon Board members are responsible for the reasonable oversight of the Compliance Program and FWA activities. These Board members receive annual FWA training and related oversight due-diligence training to help guide them in their governance role. The JCC Board has appointed CareOregon's Internal Audit and Compliance Officer as their Corporate Compliance Officer, responsible for the daily activities and overall effectiveness of the Compliance Program and related FWA activities. The Compliance Officer provides both the JCC and CareOregon Boards with periodically reports on compliance and FWA concerns. A significant number of internal audits are performed each year 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. JCC's 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.

Subcontractors and delegated entities are monitored and audited by a combination of JCC and CareOregon personnel to include: department 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 internal business owner and vendor relationships, and the 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.

Regardless of how the noncompliance or FWA is identified, CareOregon will initiate a reasonable inquiry as quickly as possible, but no later than two weeks after the date 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 JCC. 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.

In addition to the robust auditing and monitoring activities reference in 7.8.a, additional audits are triggered 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; 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
Oregon will continue to develop and maintain a Transformation and Quality Strategy to assess and improve the quality of CCO services and to ensure compliance with established standards. CCO accountability measures and related incentives will be core elements of the state's Quality Strategy. Oregon will continue its robust monitoring of CCO system performance and will continue to assure that established standards for quality assessment and improvement are met.

7.9.a. Please describe policies, processes, practices and procedures you have in place that serve to improve Member outcomes, including evidence-based best practices, emerging best practices, and innovative strategies in all areas of Health System Transformation, including patient engagement and activation.
JCC uses a population health strategy approach to improve member outcomes. All JCC actions will be informed and prioritized using the evidence-based approaches of using data, community input/needs assessment, current clinical evidence, and emerging practices. The CAP has developed a strategic approach to quality that combines the JCC Board of Director's strategic plan, the state mandated health care transformation and quality 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 JCC population. These priorities are reviewed and executed by the JCC CAP and, for relevant work, JCC's local Community Advisory Councils (CACs).

JCC's current focus is on the following clinical strategic priorities: (1) achievement of CCO incentive measures, (2) continued advancement of regional improvements in opioid prescribing, (3) development of additional services to address SUDs and alcohol abuse, (4) focus on tobacco cessation, (5) continued training and programs to reduce health disparities especially through improvements in interpretation services, and (6) implementation of strategies addressing high risk patients and high cost practices. While 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

7.9.b. Please describe your experience and plan to emphasize and implement wellness and health improvement activities and practices within your organization for Members and staff, including partners and contracts in place to strengthen this aspect of health care.
JCC's parent organization, CareOregon, has implemented a variety of wellness and health improvement activities within its benefit structure for JCC 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. For clinic partners, JCC funds health and wellness activities that can be provided to patients, including diabetes initiatives with nutritional supports, cooking classes and wellness activities. JCC's *Rx to Play* is an initiative that allows health care providers to give prescriptions to patients for wellness activities like gym memberships. JCC also directly provides members with gift card incentives to encourage annual wellness visits, childhood immunizations, tobacco cessation, pregnancy wellness, and more.

In addition, ColumbiaCare, a contracted provider specializing in the SPMI population, is in the process of implementing wellness groups for adults with SPMI focused on tobacco cessation, exercise and healthy eating.

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.
JCC has extensive experience in meeting regular performance targets and benchmarks. JCC has dedicated staff in quality improvement, analytics, primary care and behavioral health technical assistance, and provider relations to ensure that performance benchmarks are achieved. We have consistently used the CCO incentive measures and the statewide PIP metrics as a baseline for assessing the value of the health services and have incorporated them into our value-based payment methodologies. The accountability metrics have served as mechanism to effectively engage our provider network and provide a pathway for shared goals to improve member care. We review metrics at multiple external meetings including our Clinical Advisory Panel, Primary Care Collaborative, and Leadership meetings to encourage quality improvement, elicit strategy feedback

and ideas, and report on clinic-level and overall metric performance. JCC has multiple strategies and documented workplans for each metric and has created a quality workgroup to meet bi-monthly to operationalize quality improvement strategies to meet metric benchmarks.

7.9.d. Describe your policies and procedures to ensure a continuity of care system for the coordination of care and the arrangement, tracking and documentation of all Referrals and Prior Authorization.
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 objective of whole person, integrated care. The JCC care coordination team utilizes the GSI care coordination platform to collaborate among providers to make sure that information for the members' care plans is available to ensure continuity of care. Within the care coordination team, 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 member's plan of care is available to ensure 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?
JCC's parent organization, CareOregon, operates a Medicare Advantage plan (CareOregon Advantage). In addition to Jackson County, the service area includes Clackamas, 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.

Jackson Care Connect CCO Service Area Capacity		
County	Maximum Enrollment	
	Physical/Behavioral	Dental
Jackson	60,000	60,000

7.11.b. Does Applicant propose a Service Area to cover less than a full County in any County?
The questions below are not applicable. JCC will serve a full county.

If so, please describe how:
7.11.b.(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;
7.11.b. (2) Serving less than the full county provides greater benefit to OHP Members, Providers, and the Community than serving the full county; and
7.11.b. (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.

N/A. JCC proposes to serve only a full county.

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. In the context of the Applicant's Community health assessment and approach for providing integrated and coordinated care, to assess whether the Applicant has the ability to deliver services, the delivery system network data must be submitted in the required formats and evaluated.
Based upon the Applicant's Community health assessment and plan for delivery of integrated and coordinated health, mental health, and substance use disorder treatment services and supports and oral health services, describe Applicant's comprehensive and integrated care management network and delivery system network serving Medicaid and dually eligible Members for the following categories of services or types of service Providers that has agreed to provide those services or items to Members, whether employed by the Applicant or under subcontract with the Applicant:
INSTRUCTIONS: Submit the information in about each Provider or facility using the DSN Provider Report Template in Excel for all Provider or facility types in Applicant's Provider Network. The DSN Provider Report does not count toward overall page limits.
Note: As part of the Readiness Review process, Applicants will need to provide signature pages and credentialing details for Physician and Provider contracts that the OHA reviewers select based upon the OHA DSN Provider Report and Facility tables that are a part of the initial Application submission.

Please see DSN Provider Report

7.12.b. Standard #2 – Providers for Members with Special Health Care Needs (recommended page limit 1 page)
In the context of the Applicant's Community health assessment and approach for providing integrated and coordinated care, Applicant shall ensure those Members who have Special Health Care Needs such as those who are aged, blind, disabled, or who have high health care needs, multiple chronic conditions, mental illness or substance use disorder or who are children/youths placed in a substitute care setting by Children, Adults and Families (CAF) and the Oregon Youth Authority (OYA) (or children receiving adoption assistance from CAF), or any Member receiving DHS-funded Medicaid LTC or home and Community-based services, have access to Primary Care and Referral Providers with expertise to treat the full range of medical, oral health, and Behavioral Health and Substance Use Disorders experienced by these Members.

From those Providers and facilities identified in the DSN Provider Report Template (Standard #1 Table), <u>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.</u>

JCC 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.

We ensure that our provider network has expertise that corresponds to our target population by including a breadth of providers on our network, including contracting with Federally Qualified Health Centers. These safety net clinics have expertise in working with vulnerable populations and work closely with the local community to coordinate social services. The majority of our contracted clinics are PCPCH recognized at some level, with processes in place to advance the Triple Aim goals of better health, better care, lower costs by focusing on effective wellness and prevention, coordination of care, active management and support of individuals with special health

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care needs, a patient and family-centered approach to all aspects of care, and an emphasis on whole-person care to address a patient's physical, oral and behavioral health care needs.

Rural communities have significant difficulty recruiting and retaining practitioners and southern Oregon is no different. We are fortunate to have two contracting entities (PrimeCare and Asante Physician Partners) who are partners in ensuring network adequacy for OHP.

We partner closely with our network to provide care coordination for members with acute or complex health needs, substance use disorder, multiple chronic conditions, and/or mental illness. We meet weekly with all of 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 JCC to support our network with comprehensive care coordination.

To ensure that our contracted providers possess the qualifications and credentials to care for our population, CareOregon has a robust credentialing process that begins with the initial contracting of any provider. The process is designed to adhere to NCQA credentialing standards. The process is designed to ensure that providers have the legal authority as well as appropriate training and experience to provide care to our members. The credentialing process uses recognized sources (primary source) to verify licenses as well as board certification. This includes the appropriate state licensing agency/board and uses American Board of Medical Specialties (ABMS) whenever possible or seeks verification from the appropriate certifying body. This process is repeated at a minimum of every three years for all providers.

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

7.12.c.(1). Describe how Applicant has involved publicly funded providers in the development of its integrated and coordinated Application.
Jackson County Health and Human Services has been deeply involved in this application through multiple venues. The first line of involvement has been with the JCC Governing structure. The Director of Jackson County HHS serves as a JCC Board member and participates in JCC strategic planning and RFA updates. The Jackson County Mental Health Division Manager serves on JCC's CAP, where clinical strategies are developed and reviewed. The Jackson County Public Health Director serves on JCC's CAC, where strategies related to the CHIP, social determinants of health and community/member engagement are developed and reviewed.

As a Local Mental Health Authority, Jackson County Mental Health works directly with JCC to ensure adequacy of the crisis system, connections to community justice, and critical services (such as ACT). We meet regularly to review our work together and have jointly created components of this application.

The Jackson County Public Health department is an active partner in our regional CHIP and has directly engaged in creating the process for this collaborative effort with JCC.

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.

As stated above, Jackson County Health and Human Services has been a key partner with JCC since its inception. When JCC transitioned the management of the behavioral health benefit and risk from Jackson County Mental Health, we continued to contract directly with the county for the provision of key services, specifically the community mental health programs overseen and managed by the county. That contract remains in effect and both JCC and Jackson County continue to work closely to align services outlined in ORS 141.153(4), 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 the county, 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.

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

While there are no Tribal health facilities within Jackson County, and despite Tribal membership being relatively small at just .01% of population, JCC leverages the key partnerships that CareOregon has developed with the nine (9) Confederated Tribes. In particular, Klamath Tribes and Cow Creek Umpqua Band of Indians (located in Roseburg and Canyonville) are located within a reasonable distance. These partnerships make it possible for us to seek culturally appropriate advice or guidance if presented with a member who may have unique needs. These relationships take time to foster and develop, and we will continue to look for opportunities to work together.

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' access providers and healthcare services. As a result of these partnerships, CareOregon has ongoing training to expand understanding and competency, meet with Tribal clinic staff and learn 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. Programs and entire departments have become more culturally intelligent and we understand better how to partner and tap into resources with our Tribal partners who offer robust supports as well.

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.

1) Siletz Community Health Clinic-Siletz (Lincoln County) – outside of JCC's service area
2) NARA Indian Health Clinic-Portland (Multnomah County) – outside of JCC's service area

7.12.e.(2). Please describe your experience working with Indian Health Services and Tribal 638 facilities.
JCC does not have any Tribal health facilities within its footprint and a very small proportion of its membership identifies as Tribal. However, we build on the relationships through CareOregon's contract to provide care coordination services for open card Tribal members. Through CareOregon, we have strong relationships the nine Confederated Tribes and Native American Rehabilitation Association.

Include your Referral process when the IHS or Tribal 638 facility is not a participating panel Provider.
JCC's referral process for members seeking care in IHS or Tribal 638 facilities includes providing the greatest latitude possible for primary care providers (PCPs) in decision making for their patients while assuring medical services rendered are consistent with the benefit and are medically appropriate. Although JCC strongly supports the medical home model of care and encourages members to discuss specialty service needs with their PCP, JCC delegates nevertheless allows 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, JCC 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.

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

In addition, we take into consideration clinical evidence, PL and applicable guidelines notes in developing and revising our PA criteria. During the PA review process, any denial for below the line services rendered now communicates directly with 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 the regular PA process to support our members' medication 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 JCC formulary for OHA members is a closed formulary: medications not listed on the formulary are considered non-formulary and will not be allowed at pharmacy point-of-service without prior authorization. These medications may be accessed by requesting a prior authorization for coverage. Alternatively, the prescriber can choose an alternative that is available on the formulary.

Clinical criteria for use of non-formulary medications requires formulary medications have been tried and/or another specific medical issue exists that 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 when safer and more cost effective than non-formulary agents. In addition, over-the-counter medications are available for multiple therapeutic classes.

The goal is to provide sufficient choices in drug therapy to ensure 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 JCC formulary is developed and maintained by a team of health care professionals as part of CareOregon's 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 ensure 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.***

CareOregon's Pharmacy & Therapeutics Committee serves JCC. The Committee is comprised of both internal and external healthcare professionals as well as representation from each of the CCOs that CareOregon serves. 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 reviews the treatment guidelines on an ongoing basis. Pharmacy staff coordinate with QA 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.

In JCC's service area, close to 99% of our members in rural areas can access a pharmacy within a 15-mile radius. Over 99% of our members within the urban (99.4%) and suburban (100%) areas can access a pharmacy within a 2 to 5 miles radius. JCC has information available on its website providing 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.

JCC uses the pharmacy benefit manager (PBM) OptumRx to provide real-time claim adjudication for pharmacy dispensed medications (contracted through CareOregon). We can access this information in real-time and have 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. JCC manages all prior authorization requests internally (they are not delegated to the PBM or any other entity). We staff PA reviews seven (7) days per week in a manner that ensures 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 the organization level. PA turn-around-time (TAT) is one of many operational key-indicator-report (KIR) 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.**

The following is protected trade secret information.

[The upper portion of the page contains redacted (blacked-out) content including a bar-chart-like series of black bars and two redacted paragraphs.]

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 with each other best practices 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 supporting their clinic and pharmacy teams to hire initial or more clinical pharmacists and/or expand or start 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 despite increasing benchmarks year over year is indicative of positive outcomes, and clinical pharmacists were particularly involved in improvement on many of the measures, particularly diabetes. The clinical pharmacist helps their 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 in which 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.

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.

CareOregon partners with pharmacists in primary care to disseminate best practices in patient care, practice development, and clinical pharmacy integration within the patient centered medical home; we also work to align goals and initiatives with clinical pharmacy patient care activities that further support the quadruple aim of healthcare (see graphic above for ways pharmacy supports PCPCH providers). 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).
JCC uses CareOregon's 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.

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.
CareOregon publishes our formulary including PA, step therapy, and quantity limit information on our public website. Full prior authorization criteria are also published on the website. The formulary and authorization criteria 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, CareOregon and JCC 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.

When members need inpatient and outpatient hospital services, JCC is committed to ensuring all members have the same access to services within our area. Our 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 assurance processes and tools. Our care coordination team provides a single point of contact for coordinating care for members within a specific county to more efficiently and effectively provide care. If members need a higher level of care than available in the rural AB 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.

The NEMT benefit offers an additional avenue for JCC to facilitate access and appropriate utilization to health care appointments and services; this is important for a membership that often may not have reliable and affordable means of transportation to attend medical appointments. Transportation options available to CCO members include low cost options for ride-sharing, public transit, mileage/meals/lodging reimbursements, sedan or ambulatory rides, commercial train and airlines, and volunteer driver programs. In addition, for members who have special needs either limiting their physical or mental abilities to use lower cost options, members 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 provides the much-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, care coordination, and NEMT benefit administration, JCC closely partners with local organizations that can provide reliable and appropriate continuum of services that are medically necessary.

Indicate what services, if any, cannot be provided locally and what arrangements have been made to accommodate Members who require those services.

All services can be provided locally, however, in the event highly specialized services such as complex transplants are needed, those services can be done out of area. JCC has 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 specific 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.

JCC primarily contracts on a Single Case Agreements basis with out-of-state hospitals. These agreements are negotiated collaboratively between the Medical Management Department and Contracting to efficiently coordinate the approval of the services and the agreed upon contract rate for a specified length of time. 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 of Members to Referral Inpatient and outpatient Hospital services.

JCC's provider network has broad geographic distribution in Jackson County. The JCC 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. JCC has no gaps in the CMS time and distance standards for inpatient and outpatient services in our service area; this shows that JCC members have equivalent access to services equal to other people in the service area. We conduct ongoing monitoring of access, timeliness, amount, and scope of our network through the Network Adequacy Steering Committee.

JCC ensures 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.

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.

JCC uses PreManage cohorts to track ED usage for our membership. We create cohorts for notification and each member of our care coordination team receives access to these cohorts to identify and address overutilization of this service.

JCC 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.

The population of focus in this community-wide PreManage roll-out is the OHA ED Disparity Metric. A quarterly Workgroup and Steering Committee comprised of leadership and management in our local primary care, behavioral health and hospital systems works to align efforts and increase volume of care recommendations authored by primary care for ED staff to ensure member care is appropriate and waste, such as avoidable work-ups, is avoided.

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

When members enroll in care coordination, education is provided regarding the appropriate use of ambulance, emergency rooms, and urgent care/walk-in clinics. JCC's Community Engagement Team has a health literacy tool mailer designed to educate members who have utilized the ED for nonemergent needs; the mailer provides information about other immediate care options, is in both Spanish and English, and has visual aids. It provides contact information to local service providers more appropriate to meet immediate health needs and to the CareOregon customer service line for assistance establishing a primary doctor.

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).

JCC 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:
- Member is OHP
- Hospital is paid using DRG methodology
- Readmission is within 30 days of discharge
- Readmission is for a diagnosis that 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 (but not limited to) diabetes, asthma, or chronic obstructive pulmonary disease as described in OAR.

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

JCC will use a multipronged approach to reduce hospital utilization:

Community Paramedicine. JCC has supported a robust community paramedicine program with Mercy Flights, 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.

Behavioral Health and SUD Strategies. We have found that our SUD population has one of the highest utilization 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, in which 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 years 1-3.

Population Segmentation. JCC utilizes a robust population segmentation model allowing us to segment the entire 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. 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.

Value-Based Payments. As discussed in Attachment 12, question 12.G.3, JCC 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.

Cross-System Care Coordination. JCC convenes workgroups that focus on improving cross-system communication and systems to improve care coordination and decrease the need for unnecessary utilization. JCC'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.

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.
JCC manages the care of just under 1,000 CareOregon Advantage Medicare Fully Dual Eligible members who are assigned to providers in its service area. Most of these members are connected

with large health systems providers who utilize 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 JCC care coordination team relies heavily on PreManage to quickly identify care coordination needs and identify the gaps and barriers members perceive that circumvent 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.

Please see the JCC 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, JCC/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 85% 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 per PCPCH Tier Recognition		
PCPCH	Assigned Membership	% of Membership
Tier 0	4,200	13.64%
Tier 1	0	0.00%
Tier 2	1	0.00%
Tier 3	8,182	26.57%
Tier 4	13,685	44.43%
5 STAR	4730	15.36%
Total	30,798	

The programs outlined below represent our current Primary Care Payment Model (PCPM), Integrated Behavioral Health (IBH), and Comprehensive Primary Care Plus (CPC+) programs, all 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 CareOregon 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 four tracks:
- Care Management for Patients with Mental Illness (CMS BHI Model A)
- Primary Care Behaviorist Model (CPC+ BHI Model B)
- CareOregon Integrated Behavioral Health Model Tier 1
- CareOregon Integrated Behavioral Health Model Tier 2

Comprehensive Primary Care Plus Demonstration: The CPC+ Track 2 Funding Package provides enhanced payments to practices serving members with complex care needs. Funding package includes:
1. Reduced Fee-For-Service (FFS)
2. Prospective Bi-annual Comprehensive Primary Care Payment (CPCP)
3. Per Member Per Month (PMPM) Care Management Fee (CMF)
4. Per Member Per Month (PMPM) Primary Care Performance Based Incentive Payment (PC PBIP)

5. Per Member Per Month (PMPM) Behavioral Health Performance Based Incentive Payment (BH PBIP)

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.

JCC 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 and 2 clinics of $.50 and $1.00 respectively. We currently have no members assigned to tier 1 clinics and one member assigned to a tier 2 clinic.

Within JCC's PCPM, IBH and CPC+ 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
CPC+ Track 2					
	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5
PMPM Payment Range*	$0	$0	$0	$2 - $18	$2 - $18
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, 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. JCC 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:

JCC/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:

      a. Measuring provider performance against the clinic's own historical performance
      b. Exploring VBPs that consider social and medical complexity in the risk-adjustment
      c. 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;

JCC 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 5 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 and CPC+ 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, 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).

JCC also anticipates aligning with and leveraging any risk adjustment mechanisms OHA implements for CCOs based on assessing the social determinants of health that for JCC 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

JCC 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, JCC 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, JCC 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.
- We 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.

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Attachment 12 - Cost and Financial Questionnaire

12.A. Evaluate CCO performance to inform CCO-specific profit margin beginning 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 the JCC's enrolled population and managing risk borne by JCC and its parent organization, CareOregon. JCC uses the data infrastructure of CareOregon to measure clinical and financial performance. JCC staff then bring these data to a variety of internal staff-driven Committees, as well as governing bodies like the Clinical Advisory Panel (CAP) and the Community Advisory Council (CAC) (among others), in order to identify, validate and prioritize opportunities to incentivize or leverage those services that show greater value and efficiency.

One example of how the governance structure develops service opportunities based on data are the regular cross-functional joint meetings between JCC Board committees. The JCC Clinical Advisory Panel and Network and Quality (N&Q) Committee meet jointly with the Finance Committee to review annual cost and utilization strategies in the first quarter of each year. This allows Committee members the opportunity to provide clinical, quality and financial feedback to JCC leadership on proposed strategy, with a consideration for alignment, patient safety and care quality. The JCC CAP reviews and advises on clinical best practices and, with the N&Q and Finance Committees, reviews cost and utilization data in monthly meetings to advise on solutions and areas requiring prioritization.

The CAP, N&Q, and Finance Committees regularly review dashboards in the following four 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 variation and improve delivery of services to members:

- **Specialty referral rates** across multiple specialties serve as a starting point for JCC to partner with providers to discuss both over- and under-utilization of specialty services.
- **MRI/imaging rates** across the CCO as well as variant MRI cost across regional hospitals. This data allows JCC and providers to address unnecessary imaging.
- Opioid Use Disorder and associated **Medication Assisted Treatment 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, with a particular focus on the disparate use by members with severe and persistent mental illness (SPMI).
- **Pharmacy cost PMPM** to highlight trends and cost drivers, and inform formulary structures.

By using dashboards that track measures of clinical value and efficiency, JCC has identified opportunities to improve efficiencies and clinical best practice related to delivery of services to members. Examples of this include:
- *Strategically removing* some prior authorization requirements (e.g., naloxone to address opioid overdose, new start insulin and diabetic supplies to improve diabetes management).

- *Implementing* prior authorization requirements (i.e., MRI/imaging to help control cost in concert with clinical evidence).
- *Educating network providers* (i.e., guidelines for MAT).
- *Managing network optimization (i.e., refining contracts, monitoring network adequacy, monitoring provider quality).*

These measures of clinical value and efficiency have informed JCC's approach to reducing low-value care as a cost containment strategy as well as a quality improvement strategy. In 2019, we will continue to expand our ability to analyze utilization data in the context of low-value care, and we will move this strategy into implementation phase.

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 and the N&Q Committee, 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.

JCC 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) 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 grants us the ability to leverage our relationships with community-based organizations. We are also able to employ additional population health initiatives such as community benefit or social determinants of health (SDOH) remediation to keep these members healthy, ultimately avoiding unnecessary hospitalization in the distant future.
- **Risking 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 addressing 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.

JCC, 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. JCC 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 JCC staff and provider groups for specified member or patient populations. PreManage has several unique functionalities that allow users to create targeted groups, cohort 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 JCC. Disparities for service access for members who are mentally ill have 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.

Finally, JCC 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 JCC 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 above, JCC uses several dashboards to identify areas of opportunity to improve quality and outcomes and to lower costs. In addition to those tools, JCC has a robust system in place to monitor achievement of the CCO incentive measures 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 opportunities to improve. JCC primarily uses CareOregon's enterprise data warehouse, powered by Arcadia, to integrate data across service and claims types. In addition, it uses Tableau to make the data usable and actionable by staff, and available to providers to help inform their performance.

Tools to eliminate waste and inefficiency. JCC has a robust Compliance program that includes recent focus and investment on Payment Integrity activities. The JCC 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. JCC's Cost and Utilization Steering Committee monitors cost and utilization trends and makes 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. JCC 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. Specifically, the Cost and Utilization Steering Committee creates a portfolio of strategies to include monitoring and outcome metrics, an implementation plan and a timeline. Additionally, an annual dashboard monitors cost and utilization trends throughout the year, informs how strategies are performing and identifies whether refinement is needed. As we implement our low value care strategy noted above in 12.A.2, we will use our internal analytic capabilities to also develop or use an existing 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. An example of an opportunity identified and acted upon in the past is overutilization of

acupuncture and chiropractic services. Data presented in the Cost and Utilization Steering Committee, demonstrated that JCC had significantly higher utilization and cost for acupuncture and chiropractic use for members with chronic pain. We assessed the cost and utilization outcomes of members with pain and acupuncture/chiropractic interventions and those without intervention. There was little to no reduction in opioid use or ED use or cost when the two groups were compared. As a result, we reviewed the network adequacy for acupuncture and chiropractic services and aligned benefit management with the stricter OHA recommendations for chronic pain, and supported programs that have integrated Primary Care with Behavioral Health and movement or wellness benefits like acupuncture/chiropractic services; in the end this reduced costs while maintaining an adequate network and quality outcomes for our members.

A weekly cost and utilization workgroup comprised of JCC and CareOregon team members work to monitor JCC's cost and utilization portfolio. This workgroup monitors outcomes to remove waste, improve quality outcomes, and reduce costs. To this end, the workgroup works with relevant network and community partners to implement interventions or new programs and identifies and resolves gaps in resources or barriers to achieve the portfolio outcomes. In 2019, the JCC cost and utilization workgroup's weekly meetings will focus on utilization and treatment

97	…JCC Members benefited from housing case management in Rogue Retreat Total HRS services: $105,000
2,087	…JCC members were supported in achieving healthy and active lifestyles through the YMCA Total HRS services: $277,999
254	JCC Members were provided transportation resources to access supportive social services Total HRS services: $146,000

related to substance use disorders (SUDs). This has been identified as biggest opportunity for cost savings, improved quality outcomes for patients and lasting impact on our community.
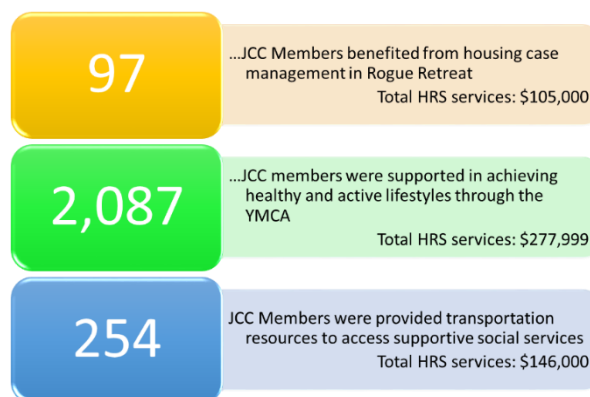
12.A.3. Does the Applicant have a strategy to use Health-Related Services to reduce avoidable health care services utilization and cost? If so, please describe.

JCC 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. JCC'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) JCC's care coordination program. By integrating the HRS strategy into these services, organizations and programs, JCC maximizes member support and reduces avoidable health care services utilization and cost, while also allowing the HRS to meet critical, immediate member needs.

When JCC identifies that a member has a critical, immediate need, JCC care coordinators convenes 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 and relevant agencies coordinate with the individual 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 JCC for an HRS-eligible item, in accordance with OAR 410-141-3150. JCC's integrated care coordination team 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 JCC follows up with the member and/or their community-embedded case worker to make payment and coordinate delivery of approved items or services. JCC'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 health care plan.

12.A.4. What is the Applicant's strategy for spending on Health-Related Services to create efficiency and improved quality in service delivery?

JCC's strategy for spending on HRS, including community benefit funding, is intended to create efficiency and improved quality of service delivery in all JCC-covered services. This strategic approach takes seriously the reality that the urgent social needs addressed by non-medical benefits or by community-based organizations are the downstream manifestations of the impact of the 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.

JCC's strategies will target the intersection of individual and population health to bridge the profoundly siloed structures of clinical medicine and public health. JCC 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 strategically respond to the increased demands mandated by health care reform.

JCC will prioritize HRS spending in the following categories:
- **Integration** related proposals will address integration of services, especially between clinical and community settings.
- **Alternate payment model** proposals address 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 to health disparities.
- **Clinical partner capacity building** will 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, County Mental Health, 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 internal processes and operations. Additionally, these strategies encourage the provider recipients 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?

JCC has built program evaluation into its investments in community agencies and clinical programs since 2015, when it first began to invest deeply into Social Determinants of Health & Health Equity (SDOH-HE) community-based programs. In order for it to meet its core value of stewardship, the JCC Board emphasizes the importance of measurement, reporting and accountability for dollars spent, including HRS.

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, JCC will continue to work on the best method(s) 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, JCC 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 JCC include gathering information relative to each program, designing the appropriate evaluation, collecting and analyzing data, and reporting the results.

With each investment, JCC 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 JCC in order to review the metrics against expected deliverables.

Overall, JCC will use a rigorous program evaluation framework to guide evaluation of all 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 JCC's investments in programs run by community-based organizations. Formal goal-setting during the program planning process will inform the selection of metrics and the threshold of success for each metric. The evaluation results will be used to improve program design, implementation, cultural competency and efficient use of funds, as well as guide decisions to sunset programs when appropriate or redirect investment into more effective initiatives.

Evaluation Process and Components: The evaluation framework will focus on both process evaluation and outcome evaluation. Analysis for both will draw on systematically-collected program data, claims data, Health-Related Services data, member interviews or survey data and other sources where relevant. 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

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 intended to develop meaningful dialogue around clinical quality performance with our hospital partners. JCC 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, JCC 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.
As it has since its inception, JCC divides Quality Pool earnings between incentives to support metrics performance and investments in community programs. These include investments in clinical partners' programs and public health partners and health-related service providers with a wide range of programs: peer and community trainings for opioid epidemic, teen homelessness and oral health, transitional housing for mental health, paramedicine care coordination, HIE (Reliance), ACEs

trainings, YMCA benefits, traditional health worker trainings, perinatal engagement program *Starting Strong*, as well as the more traditional investments in clinical programs and partners.

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.

Each year, JCC's N&Q and Finance Committees jointly review JCC's Quality Pool performance and earnings and create the policy and methodology for its distribution. The Committees consider network performance and alignment, cost and utilization portfolio outcomes and metrics performance as factors. Over the years JCC's use of Quality Pool funds reflects JCC's commitment to investing in infrastructure, SDOH, behavioral and oral health, and integrated, team-based primary care to achieve shared cost & quality goals. JCC plans to adhere to the same Board-driven process in 2020. The process has ensured that Quality Pool investment policy is transparent, broad-based in terms of input, and is aligned to both community and CCO priorities.

Currently, JCC's APMs are fully funded by the Quality Pool funds. JCC's Board of Directors has policies set for QPS allocation. As JCC works with the Committees and clinic systems toward our shared goals we have developed more sophisticated APMs (CPC+, PCPM and BHI APM; see Attachment 8 of this Application) to deeply align quality performance with the network. Currently over 90% of our JCC members are assigned to a clinic participating in our APMs, resulting in significant alignment with OHA metrics and cost of care. While this APM alignment with the network is large and has grown to become more comprehensively effective over the years, it has meant we have fewer funds for non-clinical investments from Quality Pool. Instead we use funding from Medical and BH capitation and CHIP investment funds for investments in SDOH and other Health-Related Services. (See Attachment 10 B.1-2 for a complete list of current LOAs and criteria used by JCC 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?

The JCC Board has emphasized the importance of using Quality Pool dollars as a catalyst for transformation in the community. As such, maximizing outside investments is a priority. As the Quality Pool funds become part of the CCO capitation rates, JCC plans to apply 8% of the Quality Pool funds to the costs of administering Quality-Pool-associated infrastructure, staff and metrics performance support. Of the remaining 92%, 75% will be used to fund the APMs (as described in 12.C.2 above) and 25% is used for incentives for members and providers, and for panel coordinators (clinic system support for metrics performance like chart scrubbing and technical assistance).

12.C.4. How will the Applicant decide and govern its spending of the Quality Pool earnings?

As mentioned above in 12.C.2.the N&Q and Finance Committees of the JCC Board of Directors will review and approve the Quality Pool allocation, which is then approved by the full JCC Board of Directors. Both Committees are made up of clinical and community stakeholders. Funded programs will be reviewed monthly to bi-annually at the N&Q and CAP Committees. Overall Quality Pool budget spend will be reviewed and approved monthly at the Finance Committee.

12.C.5. When will Applicant invest Quality Pool earnings, compared with when these earnings are received?

The JCC Board of Directors approves a policy for investment of Quality Pool earnings prior to the year in which they are earned and commits the earned dollars once OHA awards the final amount in

Q2 of the following year. The Board requests a 12-month budget for expenditure of the Quality Pool funds at time of receipt from OHA (6 months after completion of calendar year). Due to the delay built into the process from year-earned to year-received, JCC requires a minimum of 18 months from completion of the calendar year to invest its Quality Pool earnings.

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, JCC 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 JCC, CareOregon uses OptumRx for PBM services not performed by CareOregon directly. Most PBM services are performed directly by CareOregon staff. Exceptions are pharmacy claims adjudication, pharmacy claim modules/programs to meet specific tasks (e.g., transition, 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)

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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?

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12.D.4. Does the Applicant plan to use the Oregon Prescription Drug Program to meet the PBM transparency requirements?
No, JCC 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 broadening the transparency and impact. We will continue to encourage providers to use the PDMP to inform appropriate prescribing and strongly support the 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 formulary is posted on our website and is updated after each CareOregon Pharmacy & Therapeutics (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 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 are 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. We performed an analysis comparing our top 150 products based on claims volume and/or total paid amount with OHA's fee-for-service PDL and coverage limits in 2019. The results show nearly 98% of functional alignment by prescription volume and 89% by prescriptions paid. Functional alignment is defined as achieving the same net effect for order of product preference whether done by PA criteria or non-formulary status. JCC aligns the formulary with the 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. JCC invites local providers and specialists to participate in its P&T processes. These important provider inputs help to prioritize formulary decision making, which is vital in implementation staging.

12.E.4. Does the Applicant plan to fully align its PDL with the fee-for-service PDL? If not, please describe exceptions.

JCC will meet the OHA requirements to work together with the other CCOs and OHA to partially align PDLs in specific drugs and drug categories. JCC 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.
JCC 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 JCC 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?
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 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
12.G.1. What strategies will the Applicant employ to achieve a sustainable expenditure growth year over year?
JCC employs strategies aimed at producing high value care for members and reducing unnecessary cost to achieve sustainable expenditure growth year after year. More specifically, current 2019 strategies are to:
- Implement contracting strategy to bring large clinic and hospital systems to target budget and risk contracting with shared upside risk (shared savings) in early years moving to shared up- and down-side risk in later years.
- Implement benefit and utilization management strategies.

- Pharmacy cost savings initiative through benefit management and clinical venue technical assistance.
        - Hep C risk corridor management and optimization with Reliance HIE data review and clinic partner care coordination.
    • Create a network that produces high value care and reduces waste as evidenced by:
        - Spine/knee/shoulder MRIs: 15% reduction.
        - New face-to-face specialty referrals: 10% reduction.
        - New face-to-face ortho referrals: 10% reduction.
        - Implementation of Rubicon MD in large clinic systems to manage over and under-utilization for specialty medicine.
    • Create a community care coordination model to support high value hospital transitions.
        - Paramedicine (Mercy Flights paramedics care coordination, see Attachment 7).
        - Care Coordination model—JCC's care coordination team spreads best practices to FQHC and hospital systems on team composition, cross system care coordination process, population definition, and use of Reliance and PreManage for best practices (see Attachments 7, 9, and 11).
    • 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 PCPCH and hospital systems to use the community care coordination model above 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).
            ▪ Bridge Clinic—we will support the growth of a low threshold MAT prescribing and induction clinic at Jackson County HHS.
            ▪ Engage PCP providers in best practice learning and workflow adoption for MAT.

While specific strategies may change over the course of the 2020-2025 contract, we believe in reducing cost by consistently employing strategies that benefit the member through improved health outcomes and greater access to primary and preventive care services.

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 JCC, 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 client entities.

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 highly competent 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. Management 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.

JCC has a strong working relationship with its independent consulting actuaries (Wakely Consulting). Working with our actuaries, JCC 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. JCC 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, thus 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?

JCC has invested significant time, community and provider input, and operational expertise into efforts that will ensure sustainable expenditure growth, utilizing our VBP models. Our main strategies are in three areas: primary care payment, provider system risk arrangements, and community-based care management case rates.

In primary care, we have implemented and spread our provider co-developed Primary Care Payment Model (PCPM), which is a LAN Category 2C payment. The PCPM is a capitated payment that incentivizes providers based on quality metrics and cost-consciousness measures. Performance on CCO metrics and Medicare Star measures are monitored, shared with providers, and supplemented with EHR data to evaluate achievement of benchmarks. The capitation rate of these payment varies by the number of benchmarks providers can achieve. Starting in 2019, a cost consciousness measure was added to the payment model to track and improve the amount of Ambulatory Care Sensitive Conditions that drove an ED and inpatient admission. The addition of this measure will ensure that there is visibility and incentive that conditions that are clinically appropriate to be treated in primary care are managed there rather than in a more expensive hospital setting. Primary care providers who

show performance on managing Ambulatory Care Sensitive Conditions may also earn additional dollars within the PCPM. These PCPM payments are significant to the providers and are effective at controlling costs while incentivizing improved quality by varying the amount paid based on achievement of the measures.

In addition, JCC is actively engaged in negotiations with several key providers to enter into multi-year risk-sharing arrangements. The cost targets in these agreements will be pegged to a sustainable growth rate ensuring that there are aligned incentives between the OHA and JCC and between JCC and our providers. This model is a total cost of care target budget model contract where a provider system's total PMPM cost from the previous year is risk adjusted and forecasted forward based on the rate of growth target. If the provider is able to stay under this total cost of care PMPM target and achieve quality targets, the savings are shared between the provider and JCC. If the total cost of care is more than the target, the provider shares in the losses. This risk arrangement is managed with significant data sharing, so providers are able to understand where their members are utilizing services and put clinical programs in place to address inappropriate cost and utilization. JCC staff will also meet with these providers at least quarterly to review their progress toward meeting the budget goals and share strategies between the CCO and the provider to support the achievement of the goals. Both the PCPM payments and the risk sharing arrangements incentivize providers to manage members' costs within the sustainable rate of growth.

Finally, JCC works with providers and community-based care management programs to utilize VBP strategies to support clinically effective programs. For example, in our Mercy Flights program, a program that supports members after transitioning out of the hospital, we completed an analysis that showed that the program was cost effective, decreasing inpatient stays by 89% and ED utilization by 86% for members engaged in the program. To support the development of the program, we started with a LAN category 2A payment for infrastructure development and support of early operations. To support the program on an ongoing basis, we developed a comprehensive case rate that now counts as LAN Category 2C and are exploring the transition to a payment model in Category 3A or 4A.

Comprehensively, these VBP strategies work together, across multiple parts of our delivery system to ensure that JCC will be positioned to achieve our sustainable rate of growth targets.

12.G.4. What strategies will the Applicant utilize to contain costs, while ensuring quality care is provided to Members?
JCC is implementing strategies and controls so that in CCO 2.0 it will reach and sustain the 3.4% global medical cost trend rate target while maintaining or improving quality outcomes for our members. For example, key priorities include:
(1) Identification of opportunities to build capacity for and implementing VBP arrangements, described above, particularly risk-based contracting that are explicitly linked to quality outcomes, such as the percent of our membership assigned to a primary care provider that is on our PCPM model that significantly incentives quality outcomes and that JCC will implement at least one total cost of care risk contract prior to 2020.
(2) Pinpointing cost-saving opportunities to reduce potentially wasteful or low-value medical spending in specialty referral services. We will implement strategies that promote best practice medicine while educating providers and providing increased and more appropriate access for members. For example, we have piloted and are spreading implementation of a primary care-based e-consult service, Rubicon MD, that provides primary care providers

    recommendations from expert specialists for treatment and management in a primary care setting.

(3) Significantly expand healthcare analytics to inform population and provider cost-mitigation strategies to include SDOH-HE and quality measures in addition to cost analysis. By sharing these analytics with providers, we will ensure that we are targeting the populations with the most need and addressing areas of quality disparities. For example, we have recently focused on the population with Substance Use Disorder (SUD) to improve quality and address cost.

(4) Expanding VBP contracting with a more robust behavioral health provider network to improve member access and quality of services. These contract arrangements will include incentives for quality and integration.

(5) Development of community-driven, cross-system care coordination models which use multiple HIT solutions (PreManage, Reliance, GSI, Arcadia; see Attachment 9) as well as population segmentation analysis to appropriately identify those members at highest risks for ongoing costs and poor health outcomes (for example: the hospital transitions of care program with Mercy Flights paramedics operates with a 4 pillar model that addresses SDOH-HE, BH and PCP access and patient education and self-management.).

All programs are reviewed within the JCC and CareOregon Cost and Utilization Committee for cost/quality efficacy and alignment, as well as at the JCC CAP and N&Q Committees whose charters are to uphold Triple and Quadruple Aim focus for JCC.

12.G.5. Has the Applicant achieved per-Member expenditure growth target of 3.4% per year in the past? Please specify time periods.

JCC has not yet achieved a plan wide global medical cost growth trend rate target of 3.4%. However, historically, our physical health medical cost trend rates for non-ACA categories have been well below the 3.4% target: 2.5% (2015 to 2016), -1.1% (2016 to 2017) and 2.2% (2017 to 2018). Overall JCC trend rates have been significantly and negatively impacted by non-controllable cost-drivers due to the ACA expansion including the durational effect tied to a new population, delayed redeterminations, and pharmacy cost trends. Most of these adverse cost trend drivers are in the past as the ACA program has finally reached a point of "cost maturity," which will support JCC meeting the 3.4% cost growth trend rate target.

JCC has two ongoing factors that may impact meeting the target. (1) our smaller risk pool means that, in any one year, 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. (2) JCC has a disproportionately high percentage of members with a SPMI diagnosis (per OHA documentation) and this overrepresentation has worsened over time. Members with a SPMI diagnosis significantly impact both behavioral health costs and physical health medical costs.

Please note that OHA has provided documentation that summarizes, by CCO in the SW region, the percentage of members with a SPMI diagnosis. The report indicated that JCC had a disproportionately higher share of members diagnosed with SPMI. We believe this case of adverse selection is still present with the strong probability that the magnitude of adverse selection has most likely worsened over time. JCC is analyzing claims data to better understand the financial ramifications, and as possible to better manage the challenge. We have found that members with a SPMI diagnosis not only significantly impact behavioral health costs, but also those members' physical health medical costs and overall life expectancy. When a SPMI diagnosis has a co-morbidity

of a SUD diagnosis, the effect on physical medical costs is exponentially more expensive. To help address this problem of adverse selection, JCC has made significant and material investments to restructure how members access behavioral health providers and services. These substantial behavioral health investments have improved our behavioral health provider network and member access, as well as increasing the level of much-needed integration between behavioral health and primary care providers, resulting in both higher quality and more effective health care for our members. We look forward to sharing actuarial analysis with ASU and Optumas. We hope that our future collaboration on this emerging topic will benefit all Medicaid stakeholders.

12.H. Potential Establishment of Program-wide Reinsurance Program in Future Years
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.)
JCC's future reinsurance policy is expected to be similar to that currently in place for CY2019 (January through December). JCC delegates the financial risk for physical and behavioral health to CareOregon, thereby aggregating its member population into 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. The policy is also subject to "lasers," in which specific high-cost members may be subject to higher attachment points ranging from $600,000 to $1,000,000. Please note that CareOregon carries separate policies for its 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 JCC'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 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 JCC 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 cancelation penalties?
Policies are constructed to be in effect for each calendar year. Premium costs and estimated recoveries are based on YTD (12-month) activity. It is likely that if the organization were required to terminate a policy before the 12-month coverage period, the financial impact would be that JCC incurs higher PMPM costs than necessary. The current reinsurance policy does not have cancellation penalties, but it is not uncommon to find policies that do. It is possible that CareOregon may purchase a future reinsurance policy that includes early termination penalties. If the Oregon Legislature or Oregon Health Authority 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.

2.I.1. Please describe Applicant's past sources of capital.
In the past, JCC has received its capital from two different sources: CareOregon contributions and operations. Initially, when JCC was formed CareOregon contributed capital so it could meet the minimum capital requirements. Later, JCC and CareOregon entered into a gainshare arrangement where a portion of gains generated by CareOregon in managing JCC's risk were shared back to JCC.

12.I.2. Please describe Applicant's possible future sources of capital.
If needed, JCC 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 JCC holds very little insurance risk, it is not difficult to ensure solvency thresholds are maintained. Parent company, CareOregon, assumes all risk for physical and behavioral health, and JCC delegates dental risk to its DCO partners. Only NEMT and CCO administration expenses are borne by JCC. JCC staff and Board of Directors 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, JCC is wholly owned by CareOregon, who could provide additional capital in the event JCC is undercapitalized. In the past, CareOregon contributed capital to JCC. In addition, JCC and CareOregon have a gainshare arrangement where gains generated by CareOregon in managing the delegated risk are shared back with JCC.

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.
JCC 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 billed. The same vendor partner employs a team of clinicians and certified coding specialists to perform facility claim post-payment audits. We also have both employed and contracted certified coding specialists performing 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 the OHA via 837 and NCPDP file format within the regulatorily required timeframe. JCC 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 providers billing prolonged services. The medical record is required with the claim submission. (2) We work with a vendor partner to perform post-payment diagnosis-related group (DRG) audits. (3) We perform analytics to identify overutilization patterns along with any anomalies in the claim data and then target those provider types to perform regular post payment audits. The medical record is requested then reviewed to support 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-JCC-Att12-Form13H with Support CPC BE
RFA4690-JCC-Att12-Form13H with Support CPC MAX
RFA4690-JCC-Att12-Form13H with Support CPC MIN
RFA4690-JCC-Att12-UCAA-Supplemental Financial Analysis CPC

Attachment 8.C.1

RFA4690-JCC-Att8-VBP Data Template

Applicant Company Name: Jackson County CCO, LLC dba Jackson Care Connect   NAIC No.

FEIN: 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). Jackson County CCO, LLC dba Jackson Care Connect

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: Patrick   Middle: Marion   Last: Hocking

2.   a.   Are you a citizen of the United States?

      b.

3.

4.

12.

13.

14.

15.

Applicant Company Name: <u>Jackson County CCO, LLC dba Jackson</u> Care Connect NAIC No. _____

FEIN: <u>45-5499608</u>

Dated and signed this <u>18</u> day of <u>April</u> 20<u>19</u> at <u>3:00</u> _____. 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.

<u>V</u> I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

_____
(Signature of Affiant)

State of: <u>Oregon</u>   County of: <u>Jackson</u>

The foregoing instrument was acknowledged before me this <u>18th</u> day of <u>April</u>, 20<u>19</u> by <u>Patrick Hocking</u>

and:

☐ who is personally known to me, or

☒ who produced the following identification: <u>Oregon Driver License</u> .

[SEAL]

_____ Notary Public
Jeanette

<u>Jeanette Blanco Cortes</u>
Printed Notary Name

<u>September 10, 2022</u>
My Commission Expires

OFFICIAL STAMP
JEANETTE BLANCO CORTES
NOTARY PUBLIC-OREGON
COMMISSION NO. 979043
MY COMMISSION EXPIRES SEPTEMBER 10, 2022

OFFICIAL STAMP
JEANETTE BLANCO CORTES
NOTARY PUBLIC-OREGON
COMMISSION NO. 979043
MY COMMISSION EXPIRES SEPTEMBER 10, 2022

Revised 04/08/19
FORM 11

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).

Jackson County CCO, LLC dba Jackson Care Connect

315 SW 5th Ave. Portland, OR 97204

503-416-4934

1. Affiant's Full Name (Initials Not Acceptable): First:_____ Middle:_____ Last:_____
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.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?

Yes ☐ No ☒

If yes, give the reason if any, if NONE indicate such, and provide the full name(s) and date(s) used.

Beginning/Ending Date(s) Used (MM/YY)	Name(s) Specify: First, Middle or Last Name	Reason (If NONE, indicate such)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Dated and signed this <u>18</u> day of <u>April</u>, 20<u>19</u> at <u>3:00</u> _____. 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.

_____
(Signature of Affiant)

State of: <u>Oregon</u>   County of: <u>Jackson</u>

The foregoing instrument was acknowledged before me this <u>18th</u> day of <u>April</u>, 20<u>19</u> by <u>Patrick Hocking</u>

and:

☐ who is personally known to me, or

☑ who produced the following identification: <u>Oregon Driver License</u>

[SEAL]

_____
Notary Public

<u>Jeanette Blanco Cortes</u>
Printed Notary Name

<u>September 10, 2022</u>
My Commission Expires

OFFICIAL STAMP
JEANETTE BLANCO CORTES
NOTARY PUBLIC-OREGON
COMMISSION NO. 979043
MY COMMISSION EXPIRES SEPTEMBER 10, 2022

Applicant Company Name: Jackson County CCO, LLC dba Jackson Care Connect NAIC No. _____

FEIN: 45-5499608

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 Jackson County CCO, LLC dba Jackson Care Connect**[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.

Patrick Hocking, 1562 Cypress Point Drive, Medford, OR 97504
_____
(Printed Full Name and Residence Address)

_____   _____
(Signature)   (Date)

State of: Oregon   County of: Jackson

The foregoing instrument was acknowledged before me this 18th day of April, 2019 by Patrick Hocking, and:

☐ who is personally known to me, or

☑ who produced the following identification: Oregon Driver License

[SEAL]

OFFICIAL STAMP
JEANETTE BLANCO CORTES
NOTARY PUBLIC-OREGON
COMMISSION NO. 979043
MY COMMISSION EXPIRES SEPTEMBER 10, 2022

_____
Notary Public
Jeanette Blanco Cortes
Printed Notary Name
September 10, 2022
My Commission Expires

Applicant Company Name: Jackson County CCO, LLC dba Jackson Care Connect   NAIC No. _____

FEIN: ___45-5499608___

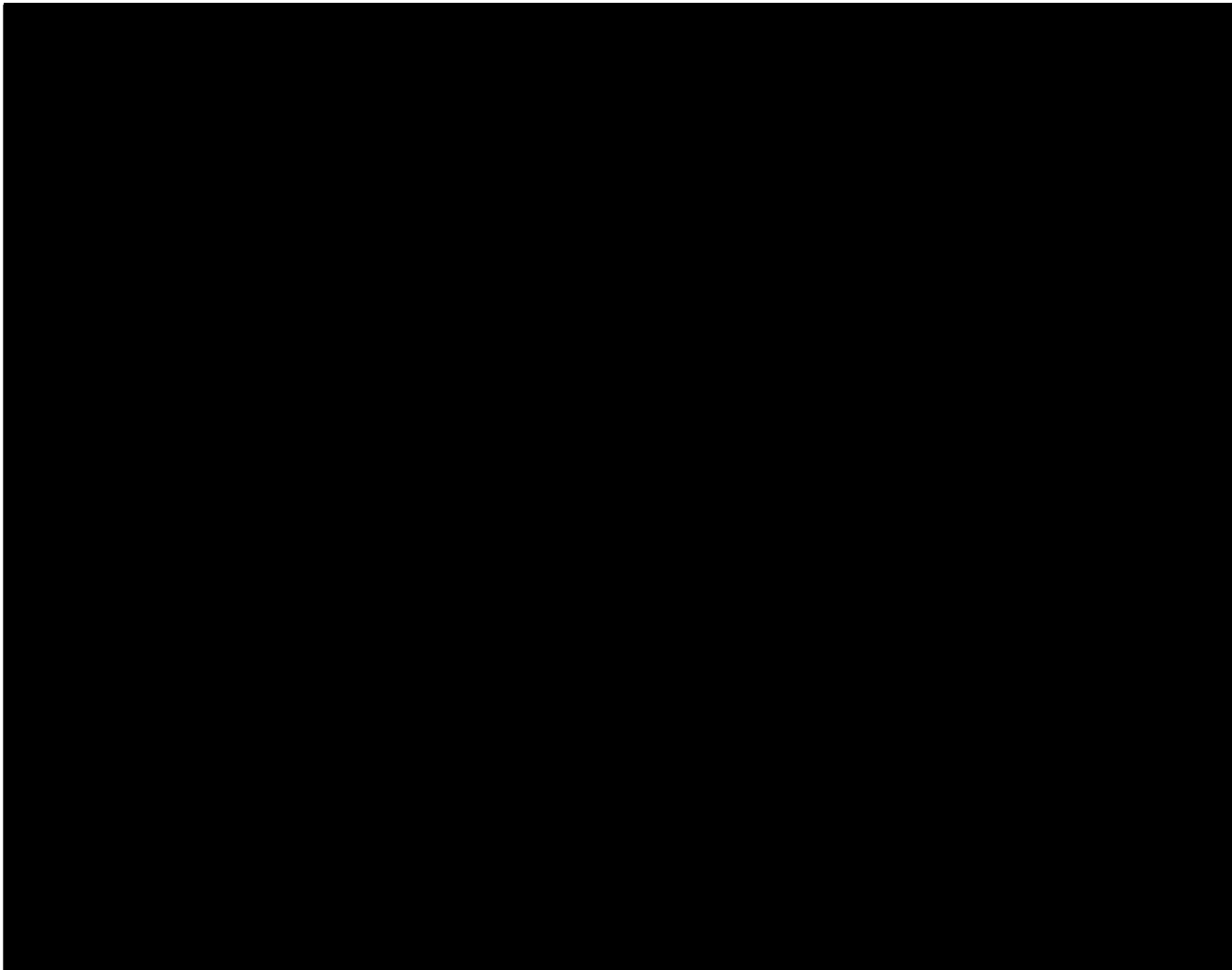## Uniform Certificate of Authority Application (UCAA)
BIOGRAPHICAL AFFIDAVIT

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). _Jackson County CCO, LLC dba Jackson Care Connect_____
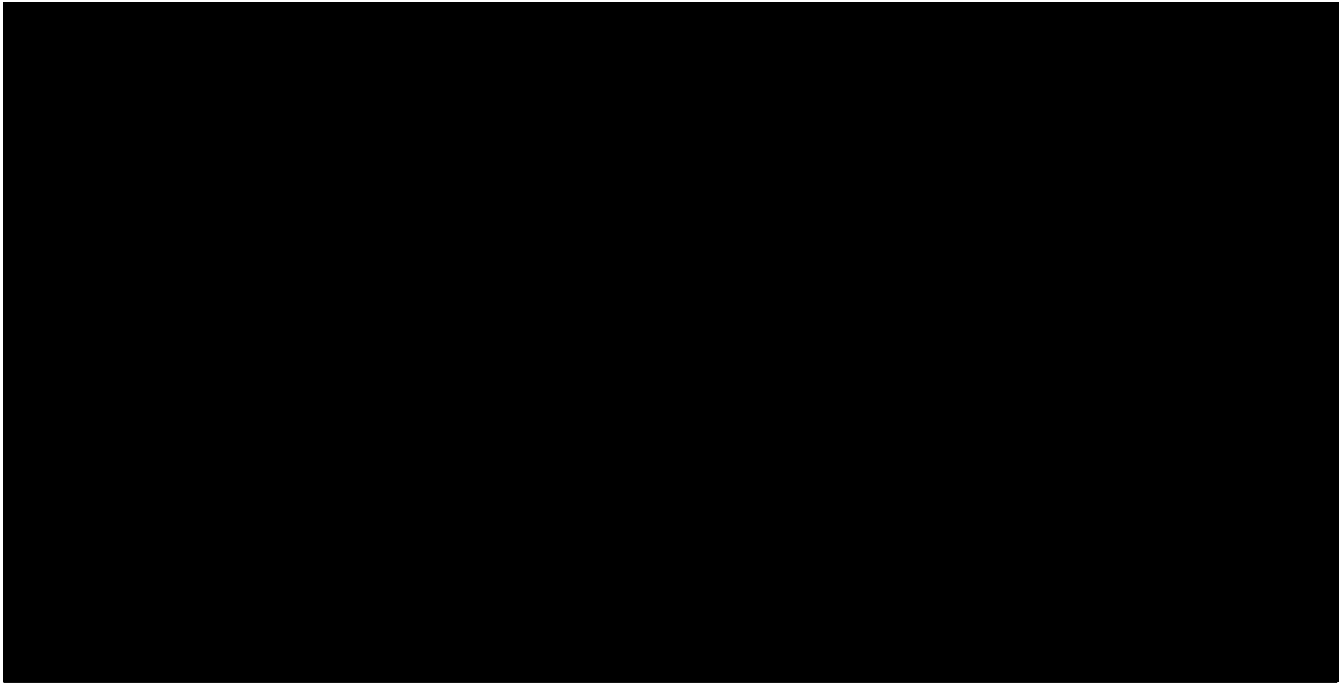
___315 SW 5th Ave. Portland, OR 97204_____   503-416-4934_____

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: Jennifer   Middle: Jo   Last: Lind

Applicant Company Name: <u>Jackson County CCO, LLC dba Jackson</u> Care Connect   NAIC No. _____

FEIN: ___<u>45-5499608</u>___

6. List of memberships in professional societies and associations:

Name of Society/Association	Contact Name	Address of Society/Association	Telephone Number of Society/Association
N/A			

7. Present or proposed position with the Applicant Company: Executive Director, Jackson Care Connect

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.
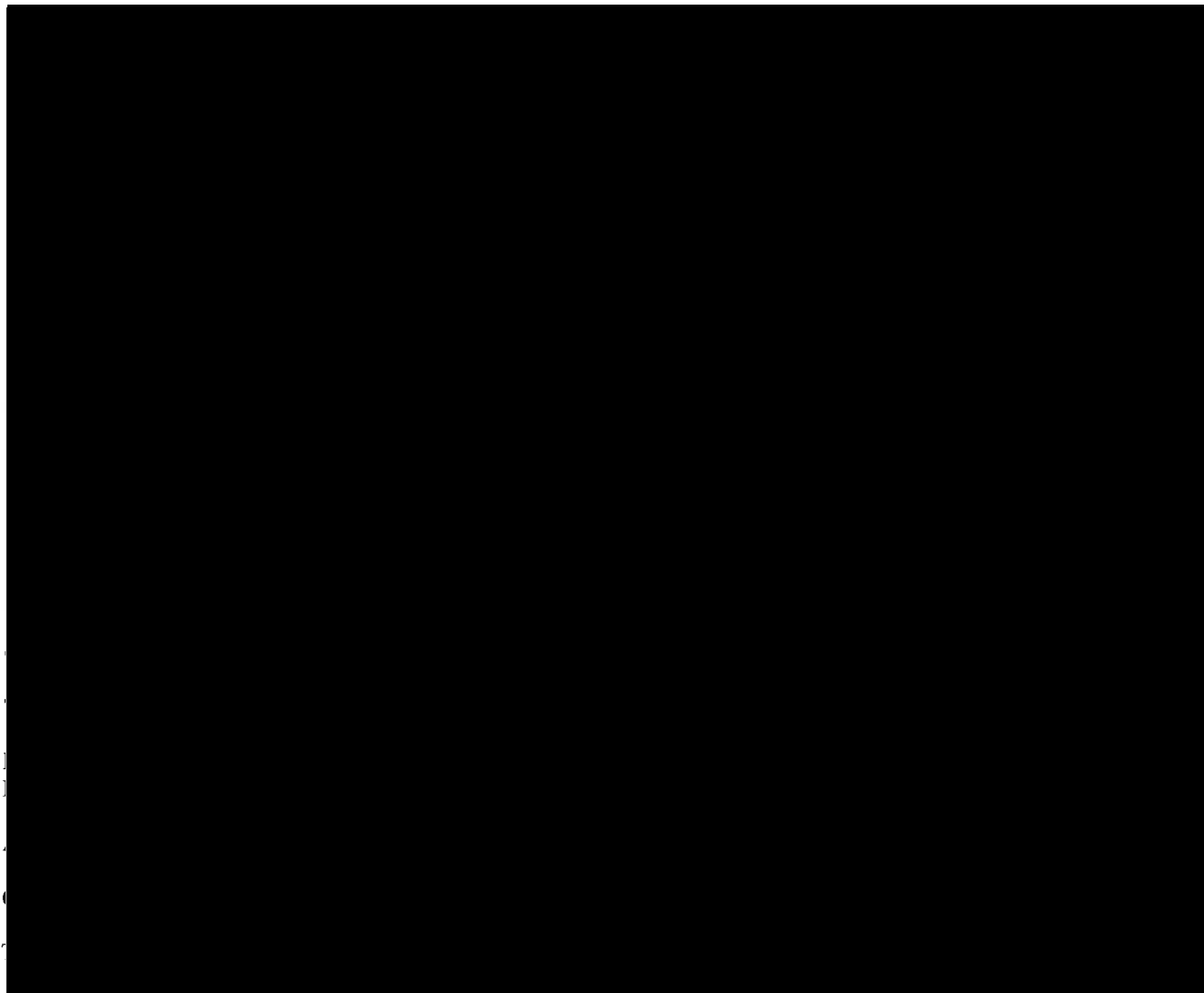
irector

Officer

Applicant Company Name: Jackson County CCO, LLC dba Jackson Care Connect   NAIC No. _____

FEIN: 45-5499608

12.

13.

14.

15.

Applicant Company Name: Jackson County CCO, LLC dba Jackson Care Connect   NAIC No. _____

FEIN: 45-5499608

███

Dated and signed this __18__ day of __April__ 20 _19_ 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.

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 18 day of __Apr__, 20 19 by __Jennifer Lind__ and:

X 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

Applicant Company Name: Jackson County CCO, LLC dba Jackson Care Connect   NAIC No. _____

FEIN: ___45-5499608_____

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).

___Jackson County CCO, LLC dba Jackson Care Connect_____

___315 SW 5th Ave. Portland, OR 97204_____

___503-416-4934_____

1.   Affiant's Full Name (Initials Not Acceptable): First: Jennifer Middle: Jo   Last: Lind
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.

Applicant Company Name: Jackson County CCO, LLC dba Jackson Care Connect   NAIC No. _____

FEIN: 45-5499608 _____

Dated and signed this __18__ day of __April__, 20 19 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.

_____
(Signature of Affiant)

State of: __OR__   County of: __Multnomah__

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☒ 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

Applicant Company Name: Jackson County CCO, LLC dba Jackson Care Connect   NAIC No. _____

FEIN: __45-5499608__

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 Jackson County CCO, LLC dba Jackson Care Connect**[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.

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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.

Jennifer Lind   443 Liberty St, Ashland, OR 97520
_____
                                (Printed Full Name and Residence Address)
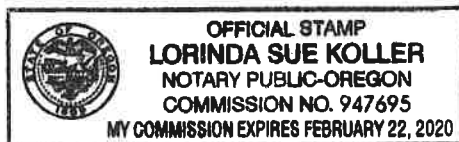
_____   __18 April 2019__
            (Signature)   (Date)

State of: __OR__   County of: __Multnomah__

The foregoing instrument was acknowledged before me this __18__ day of __Apr__, 20 __19__ by __Jennifer Lind__, 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__
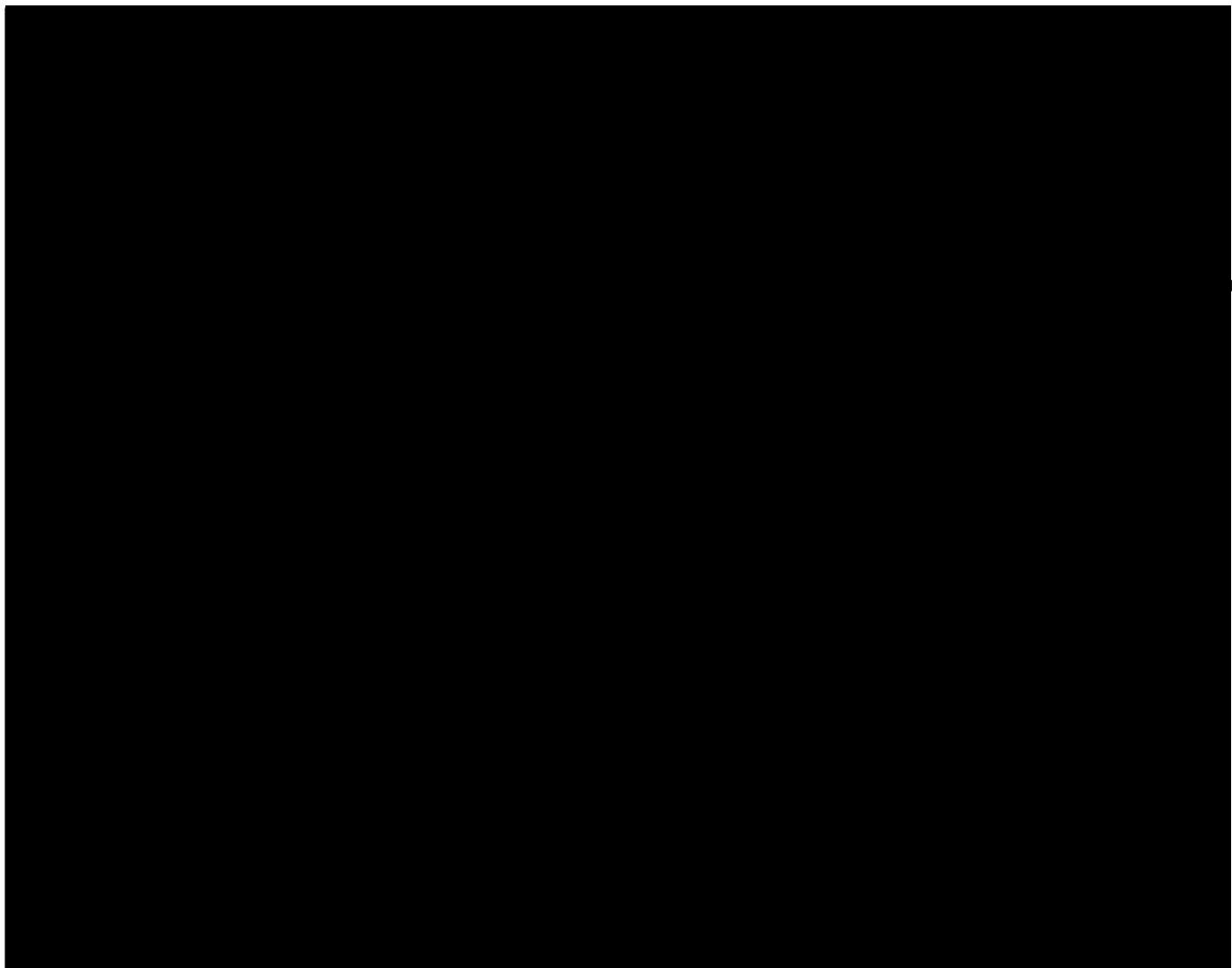   My Commission Expires

Revised 04/08/19
FORM 11

Applicant Company Name: ____Columbia Pacific CCO, LLC____ NAIC No. _____

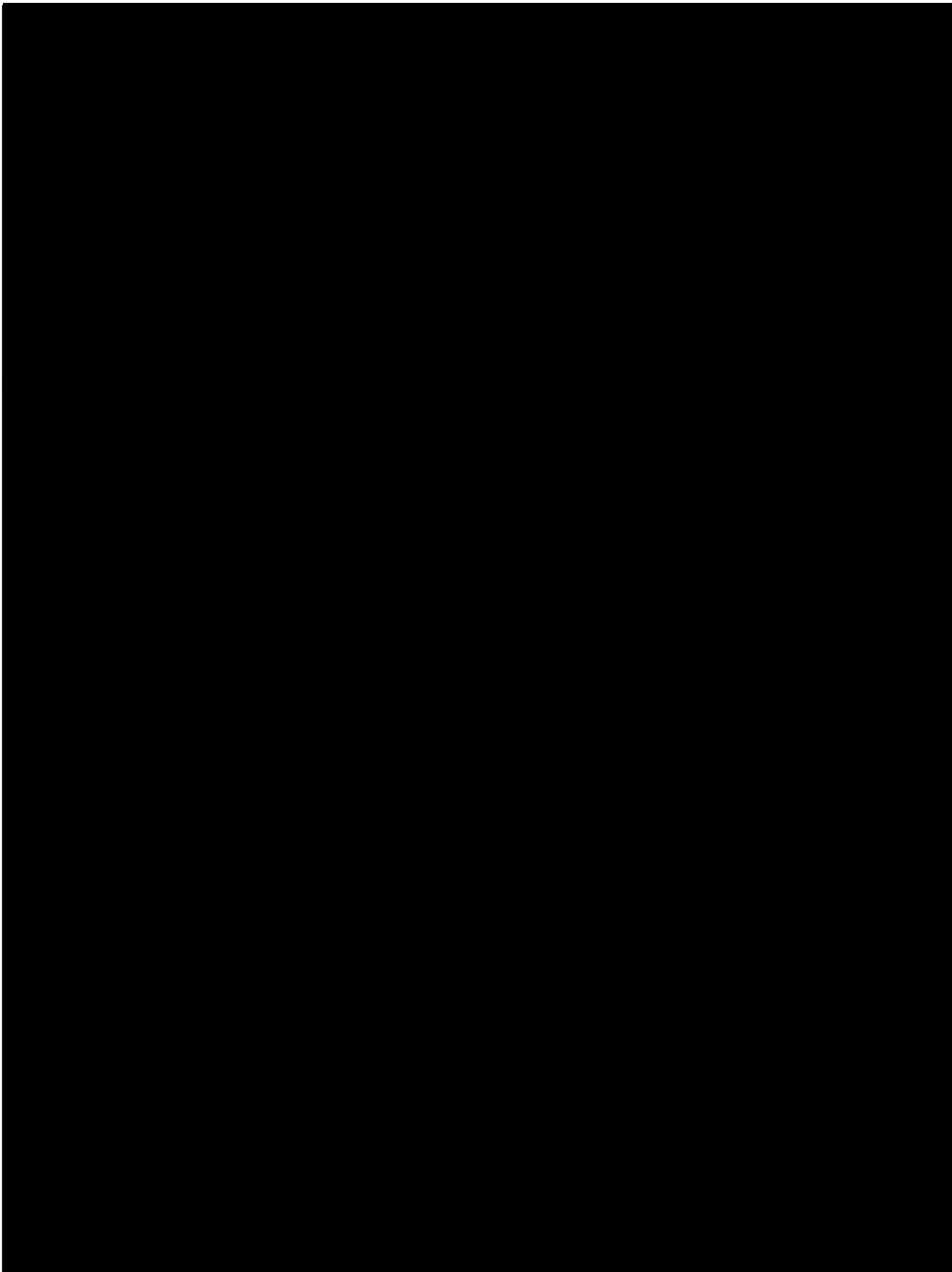Jackson County CCO, LLC, d.b.a. Jackson Care Connect FEIN: ____45-5532847____

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.

Revised 04/08/19
FORM 11

Applicant Company Name: Columbia Pacific CCO, LLC NAIC No. _____
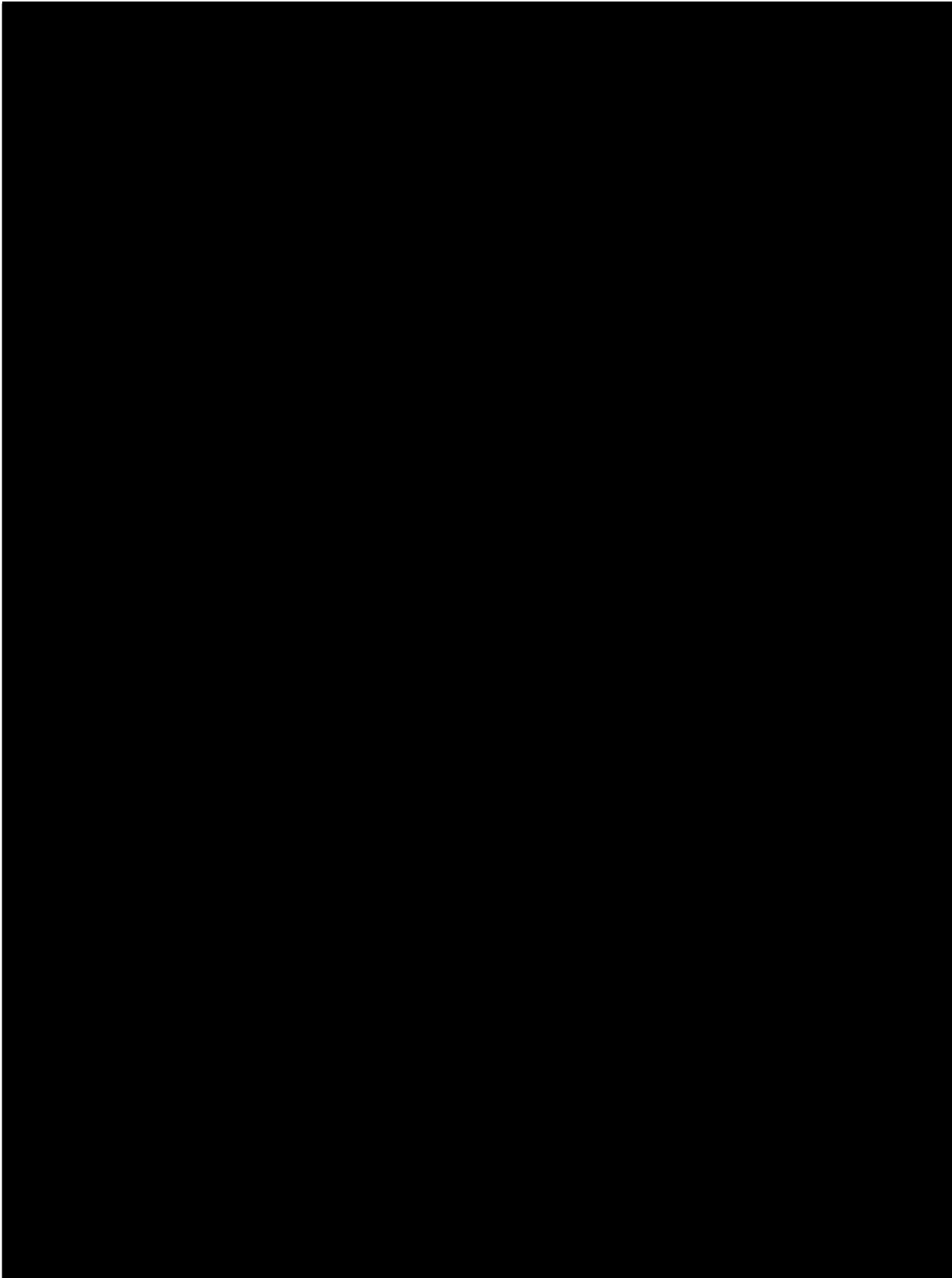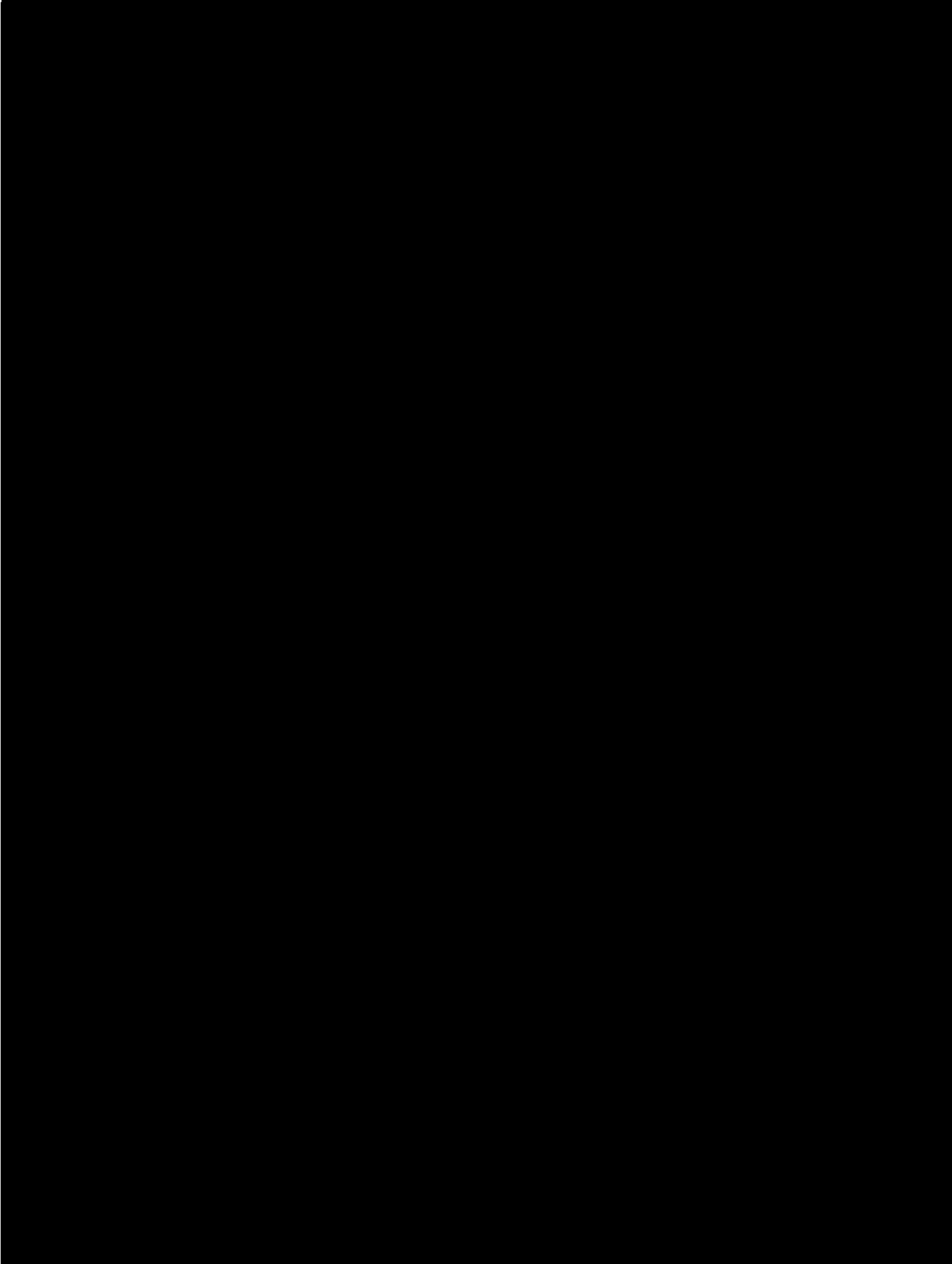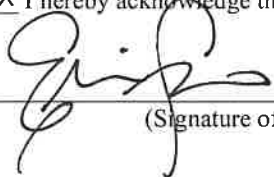   Jackson County CCO, LLC, d.b.a, Jackson Care Connect FEIN: 45-5532847

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.

9.

10.

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spring.

12.

Applicant Company Name: Columbia Pacific CCO, LLC
Jackson County CCO, LLC, d.b.a, Jackson Care Connect

NAIC No. _____
FEIN: 45-5532847
45-5499608

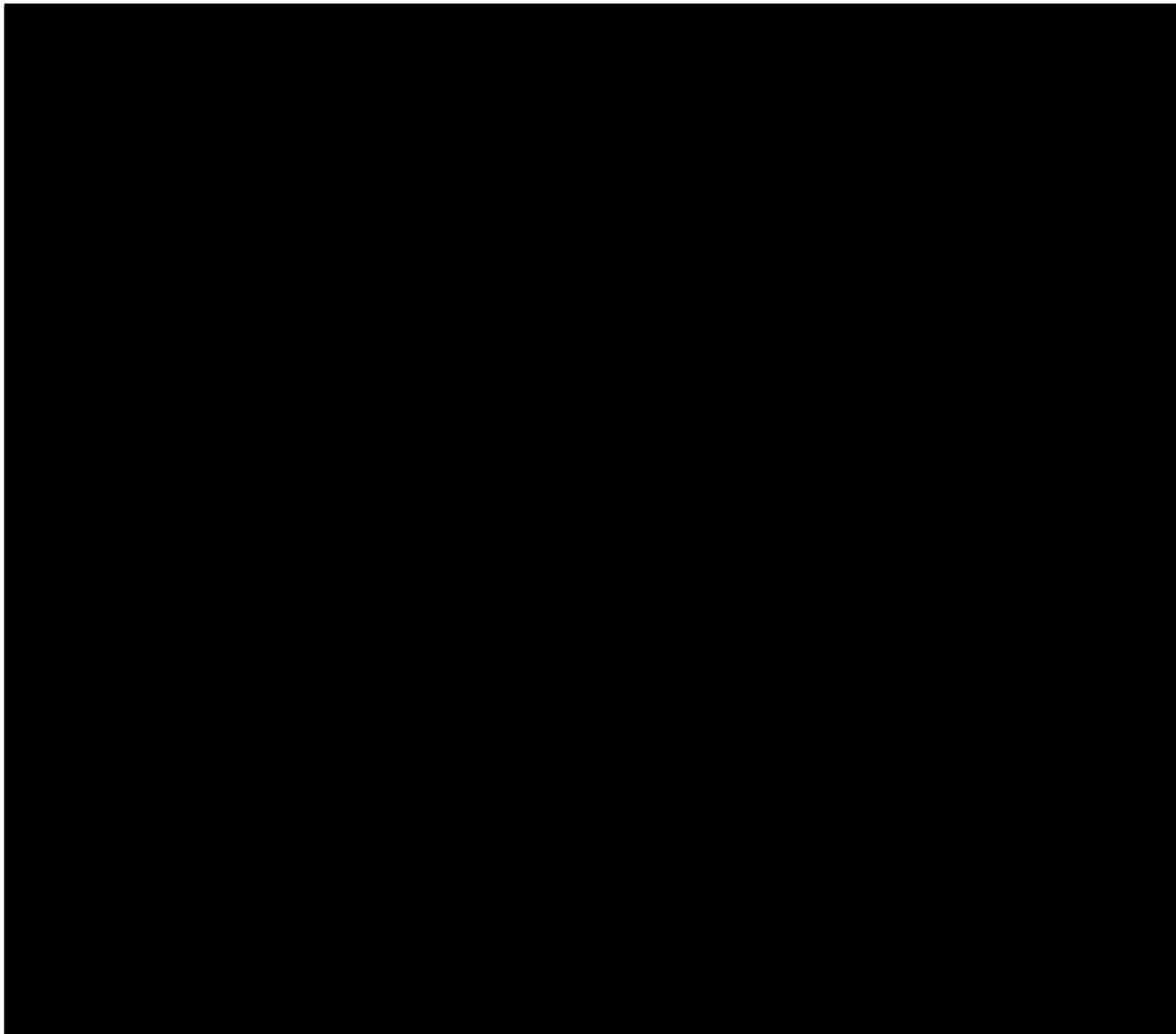13.

14.

15.

Applicant Company Name: Columbia Pacific CCO, LLC   NAIC No. _____
          Jackson County CCO, LLC, d.b.a, Jackson Care Connect FEIN: 45-5532847
                                                              45-5499608
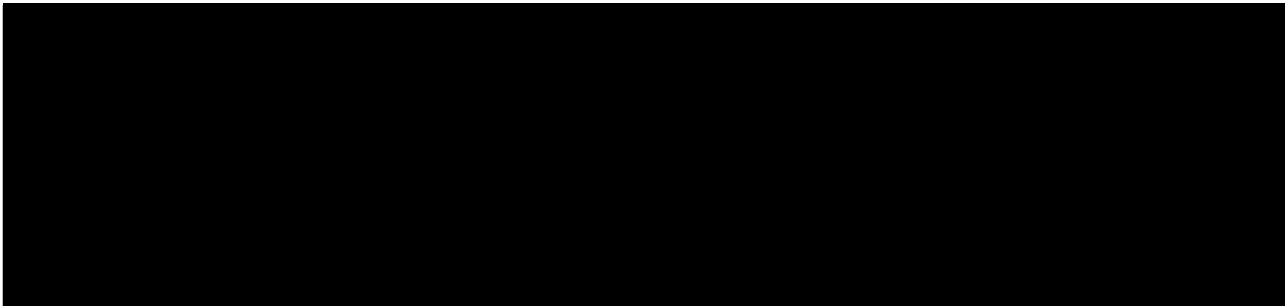
Dated and signed this __22nd__ day of __April_____ 20 _29_ at _____ . I hereby certify
under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best
of my knowledge and belief.

__X__ I hereby acknowledge that I may be contacted to provide additional information regarding international searches.
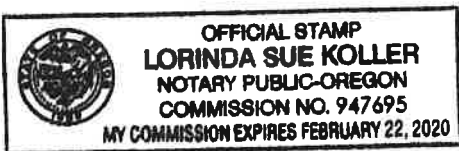
_____
          (Signature of Affiant)

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]

_____
          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

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

████████████████████████████████████

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]

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: Columbia Pacific CCO, LLC   NAIC No. _____

Jackson County CCO, LLC, d.b.a., Jackson Care Connect   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)   4.22.19

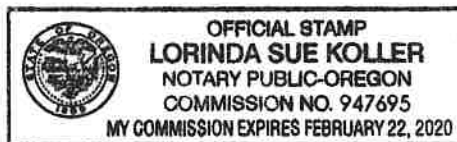_____ (Signature)   _____ (Date)

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]

Lorinda S. Koller
Notary Public

__Lorinda S. Koller__
Printed Notary Name

__2-22-20__
My Commission Expires

Revised 04/08/19

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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 JCC'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 JCC 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.

JCC does, however, remain concerned that since it has 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, JCC is 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 JCC may approach a successful transition.

To ensure the safe and orderly transition of members, JCC will cooperate with a Transferring or Receiving CCO to achieve a successful transition for members during/after the open enrollment period. JCC 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 almost 300,000 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 JCC's current service are is a Choice Area, JCC 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. JCC 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 JCC is the Receiving CCO. Because of the role OHA plays as an intermediary in providing enrollment files and client statuses, JCC 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 JCC is the Transferring CCO" section below.

If JCC is the Transferring CCO. In the event that the OHA awards a contract to a new applicant in Jackson County, JCC 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);
- 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 the Transferring CCO.

For Tiers 1-3, JCC will make lists available to the Receiving CCO with data elements described in 16.2.b below.

Since, by definition, JCC 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, JCC will make that information available as well.

JCC 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, JCC'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 JCC and other CCOs like Columbia Pacific CCO 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, JCC'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 JCC'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 JCC 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.

JCC will provide OHA and the Receiving CCO with all of the data elements listed above in 16.2.b.(1). JCC 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 JCC 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 JCC 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 our JCC care coordination, 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 care coordination to ensure continuity of care. For members with SPMI or discharging from an acute care psychiatric hospital, JCC 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, JCC 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 all provider workgroups and committees 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.

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.

Because of the role OHA plays as an intermediary in providing enrollment files and client statuses, JCC will depend on the OHA and the Transferring CCO 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 JCC, Columbia Pacific CCO 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, JCC 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 on members transferring from another CCO, along with prior provider assignments from the Transferring CCO, we can identify recently transferred members and look for prior assignments that align with our provider network. JCC also 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 that 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, JCC will arrange to staff the cases and, whenever possible, allow for a warm handoff between the transferring-in CCO and JCC. For example, to ensure the continuity of treatment course and prevent disruptions in medication coverage, pharmacy staff from JCC 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 care 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 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. JCC 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. JCC 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 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, JCC will honor all existing prior authorizations for services, pharmaceuticals and treatment plans for at least the first 90 days. JCC 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. JCC will also work with pharmacy staff, and local pharmacies in our network to ensure access to medication is not disrupted. JCC 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 JCC 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, JCC will staff each case, enroll members with JCC's care coordination, as appropriate, connect with other care providers and, whenever possible, allow for a warm handoff from the Transferring CCO.

Provider Outreach. JCC 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. Finally, JCC 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, JCC 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 JCC 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 (CBOs) 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 CBOs, and early learning hubs. During a CCO transition, we would want to encourage members and their advocates to engage with JCC 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. 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, JCC 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. JCC'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 networks to use clinical assignment data, matched

with new member rosters, to ensure safe and smooth member transitions within the JCC network after open enrollment.

We will engage our CAP 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.

Attachment 15 — Representations

Applicant Name: Jackson County CCO, LLC, d.b.a., Jackson Care Connect (JCC)

Authorizing Signature: _____

Printed Name: Erin Fair Taylor, Chief Legal Officer/Secretary of JCC Board of Directors

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?

    [X] Yes   [ ] No

    Explanation: JCC will have a Management Services contract with CareOregon, Inc., the sole Member/parent of
    JCC to manage/handle all staffing needs with regard to all of the CCO program. This arrangement will
    be identical to the arrangement JCC 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?

    [X] Yes   [ ] No

    Explanation: JCC will have a Management Services contract with CareOregon, Inc., the sole Member/parent of
    JCC to perform all of the systems and information technology to operate the CCO program for JCC
    This arrangement will be identical to its 2012-2019 systems. CareOregon also supports IT for Health Share and CPCCO

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?

    [X] Yes   [ ] No

    Explanation: JCC will have a Management Services contract with CareOregon, Inc., the sole Member/parent of
    JCC to perform nearly all of the claims administration, processing and adjudication functions. Dental claims will be
    administered directly by JCC'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?

    [X] Yes   [ ] No

    Explanation: JCC will have a Management Services contract with CareOregon, Inc., the sole Member/parent of
    JCC to perform all Enrollment, Disenrollment and membership functions. This arrangement will be identical to
    the arrangement JCC 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: JCC will have a Management Services contract with CareOregon, Inc., the sole Member/parent of JCC to perform all credentialing functions, except for dental care providers who provide dental benefits as delegated to JCC DCO partners; the DCOs will credential their network providers and JCC 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: JCC will have a Management Services contract with CareOregon, Inc., the sole Member/parent of JCC to perform all utilization operations management, except for dental utilization management, which will be delegated to JCC's DCO partners. JCC 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: JCC will have a Management Services contract with CareOregon, Inc., the sole Member/parent of JCC to perform all Quality Improvement activities. This arrangement will be identical to the QI activities CareOregon has performed on behalf of JCC 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: JCC will have a Management Services contract with CareOregon, Inc., the sole Member/parent of JCC to perform all call center operations. This arrangement will be identical to the call center operations CareOregon has performed on behalf of JCC 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: JCC will have a Management Services contract with CareOregon, Inc., the sole Member/parent of JCC to perform all financial services. This arrangement will be identical to the financial services functions CareOregon has performed on behalf of JCC 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?

[X] Yes ☐ No

Explanation: JCC 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 [X] 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?

[X] 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?

[X] Yes ☐ No

Explanation: JCC has a 2019 CCO Contract, it is an Affiliate of Columbia Pacific CCO, 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 14 — Assurances

Applicant Name: ___Jackson County CCO, LLC, d.b.a, Jackson Care Connect___

Authorizing Signature: _____

Printed Name: ___Erin Fair Taylor, Chief Legal Officer/Secretary of JCC Board of Directors___

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]

[X] 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]

[X] 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]

[X] 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]

[X] 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]

[X] 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]

[X] 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]

[X] 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]

[X] 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]

[X] 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]

[X] 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]

[X] 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

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.
JCC meets all of the required provisions in 42 CFR § 438.206 in the following ways:

- **Delivery Network**
    1. JCC 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. JCC 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 JCC will arrange for members to obtain second opinions outside of the network, if necessary, at no cost.
    4. JCC will provide out-of-network services if and when the existing network is unable to provide necessary Covered Services.
    5. JCC 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 JCC's behalf.
    7. JCC can demonstrate sufficient family planning access.
- **Furnishing of Services**
    1. Timely access – JCC 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. JCC 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 JCC 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, JCC 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 JCC'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.

JCC demonstrates is capacity to serve the entire eligible OHP population in Jackson County, 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** – JCC 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** – JCC 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**
  - o JCC ensures that every member is assigned to a PCP, with preference for assignment to PCPs who are PCPCH certified.
  - o Depending on the specific needs or circumstances, JCC 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.
  - o JCC 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.
  - o Within what is allowable under HIPAA, 42 CFR Part 2, or other regulations, JCC shares any assessment information regarding members' needs to prevent duplication of efforts. Similarly, JCC promotes HIE efforts to ensure that providers may also share health information, as allowable.
- **Additional Services for Enrollees with Special Health Care Needs**
  - o JCC 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 JCC'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.
  - o The RCT or other care coordination staff on JCC's team produce treatment plans that detail the specific needs and goals of the member and/or the member's caregivers. All of JCC's care coordination staff are trained in person-centered planning and trauma-informed care. All plans are reviewed and revised at least annually.
  - o All of JCC's members may access specialists directly. JCC's systems do not require referrals to access specialty appointments.

d. *Medicaid Assurance #4 – 42 CFR § 438.210 Coverage and authorization of services.*
- **Coverage** – JCC ensures that Covered Services rendered are sufficient in amount, duration or scope to achieve the purpose for which the services are rendered. JCC'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** – JCC does not place any limitations on family planning services. JCC's utilization management team assesses any other limitations placed on services based on:

- o regulations;
- o medical necessity; and/or
- o 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** – JCC 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** – JCC 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**. JCC 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**. JCC 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 JCC, 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 providers who 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.*
- JCC 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. JCC similarly adheres to privacy requirements described in 42 CFR part 2.

g. *Medicaid Assurance #7 – 42 CFR § 438.228 Grievance and Appeal systems.*
- JCC receives, processes, follows up, and reports on grievances and appeals in accordance with the requirements in the CCO Contract. JCC 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.*
- JCC 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.

- JCC 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.*
- JCC 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 JCC, 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 JCC 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 13 — Attestations

Applicant Name: _Jackson County CCO, LLC, d.b.a, Jackson Care Connect_

Authorizing Signature: _[signature]_

Printed Name: _Erin Fair Taylor, Chief Legal Officer/Secretary of JCC Board of Directors_

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.

[X] 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.

[X] 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?

[X] 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?

[X] Yes   [ ] No

If "no" please provide explanation: _____

_____

2. Have you reviewed the VBP reference documents linked to the VBP Questionnaire?

[X] 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?

[X] 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?

[X] 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.)

[X] 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?

[X] 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?

[X] 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?

[X] 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?

[X] 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?

[X] 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.

[X] 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.

[X] 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?

[X] 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?

[X] 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.

[X] 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?

X 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?

X 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?

X 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?

X 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?

X 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?

X 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?

$\boxed{\text{x}}$ Yes $\square$ No

If "no" please provide explanation:

e. Is Applicant willing to faithfully execute the finalized Health Equity Plan?

$\boxed{\text{X}}$ Yes $\square$ 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?

$\boxed{\text{X}}$ Yes $\square$ 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?

$\boxed{\text{X}}$ Yes $\square$ 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?

$\boxed{\text{X}}$ Yes $\square$ No

If "no" please provide explanation:

c. Is Applicant willing to fully implement the best practices developed in collaboration with the THW Commission?

$\boxed{\text{X}}$ Yes $\square$ 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?

$\boxed{\text{X}}$ Yes $\square$ 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?

$\boxtimes$ Yes $\quad \square$ 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?

$\boxtimes$ Yes $\quad \square$ 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?

$\boxtimes$ Yes $\quad \square$ No

If "no" please provide explanation: _____

_____

ee. Will Applicant ensure Members with SPMI are assessed to determine eligibility for ACT?

$\boxtimes$ Yes $\quad \square$ 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?

$\boxtimes$ Yes $\quad \square$ 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?

$\boxtimes$ Yes $\quad \square$ 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?

$\boxed{\text{X}}$ Yes $\quad \square$ 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)?

$\boxed{\text{X}}$ Yes $\quad \square$ 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?

$\boxed{\text{X}}$ Yes $\quad \square$ 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?

$\boxed{\text{X}}$ Yes $\quad \square$ 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?

$\boxed{\text{X}}$ Yes $\quad \square$ 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?

$\boxed{\text{X}}$ Yes $\quad \square$ 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?

[X] 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?

[X] 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?

[X] 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?

[X] 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?

[X] 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%?

$\boxed{\text{X}}$ Yes $\square$ 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?

$\boxed{\text{X}}$ Yes $\square$ No

If "no" please provide explanation: _____

e. Will Applicant maintain the required restricted reserve account per Contract?

$\boxed{\text{X}}$ Yes $\square$ 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?

$\boxed{\text{X}}$ Yes $\square$ No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to engage in activities to improve the quality and accuracy of Encounter Data submissions?

$\boxed{\text{X}}$ Yes $\square$ 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?

$\boxed{\text{X}}$ Yes $\square$ No

If "no" please provide explanation: _____

_____

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?
Jackson Care Connect (JCC) is an integrated CCO, meaning that JCC will directly contract with all its physical health and behavioral health providers and a portion of its dental providers. No behavioral health risk or benefit management will be delegated separately from the physical health risk. When dental benefits are delegated, it will be done with the strategic and operational intent to minimize impact or disruption to the member, while securing adequate access to a broad range of providers in a variety of settings.

Members will be able to access behavioral health services from an open network, with no wrong door and no prior authorization, for a comprehensive assessment of, and response to, their needs. 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. Dental services are available to all members and coordinated at the CCO level with support from dental providers and partners. The goal is to offer dental services and engage members with the strategic and operational intent to minimize any confusion or disruption for the member and to secure adequate access to a broad range of providers in a variety of settings.

When a member is seeking services of any kind, they will be able to contact the JCC member services number for assistance with their physical, behavioral, and oral health needs. This includes access to care coordination, grievances, appeals, translation support, etc. Members will be truly served by one entity, Jackson Care Connect, for their full 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?
Since January 1, 2017, JCC has successfully managed a fully integrated behavioral and physical health benefit with no delegation of risk or benefit management to another entity. This allows for one Global Budget, with focus on an overall or combined medical benefit ratio. While JCC tracks and will track the revenue received by its designated category (*e.g.* physical, mental health, substance use disorders), there is a commitment by JCC's Finance Committee to ensure that actual funding of services is not driven by this allocation, but by the health needs of our members. We believe that by funding access to behavioral health and substance abuse services in accordance with our members' needs we will improve our population's health and decrease unnecessary emergency room utilization and hospitalization.

The integration of the Global Budget will not only allow us to better serve our members, 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 greater detail throughout this section and overall in JCC's response to 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?

JCC 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 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 JCC is not in conflict with the parity regulations. In addition, our Network Adequacy Committee is combined for physical and behavioral health, ensuring that standards are aligned and providers are treated consistently.

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?

JCC has robust tracking and monitoring systems in place that will be used to ensure members have access to high quality and timely behavioral health services. JCC will require providers to report on access monthly. This information, along with waitlist data, member complaints and penetration rates[1] will be reviewed by the JCC's Behavioral Health Network, Quality and Compliance Committee on a monthly basis 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 need a substance use or mental health intervention are identified and linked to the most appropriate intervention. JCC firmly believes that access to needed behavioral health treatment will improve health and reduce overall medical expenses. When capacity is limited, the Committee will review applications for additional providers and offer contracts to add needed capacity.

As stated earlier, there will be no cap or separate standalone budget for behavioral health services. Behavioral health services will be funded based on current utilization and prevalence targets, limited by JCC's overall budget and medical benefit ratio, not by a discrete behavioral health medical benefit ratio. When overall funding becomes a limiting factor, JCC will first look for interventions 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?

JCC will support an integrated, team-based model of behavioral health services in primary care. We will offer an alternative payment model to clinics that can demonstrate Tier 3 patient centered primary care home (PCPCH) certification and an integrated behavioral health consultant. Funding for both integrated and co-located behavioral health services in primary care will come from the

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[1] JCC has set penetration rate targets for both mental health and substance use disorder treatment based on national prevalence data.

global budget and require the clinics to have only one, integrated contract. This will include internal medicine, family practice and pediatric primary care, as well as school-based health centers. JCC will use a payment model for its PCPCH clinics that requires integrated behavioral health services in order to receive the enhanced alternative payments.

In addition, JCC will support physical health services that are integrated into specialty behavioral health settings through the same single contracting process. JCC will work with its largest provider of specialty behavioral health services for adults, ColumbiaCare Services, to integrate primary care, pharmacy, and dental into its main clinic in Medford. These services will be reimbursed through one single contract and funding stream to support innovation and the spread of value-based payment models.

JCC is currently funding a handful of integrated care pilots across the network that will inform future contracting and funding opportunities:

- JCC provides an alternative payment model to support the Birch Grove Collaborative, a primary care clinic targeting members with mental health and substance use disorders that provides integrated and co-located behavioral health services. Birch Grove has on site access to assessments and substance use disorder treatment, and we are seeing a lower utilization of ED and inpatient services by this clinic than for the average clinic without a high prevalence of MH and SUD in the panel.

- JCC funds an embedded case manager from ColumbiaCare Services, a large provider for adults with a mental illness, in the Birch Grove Clinic at La Clinica, where there is a large number of shared members. The case manager attends medical appointments and facilitates communication between the medical and mental health providers to improve care. The case manager can also facilitate a warm handoff to ColumbiaCare for members who are not yet engaged in mental health treatment. We believe this is reducing utilization of medical and ED services for this population and are currently in the process of analyzing the data. In addition, the project has had an unintended benefit of improving provider experience. Having an embedded behavioral health case manager is showing signs of reducing provider burnout by improving job satisfaction and sense of effectiveness, as the case manager is a conduit to SDOH-HE resources such as housing, food, public benefits, and transportation.

- JCC is supporting the Oasis Center, a program located with Addictions Recovery Center, that provides integrated treatment and coordination of care for women with substance use disorders who have children in the child welfare system. JCC will support innovation and developing new models of care through pilot funding, alternative payments, and technical assistance. This intervention can improve outcomes for children. It addresses ACEs and promotes trauma informed care and resiliency. It is designed to enhance protective factors (*e.g.*, positive parent-child interaction and parenting behavior) and reduce risk factors (*e.g.*, hostile, negative, or overreactive parenting) and prevent later disruptive behavior disorders in children and adolescents, which shows that the risks to children of women with substance abuse issues could be minimized with intervention. If this intervention for mothers with substance abuse issues is successful in improving parenting outcomes, it may reduce costs (in terms of foster care placement, emergency room visits, medical and psychiatric admissions, child treatment, crime, etc.) and enhance healthcare and social service delivery.

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, JCC will manage the behavioral health benefit for its members in Jackson County. JCC will not delegate the management of the behavioral health benefit to a third party. JCC will directly contract with a host of community-based mental health and addictions organizations to ensure we will be able to provide the services offered under the behavioral health benefit. JCC already has contracts in place in Jackson County that will provide most of the services, including: all levels of community-based services for children and adults; supported housing; respite for youth and adults; subacute, psychiatric residential treatment; substance use disorder residential and withdrawal management treatment; and a variety of specialty programs. We have contracts with statewide resources for those services that are not available locally.

JCC also has a robust care coordination program that will work with members to ensure they have access to services and to remove barriers to entry or authorization as needed. In addition, this care coordination team will do 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 get those needs met. (See more under the care coordination section 11.E.3.)

When transportation is a barrier, JCC 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.

11.A.7. How will Applicant ensure timely access to all Behavioral Health services for all Members?

JCC has tracking and monitoring systems in place that will ensure members have access to high quality, timely behavioral health services. JCC will require providers to report on access monthly 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 Network, Quality and Compliance Committee will review applications for additional providers and offers contracts to add needed capacity.

JCC has also invested in national expert consultation and technical assistance for our two largest outpatient mental health providers to move toward centralized scheduling and 100% same day access. This investment has paid off in improved services. Both providers now have 100% same day access to routine outpatient mental health services and will continue this same day access into the future. During 2019, JCC is offering the same consultation and technical support to our two largest providers of substance use treatment with the expectation of moving them to 100% same day access and removing wait time for critical services.

Internally, JCC tracks and monitors turnaround times for prior authorization and concurrently 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.

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?

JCC's care coordination and utilization management teams will work closely together to ensure that members have access to out-of-area services. JCC'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. Because JCC is supported by CareOregon, which has contracts with providers statewide, there is typically no barrier to getting members served out-of-area. In the event an existing contract is not in place, JCC will either work with the provider as a non-participating provider or develop a single case agreement to ensure payment. The care coordination team will stay involved to ensure that when a member returns to the community there are services in place to support a safe and successful transition.

When members are already out of the area before being identified as needing services, JCC 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.

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?

JCC will work closely with the primary care, oral health, and behavioral health networks to support comprehensive screening using evidence-based screening tools. We 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 will ensure that our primary care providers routinely use screening tools such as the PHQ 9, SBIRT, and oral health risk assessment. These tools are supported in several ways: through billing codes to provide reimbursement; through the CCO incentive funding; 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.

The dental network routinely screens and will continue to screen for blood pressure in addition to dental caries and periodontal disease. Some JCC providers recently piloted One Key Question and SBIRT in the dental setting; we will evaluate pilot results to determine potential for broader implementation. Diabetes screening, including HbA1c, will also be developed and implemented in the dental setting.

In JCC'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. Our two largest mental health providers, for youth and adults, are now piloting embedded case management in primary care clinics to ensure strong coordination of care for members with co-occurring medical and behavioral health disorders. This will be expanded to four clinics by 2020 and then evaluated for expansion to additional providers.

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?

JCC has a strong relationship with Jackson County Mental Health (JCMH), the Local Mental Health Authority/Community Mental Health Program. We will fund the crisis program in proportion to our CCO membership in order to ensure a robust and sustainable safety net for Jackson County. Our contract with Jackson County Mental Health (JCMH) will ensure compliance with the Oregon

Performance Plan and Oregon Health Authority requirements for telephonic, walk-in, and mobile crisis services.

JCMH 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. JCMH 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.

JCC is currently working closely with JCMH to develop a work plan to address the findings from a sequential intercept mapping activity; the plan will include alternatives to arrest and avoidance of incarceration which will be implemented over the next year. It will be presented to the Local Public Safety Coordinating Committee in April of 2019 and then workgroups established for each priority area. JCC is part of a community-wide effort involving all sectors of the system of care to reduce utilization of jail for adults with a behavioral health disorder.

11.A.11. Describe how Applicant will utilize Peers in the Behavioral Health system.

JCC 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 Wraparound program includes youth and family peer support. Both of our large mental health providers for youth and adults have peer support specialists as part of the treatment team. In these settings, the peers are part of a multi-disciplinary treatment team and have a peer as their integrated supervisor.

JCC will continue to fund a clubhouse model of peer support, Compass House, which serves over 400 of our members with severe and persistent mental illness (SPMI) per year. This is a low-barrier opportunity for members to access support as often as daily, with integrated educational and employment services, transportation, skill building and social support.

In the substance use disorder treatment network, JCC will support and fund recovery mentors to work with members prior to treatment, during treatment and into recovery. JCC is currently working with the Addictions Recovery Center to develop a funding model that will support pre-treatment outreach and engagement using recovery mentors. JCC is also working with a large group of community stakeholders and OHA to develop and implement a peer support component for low-barrier access to medication assisted treatment in Emergency Departments, hospitals and bridge clinics. Bridge clinics are a low barrier access point for someone ready and willing to begin buprenorphine and other medication assisted treatment (MAT) for opioid use disorder, without the traditional work-up and wait times. In Jackson County, the bridge clinic is co-located with the syringe exchange program as an attempt to meet people where they are and where they might be willing to get started on MAT (in other communities, this may be located in an ER, urgent care, primary care, specialty care, or similar location).

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

JCC has developed robust partnerships with various community organizations to support the SDOH-HE needs of our members. This work is funded through various streams, including quality pool earnings, community benefit funds, and gain share funds available for reinvestment into the community. One of the largest areas of identified need in the Jackson County community is housing.

Lack of housing has been a barrier to success in treatment, reunification of children with their families, and sustained recovery from behavioral health disorders.

JCC currently supports Rogue Retreat, a non-profit offering short and long-term transitional housing for members discharging from substance use disorder residential treatment, including women with children. JCC will strengthen this partnership through enhanced funding because the outcome data clearly reveals cost-savings and successful recovery for members in these programs.

Other programs JCC will support financially or through technical assistance include:
- Scholarships to cover membership fees to Rogue Valley YMCA and Ashland YMCA.
- Peer support wellness programs at Rogue Valley YMCA, using a group center model that focuses on supporting members through social connection in achieving a healthy weight, eating for their health, and moving more. Over 50% of members engaged in the wellness program have a severe and persistent mental illness (SPMI) diagnosis.
- Peer-run drop-in center that is based on the Clubhouse model used at Compass House. The drop-in center also includes peer mentors meeting members in the emergency department and inpatient unit to make a connection.
- Transportation through Non-Emergent Medical Transportation (NEMT) to non-medical appointments and supports such as NA/AA and Compass House.
- 10 beds of short- and medium-term transitional housing through ColumbiaCare Services for adults with mental illness or substance use disorders as part of the overall continuum of services and supports.
- The Maslow Project, which provides social connections, case management, and resources for homeless youth.
- 15 Rental Assistance Program (RAP) Beds for transition age youth and Veterans with OHP thorough ColumbiaCare. RAP helps reduce barriers by subsidizing rent, helping with move-in costs, and accessing other housing resources through the on-site resource coordinators.
- Swing Lane supportive housing program, also through CCS, provides five (5) permanent housing units for members with SPMI who are need of intensive treatment to support housing stability.

11.B. Billing System and Policy Barriers to Integration (recommended page limit 2 pages)
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.
JCC is proud of the work that has been 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 SAMSHA. 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 Behavioral Health Innovation Specialist (BHIS) who provides technical assistance and support to improve 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.

JCC 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 authorization. JCC will use a newly developed pathway (expected completion by June 2019) in primary care for psychological testing to evaluate for autism spectrum disorder without a prior authorization; this will remove barriers to access services such as applied behavioral analysis.

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?
JCC 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, JCC will pay an enhanced rate for services provided outside of the provider office to account for travel time.

JCC will routinely review claims data 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. JCC will also review member grievances and complaints to ensure that availability of and access to in-home care is not 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.
JCC has multiple methods of ensuring and participating in discharge planning, based on the level of care the member is currently receiving or trying to access.

In higher levels of care, in which JCC is engaged in authorization or concurrent review, JCC'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 JCC's Care Coordination 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.

In lower levels of care, JCC will hold providers responsible for their role in discharge planning through their Provider Agreements. JCC will evaluate adherence to this requirement during the compliance monitoring reviews. When an issue is identified, JCC will work with its provider community to develop a solution. For example, in outpatient treatment, JCC became aware during routine monitoring that discharge criteria were not clear in member treatment plans. As a result, JCC provided 21 hours of training to the entire provider network on documentation and service plan development, with an emphasis on measurable goals and discharge criteria in which the member and/or the member's family are fully involved.

Lastly, we contract with Mercy Flights (our local nonprofit paramedicine organization) to conduct a Transitions program for high risk members. Mercy Flights and JCC's care coordination team utilize PreManage as an alert when a high risk member is admitted to an inpatient setting. This alert triggers an automatic referral to Mercy Flights' Transitions Program and they conduct an initial visit with the member prior to discharge. JCC and Mercy Flights are building disease specific protocols that include behavioral health diagnoses and Mercy Flights staff are actively managing all conditions during members enrollment.

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.
JCC's primary objective is to ensure members with both Medicare and Medicaid get the behavioral health services they need. We will ask our contracted providers to first bill Medicare for those services covered by Medicare. To ensure providers will offer services to our members, JCC 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 JCC as the secondary payer.

JCC will work closely with Jackson County Mental Health (JCMH), the main provider for Medicare-eligible individuals, to ensure continuity for members who gain and lose secondary OHP eligibility. JCC will also work closely with ColumbiaCare Services, which is the main contracted provider for adults with mental illness and a certified Medicare provider.

 JCC's parent company CareOregon has a Medicare Advantage plan and will provide seamless, integrated care and billing for our dual eligible members.

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.
11.C. 1. Describe how Applicant plans to develop a comprehensive Behavioral Health plan for Applicant's Service Area. Please include dates, milestones, and Community partners.
JCC has partnered with Jackson County Mental Health (JCMH), the local Community Mental Health Program, in a variety of areas over the past six years to guide the development of the local system of care. Examples include:
- JCC and JCMH worked together as members of the Jefferson Regional Health Alliance to develop several phases of behavioral health services mapping and needs assessments.
- JCC participated in the sequential intercept mapping project to identify areas for intervention with members touching law enforcement and criminal justice.
- JCC co-funded a needs analysis of the current behavioral health system capacity in 2016, in partnership with JCMH.
- As the delegated authority of the mental health benefit for JCC for the first 4 years of the CCO, JCMH and JCC worked to develop infrastructure and oversight of the mental health system, growing capacity through the creation of a provider network and specialty services to serve the JCC membership.
- We developed a quality assurance structure and worked towards development of alternative payment structures to incentivize providers to serve the JCC population which has been

more complex and challenging than other CCOs due to the high number of SPMI members in their CCO.

- JCC in partnership with JCMH has worked to develop a level of specialty for populations needing additional supports and treatments such as LGBTQI training, DBT supports, Motivational Interviewing training and ongoing trainings aimed at creating stronger clinical basis for treating providers.

- JCC worked with JCMH in the creation of the Compass House, the first accredited Clubhouse Model in the state of Oregon to serve their members and the community at large with mental health issues providing opportunities for education, employment, and social connectedness outside of treatment.

- JCC funded the crisis system and mental health court at JCMH.

JCC has also partnered closely with Jackson County Public Health as the Local Public Health Authority and will continue to do so. Examples of areas where we intend to collaborate and integrate funding include:

1. Reimbursement of full cost for immunizations, reproductive health services, sexually transmitted infection services, and other communicable disease services.

2. Active coordination between Jackson County Public Health and JCC, where applicable, and financial support for the following programs:
   - Alcohol, tobacco, and other drug prevention programs
   - Sexually transmitted infection investigations
   - Tuberculosis
   - Nurse home visiting programs
   - Women Infants and Children (WIC) and Breast Feeding Peer Counseling
   - Syringe Exchange Program

JCC is working with JCMH to develop a comprehensive behavioral health plan for the County as part of our regional CHIP. This is a collaborative effort (describe in Attachment 10) with participation that includes JCMH, all anchor behavioral health providers, Jackson County Public Health, both FQHCs, both hospitals, JCC, and all other CCOs in region. JCC will provide data analysis in partnership with JCMH to inform strength and need areas not only for treatment services, but also for housing, social determinants of health, food, etc. JCC intends to partner with JCMH to identify solutions and create strategies to remove barriers and improve the system of care and outcomes for our members. We are specifically focused on expanding the capacity of services targeted to the forensic and criminal justice involved populations.

JCC and JCMH began collecting data for the CHA in 2018 and will have the CHP complete in 2019. All participants have agreed on the following 3 priorities for our collaborative CHIP:
- Behavioral Health (mental health and substance use)
- Housing
- Parenting Support and Life Skills

JCMH is providing leadership to the Behavioral Health and Wellness Work Group of the CHIP. As the co-chair of this workgroup, the JCMH Division Manager is working to ensure this will become

the community guide for behavioral health. The County will augment the CHIP with a Biennial Implementation Plan that is specific to the LMHA roles and responsibilities.

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.
JCC has a history of collaboration with Jackson County Mental Health (the LMHA) and the Jackson County Public Health Department to develop the Community Health Plan (CHP). We jointly participate in the Community Health Needs Assessment (CHNA) process, led by Jefferson Regional Health Association, which informs the CHP. JCC and Jackson County Health & Human Services (HHS) both recognize the importance of a thorough CHNA process to inform where our collective and limited resources should be allocated and prioritized. To that end we work closely with Jackson County HHS to develop a CHP that is reflective of the community's needs and priorities.

The CHNA continues to be a robust process conducted in partnership. We just completed a regional CHNA in 2019 that will be utilized by Jackson County HHS (including the Local Mental Health Authority and the Public Health Department) and we are now partnering to create a collaborative, community CHP. Jackson County Public Health is providing an epidemiologist to lead the collaborative CHP process and JCC is leading several of the workgroups. Our close collaboration to date has been instrumental in gaining broad commitment to this collaborative CHIP. The top 3 priorities for our regional CHP are: (1) Behavioral Health, (2) Housing, and (3) Parenting Support and Life Skills. JCMH is the co-chair of the Behavioral Health and Wellness Work Group for the CHIP. We will meet the following timelines for completion and adoption of a regional CHP.

When	What	Who
April 2019	Complete selection of goals Select final outcome measures and strategies Continue refining draft CHIP document	Core Team, Steering Committee, Workgroups
May 2019	Complete initial draft of CHIP document Review draft document	Core Team, Steering Committee
June 2019	CHIP document finalized and adopted	Core Team, Steering Committee
July - December 2019	Develop implementation and action plans Establish schedule and process for CHIP monitoring	Core Team, Steering Committee

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.
JCC recognizes the important role of the Local Mental Health Authority in the oversight of the safety net and community behavioral health system of care. The LMHA is responsible for creating a biennial local plan encompassing prevention activities, an array of treatment services, recovery supports to maintain a behavioral health safety net, and strategies to address health disparities for children, youth, adults and older adults. We see this as a subset of the larger initiatives that come to form the community health improvement plan and will participate with JCMH to ensure we are supporting the overall process.

Our goal is to ensure any plan developed is closely aligned with other plans to ensure minimal duplication of effort and the broadest scope possible. For this to be successful, the plan will complement efforts already underway with the current Community Health Improvement Plan and

existing strategic plans. In addition, we understand that the LMHA will be building on the CHIP to guide its Biennial Implementation Plan (BIP) in 2020.

JCC and JCMH have both signed agreements to participate in the CHIP development. And JCMH intends to have the CHIP serve as its guidance for the Behavioral Health Plan (of Biennial Improvement Plan/BIP). As part of this process, JCMH has analyzed data, held focus groups and solicited input from community stakeholders and community members. This information is all informing both the CHIP and the local plan. JCC and JCMH will continue to meet regularly to collaborate and coordinate to identify service needs, strategies to fund and support, and efforts to operationalize care coordination and access to services.

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.
No.

11.D. Provision of Covered Services (recommended page limit 6 pages)
11.D.1. Please provide a report on the Behavioral Health needs in Applicant's Service Area.
JCC has seen an increase in penetration rate for mental health services since integrating the benefit in 2017. As shown in the table below, after adding capacity for mental health services and increased same day access, our penetration rate increased from 12.2% to 17.3% just in specialty mental health. When including services provided in primary care, the rate has gone from 18.6% to 23.2%, using the OHA definition of penetration. This clearly indicates a pent-up demand for unmet needs that is now being addressed in the expanded network.

Year	Unique Members Served in Specialty MH Services	Unique Members Served in Specialty MH and in Integrated BH in Primary care
2016	3716	5684
2017	4618	6484
2018	5359	7185

JCC also tracks mental health penetration by age and ethnicity. In the age 0-5 population, we have seen a smaller increase in utilization of services, from 6.1% in 2016 to 7.5% in 2018. JCC will 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 Family Nurturing Center, Head Start, etc.

In terms of race and ethnicity, it is notable that for the Hispanic/Latino population the utilization rate is only 10.8% in 2019, compared to the overall population utilization rate of 23.2%. However, close to 20% of members do not provide race/ethnicity information.

JCC has seen a much slower growth rate in penetration of treatment for substance use disorders. We believe this was because one of the largest providers of treatment in the community had to close to new referrals for close to a year. Given that barrier and the fact that the rate did not decline, now that the provider is again accepting referrals we expect to see a significant increase in utilization of services.

Year	Unique Members Served in Specialty SUD Services	Unique Members Served in Specialty SUD and in Integrated BH in Primary Care
2016	1878	2246
2017	1907	2315
2018	1938	2432

JCC's overall penetration rate for specialty SUD treatment only is currently 6.3%; when including services provided in primary care, it is 7.9%. Based on a national review of data, we believe the prevalence to be closer to 12% and have set a target of increasing our penetration to 10% during 2019. We do not yet have the SUD penetration data broken out by age and ethnicity, but we will generate this data in 2019.

We also know that only 30% of members who access detox or withdrawal management services also have a follow up treatment appointment within 15 days. One of the largest barriers to continuation of treatment is housing and we are actively working to expand access to transitional housing for members in SUD treatment. We have set a target of increasing this number to 60% during 2019 for those members leaving detox who have an opioid use disorder.

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.
JCC 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 age group and 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.

JCC defines engagement as having a second appointment within 15 days of the assessment and retention as having 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 for youth 0-18 was 75% and the average rate of retention was 55%. For adults 18 and older, the average rate of engagement was 68% and the average rate of retention was 45%.

We are actively working with the network to set improvement targets, 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?
JCC participates on the Southern Oregon Success (SORS) Steering Committee, a leadership group focused on collective impact on early childhood and student success initiatives, trauma informed

communities, and other jointly-identified community efforts. This committee includes leadership from Southern Oregon University, Rogue Community College, and WorkSource Oregon, the workforce development and vocational rehabilitation organization. This is a venue to address challenges, such as developing the clinical workforce for the behavioral health system and create shared solutions. JCC will identify workforce as a SORS issue in 2020 and develop an action plan with our collective impact partners.

11.D.4. What is Applicant's strategy to ensure workforce capacity meets the needs of Applicant's Members and Potential Members?
JCC is committed to maintaining high 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, JCC has and will employ 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 in order 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.

11.D.5. What strategies does Applicant plan to use to support the workforce pipeline in Applicant's area?
A primarily workforce pipeline need in the JCC area is for traditional health workers (THW). There is a growing reliance on THW to serve our members and maximize the capacity of clinical providers. JCC staff will continue to provide THW training for Rogue Community College. We have created pathways to employment for newly certified THWs and will recruit into the program through community relationships and partnerships with community based organizations.

To further support the workforce pipeline, JCC has several contracted providers that provide education to bachelors and masters level students at Southern Oregon University in the field of substance use disorders and clinical social work. We then support these students in internships throughout our provider network by allowing payment for services provided by registered interns.

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?
JCC is excited to develop monthly and quarterly reporting for our SPMI member population to enhance the quality and capacity 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. JCC will work directly with our providers and the housing authority to create targeted housing where gaps are identified.

- Review data on readmission to EDs, inpatient units, 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 readmission, such as system gaps, lack of timely access, lack of guardianship, etc., in order to develop targeted system improvements.
- JCC is already reviewing data on members who readmit to psychiatric inpatient care in order 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.

JCC 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?
JCC does not have Tribal facilities in our service area and under 1% of our membership are Tribal members. Regardless, we prioritize access to culturally relevant and high quality services for all of our members and are proud to build from the Tribal relationships developed at CareOregon. For several years, CareOregon has actively built a 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 service to that partnership, we have ongoing training in expanding 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. In addition, our parent organization CareOregon has reached out to all nine (9) Federally recognized Tribal Health Centers throughout the state and engaged clinic staff to better understand and partner on Tribal member needs and care coordination staff have visited seven (7) of the Tribal Health Centers. CareOregon also holds weekly calls with Tribal Leaders to share about the barriers that exist for Tribal members in both rural and urban areas in the state.

Further, JCC through care coordination and improving access to services has worked and will continue to work to improve the specific care that Tribal members experience. Throughout the state and in the Jackson County 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 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 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. 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.

11.E. Covered Services Components (recommended page limit 36 pages)
11.E.1. Substance Use Disorder (recommended page limit 2 pages)
How will Applicant support efforts to address opioid use disorder and dependency? This includes:
E.1.a. How will Applicant provide, in a culturally responsive and linguistically appropriate manner, SUD services to Members, including outpatient, intensive outpatient, residential, detoxification and MAT services?
JCC is committed to providing SUD services in a culturally responsive and linguistically appropriate manner. Both of our large SUD providers have bilingual staff who are direct service providers. JCC also contracts with two language service providers, Passport to Languages and Linguava, for the benefit of members. Linguava will partner with contracted agencies and create an agency-specific language access plan for members. We also employ an equity and inclusion coordinator at JCC who works with our network providers to spread best practices and educating about equity, diversity, and inclusion.

We contract and will continue to contract with a network of substance use disorder treatment providers, both locally and across the state to ensure timely access to the full continuum of services. Within the Jackson County service area, we will contract for the following services:

- Youth and adult outpatient services, including intensive outpatient services and a specific outpatient program through On Track that is offered in Spanish for our Spanish speaking members.
- Residential services for adult men, adult women, fathers with children, and mothers with children. We recently funded a program expansion for 12 additional beds at the Addiction Recovery Center.
- Withdrawal management/detox services provided by Fresh Start Detox and by other providers for members who choose to access programs in other parts of the state.
- Utilization and expansion of Medication Assisted Treatment (MAT) through contracts with various providers of this service. We will contract with Opioid Treatment Program, Allied, and offer MAT within specialty SUD treatment and in primary care. More information on this is included in the following question.

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?
JCC believes that prevention cannot effectively be done alone and will seek to support and leverage the collaborative effort of multiple agencies working together. For example, we participate in the local public health authority's *Jackson County Prevention Coalition*. This Coalition collaborates with schools, non-profits, and other community organizations to effectively reach youth to prevent alcohol, tobacco and drug use and abuse. http://jacksoncountyor.org/hhs/Public-Health/Health-Promotions/Alcohol-Tobacco-Other-Drugs. Jackson County Public Health provides a wide range of prevention and education information and JCC refers members to them.

JCC will provide universal prevention and education services to all members via our member handbook. The handbook is written in both English and Spanish and in 6th grade language.

Members can access the handbook online, via the JCC website; it is also available in printed copy upon request. The handbook currently provides information explaining that alcohol and drug treatment is a covered service. JCC will update the handbook to provide specific information about common warning signs and resources for support. Information will be formatted similar to that currently used for the suicide prevention section of the handbook: http://www.jacksoncareconnect.org/docs/default-source/default-document-library/jcc-handbook_en-2014.pdf?sfvrsn=18.

JCC also provides direct prevention and education services that are culturally and linguistically appropriate. All providers have prevention and education materials available and work directly with members in these areas. JCC has one outpatient substance use disorder treatment provider who operates a bilingual program in Spanish, including educational services.

JCC is committed to providing prevention and education services in a culturally responsive and linguistically appropriate manner. Bilingual services are readily available in both English and Spanish. In the event that a member seeks services from a provider that does not have bilingual staff, JCC contracts with Linguava, a comprehensive interpretation service. Linguava can provide interpreters for all languages, including Chinese, Japanese, and Russian. JCC's equity and inclusion coordinator will work with our network providers to spread best practices and educating about equity, diversity, and inclusion when providing education, prevention and other services.

In addition, specifically for tobacco, JCC provides information on Quit for Life, which provides telephonic counseling and referral services. Contact information for Quit for Life is included in the member handbook.

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?
Information about benefits and services will be available to members and referenced in the Member Handbook and the Member Presentation Folder. Both are available in Spanish. As described above, JCC contracts for on-demand interpreter services which all members can request and access.

To further support culturally responsive and linguistically appropriate information dissemination about SUD services, JCC will share this information in our regular meetings with BH network providers. This space is a forum for JCC to provide updates and to educate the network on topics such as equity, diversity, and inclusion (EDI). JCC will dedicate at least one of the six (6) annual provider meetings to EDI as a way of supporting the network in their efforts to serve our members and will leverage our equity and inclusion coordinator for network training.

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.
JCC, in partnership with its Clinical Advisory Panel (CAP), has prioritized the issue of opioid use disorders as a clinical priority for 2019 and into the future. The CAP will be chartering a subgroup to develop specific network strategies and targets, such as engagement in MAT and capacity of prescribers.

To ensure success with the above, JCC has a robust training and support program for primary care providers. Our Innovation Specialists will provide technical assistance and training through on-site coaching and learning collaboratives. One of their priority topic areas for training will be the identification and treatment of Opioid Use Disorder (OUD) and opiate prescribing. The Specialists will share best practices such as using the PDMP and designing workflows and systems to support best practices, including induction and stabilization of medication to treat OUD.

In addition, JCC will create monthly dashboards for each clinic that summarize opioid prescribing and co-prescribing of naloxone. JCC will use our Clinical Advisory Panel to set and monitor targets; the Panel will also champion this important work.

JCC will also continue the current initiatives underway for members with co-occurring SPMI. JCC allows the current psychiatrist working with our ACT team, to prescribe Vivitrol without any prior authorization to remove barriers to addressing opioid use disorders among that population. We are also working with ColumbiaCare Services to develop internal capacity to prescribe medication for co-occurring opioid use disorders.

11.E.1.e. Coordinate with Providers to have as many eligible Providers as possible be DATA Waived so they can prescribe MAT drugs.
JCC will support several venues for providers to learn about the data waiver process and will continue to sponsor data waiver trainings. JCC will host 1-2 data waiver trainings in 2019 and will provide additional trainings in 2020, if the demand continues to exist. To assess capacity, we will track the total number of waivered providers, the amounts on their current waivers, and the number of members for whom they are prescribing MAT drugs.

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.
In 2018, JCC convened a community-wide stakeholder group to build an integrated system of care focused on members with OUD. As a result, we developed the Pathways to Substance Abuse Disorder Treatment committee, which ensures that members have warm handoffs from any point in the community where they initiate MAT (inpatient medical, emergency department, bridge clinic, etc.) to an ongoing treatment provider. This committee includes representation from SUD providers, data-waivered primary care physician champions, emergency departments, community paramedics, MH providers, OTP programs, hospitals, public health, community paramedicine, and peer support providers.

In 2020, the Pathways to Substance Use Disorder Treatment committee will continue its previous work and launch a new addiction consult service providing MAT on the inpatient unit, with peer and social work support to assist in engagement and discharge planning.

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**

In addition to the initiatives described above, JCC will work closely with Jackson County Public Health to track overdose and overdose related deaths, which spiked in 2018 due to an infusion of fentanyl into Jackson County. JCC will track community utilization of naloxone for rescues and work with our pharmacy benefit management team to ensure low barrier access to naloxone for members.

The Pathways to Substance Use Disorder Treatment committee will continue to actively work on care coordination pathways between levels of care, integrated within the addiction consult model and our community paramedicine work. To assess interventions, every month JCC tracks penetration of SUD treatment, as well as initiation and engagement in treatment. We will use set baseline and improvement targets and will regularly share this information with our SUD provider network.

By working closely with internal data analysis teams, JCC has developed and employed a MAT Gap analysis tool which increases our ability to identify at the member and clinic level those members who are diagnosed with an OUD, and of those, who has initiated MAT treatment and their level of engagement. We utilize the Medication Possession Ratio (MPR) which is the days on MAT/the total days in MAT Treatment episode to measure engagement. For 2019, we will focus on increasing the MAT high engagement as measured by MPR to greater than .75.

Lastly, we will continue to partner with Jackson County Public Health to support the needle exchange program as a harm reduction strategy and a first point of contact for referral to MAT services.

11.E.2. Fewer readmissions to the same or higher level of care. Prioritize Access for Pregnant Women and Children Ages Birth through Five Years (recommended 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.
11.E.2.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?
JCC will incentivize providers to perform periodic social-emotional screening for all children. The CCO incentive metric "Developmental Screening in the First 36 Months of Life" will ensure our provider partners are proactively screening all children using an approved screening tool, including the Ages and Stages Questionnaire (ASQ-3). To further encourage screening, JCC will review clinic progress monthly and share member gap lists with providers. In response, provider teams will conduct outreach to ensure all children receive developmental screening.

For children whose screening identifies developmental and behavioral concerns, JCC will provide follow up for the child and parent(s)/caregiver(s). Follow up will include referral to and coordination of resources for further screening, diagnosis, and as appropriate based on the diagnosis, early receipt of services with the goal of helping at-risk young children be ready for kindergarten.

In 2020, JCC will implement a project to improve receipt of services for young children identified as at-risk for developmental and behavioral delays. The project will be modeled on a similar effort in another Oregon CCO, which provided a large, 24-month grant to community partners. That project achieved positive outcomes that JCC will seek to replicate:

- The project supported the development, implementation, and evaluation of improved follow-up after developmental screening (ASQ), led by the local Early Learning Hub with support from the Oregon Pediatric Improvement Project (OPIP). The team identified current pathways from screening to services within the service region, existing community-level assets and resources that support follow-up, and gaps where children are falling out of pathways and not receiving appropriate services.
- County-level workgroups identified priority areas for follow up and early learning resources where improvement was needed. As a result, they developed community-specific triage referral system maps (pathways) and identified needed additional pathways to develop. 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 along with secondary referral and support strategies for children initially found ineligible for services. Referral pathways have built in feedback loops to improve communication and coordination.
- Provider sites received on-site training and support, and refinement to improvement tools based on lessons learned and barriers identified. The project also developed 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 also spread best practices and tools including the use of primary care innovation specialists and behavioral health innovation specialists to provide clinic training and support, and community-based maternal and child health-focused Community Health Workers (CHWs). All workers support closed-feedback-loop communication and coordination, along with secondary referral pathways.

By learning from the model project and implementing similar efforts, JCC will create additional structures and local knowledge that will ensure that periodic social-emotional screening for all children birth through five years is conducted in the primary care setting and improve access for pregnant women and young children to health services, developmental services, early intervention, targeted supportive services, and behavioral health treatment.

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?
At the overall member level, JCC will use the Pediatric Medical Complexity Algorithm tool among OHA/OPIP's pediatric health complexity data to identify adverse childhood experiences among our pediatric membership. OHA/OPIP data will then be integrated with JCC internal utilization data to identify resiliency and level of complexity prior to clinic or member outreach/intervention.

JCC will work to identify clinics appropriate to implement screening tools for ACEs. JCC will also work with the Southern Oregon Success (SORS) collective impact community collaborative which is focused on ACEs, resilience, and trauma informed care to further identify screening tools, ways of assessing for resiliency and ways of evaluating the use of screenings in service and support plans, and then to spread best practices in these areas.

For primary care, in 2019, JCC will focus our pediatric APM on incentivizing participation in:
- Developing appropriate screening tools to identify social and medical complexities.

- Integrative behavioral health target measures include screening for ACEs and follow-up (specific focus on children ages 0-3 years).

In 2020, the JCC Pediatric APM will focus on demonstrating population-level segmentation and targeted interventions to improve services and supports resulting in the triple aim.

Through available technical assistance from OHA for OPIP's pediatric health complexity data, JCC will identify appropriate screening tools to identify ACEs, assess for resiliency, and evaluate use of screenings to improve services and supports.

For example, the ASQ-SE can be a proxy for further follow up and examination of contextual factors (like ACEs) in the family system that may be impacting development. JCC is developing (2019) and will use ongoing assessment of ASQ follow-up with OPIP and pathways, screening tools and an implementation toolkit to improve on multiple aspects of care.

Although many providers screen for resilience and family supports, they do not identify it through the lens of trauma-informed care. JCC will use the training opportunity around ACEs and Resiliency to highlight and build on existing provider screening practices during well-child checks with the goal of further promoting trauma-informed care.

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?

JCC will support clinics in following the American College of Obstetrician and Gynecologists (ACOG)'s recommendation that all obstetricians and gynecologists complete screenings related to mood, emotional well-being, and behavioral health needs, perinatal and postpartum. To do this, JCC will provide a new staff position 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 JCC has had for several years and will provide on-site technical assistance and support to providers. Because this new position is focused specifically on maternal-child health, it 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.

JCC will also encourage members to access care and thus participate in screenings. We will do this through the *Starting Strong* program which incentivizes members in accessing prenatal and postpartum care by giving them credits toward supplies such as car seats, diapers, etc.

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?

JCC 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.

JCC will also engage community-based organization and clinics with a goal of developing relationships with organizations/clinics that can support members of all backgrounds, languages,

races, ethnicities, and needs. JCC will use these relationships to improve postpartum care engagement and follow-up for behavioral health related needs.

To ensure we are prepared to refer patients and to follow up for diagnosis and treatment, JCC is developing an obstetrics alternative payment model to support clinics that offer integrated behavioral health and specialty behavioral health. JCC is considering a value-based payment model incentivizing a metric for postpartum care screenings and follow-up/interventions. Further, current and future primary care APM includes integrated behavioral health to improve timely access to behavioral health services. We will also explore mechanisms to enhance workflows between specialty mental health and OB clinics.

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?
JCC currently contracts, and will continue to contract, with several organizations that provide dyadic treatment, including the Family Nurturing Center, Kairos, and Jackson County Mental 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.

JCC works closely with our local child welfare branches to ensure that youth in the child welfare system have access to these services, as well as families who are at risk of entering the system and have been identified through other areas such as self-sufficiency programs. 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)?
Through JCCs *Starting Strong Perinatal Incentive Program*, we partner closely with several local organizations that conduct in-home assessments, including the local Nurse Family Partnership, Healthy Families, Early Interventions, CaCoon, Babies First, Family Nurturing Center, Early Head Start, and WIC. All of these partner organizations conduct in-home assessments and offer supportive services, including vouchers for JCC's *Starting Strong* store.

JCC provides a wide variety of resources at our *Starting Strong* store. Members who come to the store are assessed for service needs and appropriate referrals are initiated. The organizations listed above offer incentive vouchers to JCC members (prenatal and children up to age 4) which can be exchanged at the store for diapers, wipes, car seats, cooking supplies, and other essential items. Our *Starting Strong* Specialist regularly intersects with program staff from the partnering organizations to maintain and strengthen these relationships.

In addition, JCC is performing Accountable Health Communities screening at the *Starting Strong* store and, through this process, connecting members to resources and initiating Navigation support.

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.
JCC has established a steering committee 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.

JCC is reviewing pediatric APM 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 being developed to support integration of obstetrics care with substance-use disorder treatment. Through this, JCC will use a payment model that supports integration of behavioral health, addressing social complexities (THW) and complex case management for pregnant women with substance use disorders.

JCC 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.

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. We have begun discussions on how to productively utilize trauma-informed trainings in a sustainable way. This will further support care for children 0-5, and their caregivers, who have 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?
JCC's goal is to keep children in their local communities whenever possible. By keeping children in their local communities, they are able to continue dyadic treatment with their parents or primary caregivers. We have contracts for day treatment and psychiatric residential treatment in the local community. 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.

In the rare circumstance where a youth is placed out of the community in a higher level of care, we will work with our Non-Emergent Medical Transport (NEMT) provider to ensure the family is able to attend regular visits and treatment appointments with their child. If that is not possible, our last resort is to use technology to support visits via video or telehealth. Again, this is a very rare occurrence as we have implemented contracts and partnerships so that youth can be served locally to the greatest extent possible.

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.
JCC will offer its staff and contracted providers annual training in trauma-informed approaches, practices, tools, and interventions that foster healing and promote resiliency for youth and their families. Heath plan staff will complete trauma-informed training upon hire, with annual follow-on training to include emphasis on the Neuroscience, Epigenetics, ACEs, and Resiliency (NEAR). JCC will expect that its contracted providers will include the same training in their annual required training plan for staff. Two of JCC's largest contracted providers, Kairos and ColumbiaCare have ACEs as a required training for their new employees. JCC will leverage SORS trainings on ACEs as

described below to ensure that our contracted providers have access throughout the year to training on ACEs, trauma informed approaches and practices, healing from trauma and creating resiliency. All training provided for both health plan staff and contractors will be evidenced-based.

In addition to the focus on specific providers above, JCC advocates for a community-wide training plan to promote and ensure trauma-informed practices and approaches, including those that promote healing from trauma and supporting resiliency. We support such trainings being available to our members, schools, social service agencies and community partners.

To achieve this, JCC will leverage its partnerships within Southern Oregon Success (SORS), a regional collective impact initiative partially funded by JCC, which has been tasked with creating a Learning Community where NEAR (Neuroscience, Epigenetics, ACEs, and Resiliency, as well as trauma-informed approaches) training and outreach takes place. Master trainers will offer NEAR science training and related practices, strategies, and activities, at the individual, organizational, and community level. Community trainings will be offered at least once per quarter and will be open to the public.

SORS is cross-sector and includes the following partners: DHS Child Welfare and Self Sufficiency, Juvenile Justice, Southern Oregon Educational School District, Medford School District, Phoenix-Talent School District, Allcare Health, Options for Southern Oregon, Kairos, Youth Move, Jackson County Mental Health, the Addictions Recovery Center, Southern Oregon Early Learning Services, I/DD, Local Law Enforcement, Rogue Community College, Southern Oregon University, Children's Advocacy Center, Maslow Project, Workforce Oregon, and Wrap.

In the coming year, SORS has set the following goals related to NEAR training:
- Develop and promote increased parent trainings in all interested school districts.
- Hold at least one "train the trainer" workshop for Family Cafés and promote a regular Family Café in interested school districts.
- Continue to offer ongoing-NEAR training across sectors, with at least one open community training every quarter in Jackson County.

In the remaining years, JCC, in partnership with SORS will:
- Continue to expand awareness of the impacts of toxic stress on development along with evidenced-based interventions. This will include awareness of ACEs, self-regulation, and resiliency trainings, with major focus on parent training.
- Introduce trauma informed practices across sectors, including Jackson County Community Justice, Southern Oregon Pediatrics, our CCOs, Rogue Workforce Partnership, Kairos, Options, DHS, OHA, and local law enforcement.
- Play a central role in the System of Care governance structure.
- Work with DHS to use a predictive analytics approach to help them focus on the most at-risk families, with the goal of reducing the number of youth in DHS custody.
- Focus on advocacy at the state level by being central agent in convening a southern Oregon regional legislative delegation with steering committee to set a southern Oregon legal agenda for the 2021 legislative session and beyond.

References:

SORS:
http://www.southernoregonsuccess.org/about-us/aces-and-the-self-healing-communities-initiative/

ACE Interface:
http://www.aceinterface.com/

Robert Wood Johnson Self-Healing Communities:
https://www.rwjf.org/en/library/research/2016/06/self-healing-communities.html

Trauma Informed Oregon:
https://traumainformedoregon.org/

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 JCC members have access to care coordination through our JCC team-based model of integrated care coordination. The care coordination team provides appropriate care coordination services and supports to meet member needs. Care coordination teams 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. JCC 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. Members can be referred into care coordination through several avenues:

- JCC sends an Initial Health Screening to all adult members at the time of enrollment. This screening asks member's 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 JCC Triage Coordinator reaches out to connect the member to care coordination. Members are contacted by the prospective care coordinator first by phone with follow-up communication by letter.
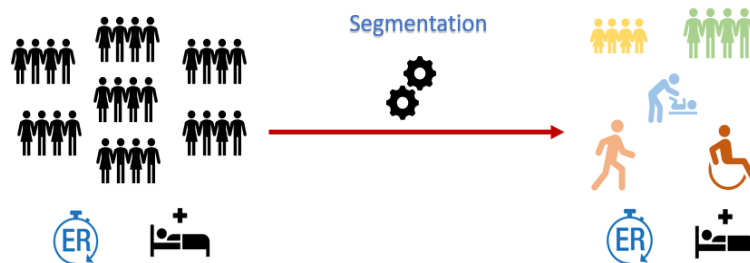
- Identification via segmentation of our member population, based on a combination of predictive analytics (cost and utilization), risk stratification, clinical judgment, community input, and member choice. Stratification is conducted to ensure that our population receives not only care coordination, 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 JCC care coordination team outreaches to members who have been identified as having behavioral health or substance use disorder rising risk based on 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 Triage Coordinators review this list each week and proactively reach 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. JCC 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. JCC facilitates collaboration among these providers and services with the goal of improving access to services and coordination between systems.

We consistently reach out to providers (primary care and behavioral health) to explain how to access care coordination services. We encourage providers to call customer service or the JCC Care coordination team directly to access the care coordinator who is dedicated to their clinic. The provider can also ask to submit a referral via email or our provider profile. 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 welcome packet. The Population

Health Portfolio Manager spends time connecting to community partners who 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. The Population Health Portfolio Manager 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 JCC website. They can call Customer Service for support, call the care team directly or use the emailed referral form.

Once a referral is received, 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 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 need in the care plan including, behavioral health, physical health, and social determinant issues.

We regularly inform internal referral sources 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 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?
JCC 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 care coordination team for targeted telephonic outreach.

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 which 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 Customer Service, 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 PCPCH.

11.E.3.c. Please describe Applicant's proposed process for developing, monitoring the implementation of and for updating Intensive Care Coordination plans.
JCC's integrated care coordination team 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.

JCC Triage Coordinators are responsible for monitoring members who may have ICC needs. They will pull monthly reports of members meeting criteria (Using OHA PERC codes) and route care plans for review to the assigned JCC 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, at minimum, on a semi-annual basis or more frequently as requested or indicated by a change in the patient's status.

11.E.3.d. How does Applicant plan to provide cost-effective integrated Care Coordination (including all health and social support systems)?

JCC 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 distinction of JCC's team-based integrated care coordination 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 JCC care coordination team 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.

Finally, JCC implemented a robust care coordination platform (GSI HealthCoordinator) that has dramatically increased efficiency. The platform has given JCC greater access to comprehensive and structured assessments of member needs. It uses strict workflows to improve efficiency and avoid errors, and it allows the care coordination team 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. JCC can deliver secure messages directly to the provider's 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, JCC is leveraging payment methodologies to improve cost-effectiveness. In 2018 we added a Cost of Care Incentive Payment to the primary care APM program. 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 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 JCC 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.

Trauma Informed Care	An organizational structure and framework that involves understanding, recognizing, and responding to the effects of all types of trauma. Trauma Informed Care also emphasizes physical, psychological, and emotional safety for both consumers and providers, and helps survivors rebuild a sense of control and empowerment.
Person-Centered Approach	Ensuring patenient/member is at the center of decisions which relate to their life. A person-centered process involves listening, thinking together, coaching, sharing, ideas, and seeking feedback.

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 time of employment and readdressed as needed. The completion of these trainings is tracked using CareOregon's Online Learning 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. JCC care coordination 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?

JCC 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.

JCCs parent, CareOregon, operates a D-SNP Medicare Advantage plan in Jackson County. The care coordination program defined in this RFA applies to our Medicare Advantage members served by JCC.

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, JCC will use its population segmentation capability to proactively identify and engage members with specialized or intensive care coordination needs. Once needs are identified, the JCC care coordination team 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, JCC 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. The member 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.

We also believe that the use of health-related services (HRS) 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 JCC care coordination services when and if needed. This allows continuity of care for members and for the 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 as long as they are a member of JCC. This allows the care coordination team to pick up where they left off if/when the member comes back into care coordination.

JCC's 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 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 JCC care coordination team 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 member and all documented interventions also follow them. This allows for continuity as staff 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 area. This allows all members of the care team, in and outside of JCC, 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.

JCC 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 JCC's service area. When JCC members require services that are not available within JCC's service area, JCC ensures that members receive all necessary services and that providers are compensated for those services. JCC's BH 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. JCC 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?

JCC assigns a care coordinator to members *upon admission* to any of these facilities/services:

- Psychiatric acute care settings
- Oregon State Hospital/Secure Child Intensive Program/Secure Adolescent Intensive Program
- Subacute
- Psychiatric Residential Treatment Services
- Oregon Youth Authority facilities
- Secure Residential Treatment Facility/Residential Treatment Facility(H)

The JCC 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.

When members are admitted to the Behavioral Health Unit at Rogue Regional Medical Center, or youth are admitted to the emergency department, JCC uses ColumbiaCare Services (CCS) and Kairos to provide outreach and follow up services. CCS meets adult members the day of discharge to facilitate a warm hand off to community-based services, and Kairos staff work with our local emergency departments to provide rapid access to services for youth and families.

For JCC members who admit to the Portland-based psychiatric hospital, Unity, we have two health resilience specialists who work specifically with JCC 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 JCC care coordination team 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. This allows all staff members working with the member to be informed about next steps on behalf of the member.

For a complete description of our discharge planning and special services for members transitioning from inpatient settings that are not psychiatric, please see responses in Attachment 7. These services include our work with Mercy Flights, care coordination services that include medication reconciliation by pharmacists, and integration care coordination by teams that include clinical experts from across many disciplines.

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 Intensive Program/Secure Adolescent Intensive Program
- Subacute
- Psychiatric Residential Treatment Services

- Oregon Youth Authority facilities

JCC 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 additional care coordination team members will stay involved in the member's care to ensure a smooth transition and that the member's needs are met.

Although Oregon Health Plan benefits are suspended when a member enters the criminal justice system, we have strong partnerships with this system and have educated them on how to connect to our care coordination staff when the member is discharge from the criminal justice system. We work to inform the Health Assessment Team, who work with patients discharging from the criminal justice system, regarding the best way to connect members to the JCC care coordination team once their benefits have been established.

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?
JCC is working to identify an outcome measure tool for Care Coordination services to be used in the 2020 contract. Regardless of the specific tool, JCC will utilize the reporting capabilities of its care coordination platform 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?
- Member engagement rates

JCC will also monitor the movements within the population segmentation process and care coordination team engagement overlay to extract evidence that interventions employed during care coordination met goals laid out within the segment (*e.g.* keep rising risk members from progressing to high risk, keeping healthy 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?
JCC believes in the application of HIT as a mechanism to improve quality care for our members. Since our inception, we have been committed to ensuring behavioral health providers also have access to HIT resources. As a result, our anchor behavioral health providers utilize EHRs, PreManage, and Reliance HIE. And we will continue to facilitate integration of care through

appropriate data sharing. Primary care providers and other providers involved in a member's care will be notified upon enrollment into the JCC 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, caregivers, 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 utilize the PreManage application to communicate critical information to providers. Lastly, our community has wide adoption of Reliance HIE that allows for critical data sharing through its community health record and closed loop referral functions.

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?
JCC's behavioral health director and manager will be actively involved in state level discussions about overall improvements to the behavioral health system for adult members 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, JCC 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.

JCC's behavioral health director is a co-chair, with OHA's behavioral health director, of the state-level CCO behavioral health director's meeting, which is becoming a sanctioned OHA group. This group will be an important venue to bring local experience and data to the state-level conversation about the continuum of care for adult members 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; JCC is excited to contribute to this effort.

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?
JCC will provide a care coordination position specifically to focus on members receiving services in the Oregon State Hospital and 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 members, the Jackson County CHOICE Coordinator, treatment providers and the utilization management entity. When members no longer meet 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 be part of the JCC care coordination 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.

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 JCC members referred for care coordination services will receive a full health 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. JCC has an available continuum of housing support targeted for members with SPMI, including shelters, transitional living, rental assistance, supportive housing, and respite.

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?
JCC's intensive care coordination staff will work individually with identified members who have SPMI and need housing supports. JCC has and will maintain direct contracts with ColumbiaCare Services for rental assistance/supported housing, respite, transitional housing, supportive housing, and board and care housing. These services are only for JCC members and therefore are prioritized for members with the greatest needs. 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 members' clinical needs are addressed. We currently have 43 members in the program for rental assistance with 37 being permanently housed. The wait list for these programs is consistently full demonstrating increased need for supported housing solutions in our community. (See Attachment 10 for more information on metrics for assessing impact in investments in housing.)

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?
JCC contracts with Jackson County Mental Health (JCMH) to provide ACT services to our members. Based on the number of referrals to ACT in 2018, JCC has negotiated 15 total ACT slots that are paid for on a capacity contract. The ACT census holds steady with rare openings. The contract can be increased by mutual agreement at intervals that do not compromise fidelity of staffing ratios. Currently, referrals to ACT come from the Oregon State Hospital, local acute care psychiatric units, and community providers such as ColumbiaCare Services. All members discharging from the state hospital who are eligible for ACT will be referred and screened. If JCC has five or more members on the waiting list for ACT services, JCC will enter contract negotiations with JCMH 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?
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 intensive care coordinator will connect 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. 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?
JCC has a robust network for its members with mental health diagnoses that includes two providers with experience providing ACT services. While we only have one ACT team currently established, we have the flexibility to assign an intensive care coordinator to members who are eligible for ACT and decline participation. This allows us to ensure they are connected with an alternative evidence-based treatment to meet their individualized needs. JCC will contract with ColumbiaCare Services to provide intensive case management (ICM), as well as supported housing with attached ICM supports. JCC will also contract with Jackson County Mental Health to provide specialized services targeted at the forensics population; this is another potential alternative to ACT for members involved in the criminal justice system. Both these organizations have expertise in working with members eligible for ACT services and have developed evidence-based treatment models.

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?
JCC 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. JCC has a close relationship with Jackson County Mental Health, which manages the local adult foster care system. In addition, JCC has access to an array of integrated community services with various levels of support, including foster care, supported and supportive housing, and low-income housing offered by other service providers such as On Track. In the event there is not an existing program available to meet a member's individualized needs, JCC and ColumbiaCare Services 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?
JCC will continue to actively participate in the local Continuum of Care work with the housing authority and local housing providers. In 2018, JCC provided an endorsement and letter of support for the Housing Authority's application for federal funding for additional housing vouchers. JCC leverages its health-related services funding to fill in financial gaps that improves the ability for members with SPMI to access housing services.

JCC will also work with ColumbiaCare Services, our primary treatment provider for adults with SPMI, to leverage state funding for development of additional supported and supportive housing capacity. In 2016, we partnered with ColumbiaCare Services to develop Swing Lane, leveraging state funds to develop a 12-bed supported housing program for JCC members. JCC is currently partnering with ColumbiaCare Services to add additional supported housing beds in Ashland, which will increase access to low income supportive housing for our members. As need continues to develop in the future, JCC will work with our partners to develop additional supportive and supported housing and housing support services.

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.

JCC will continue to contract with local and regional acute care psychiatric facilities to provide coverage of and service delivery for members with SPMI. To further ensure care, JCC has a policy that non-contracted providers are eligible to be paid for medically necessary admissions. JCC'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 JCC members access services in an emergency department, JCC will use several methods to engage and follow up with those members. If the member is currently engaged in care with one of JCC's local contracted mental health providers, the mental health provider will receive a PreManage alert and JCC will 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.

JCC will continue to contract with Compass House, a drop-in center run by peers and based on the Clubhouse Model. Compass House works with our local acute psychiatric facility at Rogue Regional Medical Center (RRMC) to provide peer support to members prior to discharge and to facilitate engagement in peer services after discharge. RRMC has seen a significant reduction in readmissions for members engaged in the Compass House services. JCC will contract with ColumbiaCare Services for outpatient and intensive case management treatment, which includes peer support. Finally, JCC will contract with Jackson County Mental Health for crisis services, which will include a peer drop-in lounge, support with system navigation, and necessities such as food, showers and laundry.

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.

JCC has several initiatives in place and in development targeting reduction of ED utilization and we are proud to have been facilitators of a community-wide project to reduce disproportionate utilization by individuals with SPMI diagnosis.

JCC built a function within PreManage to provide an automated alert system that notifies the triage coordinator for JCC's care coordination team 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 use. Triage Coordinators will also run daily reports from PreManage identifying members with two (2) or more readmissions to an Emergency Department in a six-month period. Once the triage coordinator is notified, they will review the member history and assign the member to the JCC care coordination team, which 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 and shared with the member's treatment team and primary care provider.

In addition to the care coordination interventions, JCC will continue to lead a local initiative to spread the adoption of PreManage throughout the provider network in both primary care and behavioral health. Our two largest behavioral health providers, ColumbiaCare Services and Kairos, and our ACT provider, Jackson County Mental Health, are all on PreManage with various levels of adoption. In 2019, JCC is actively increasing provider expertise in and utilization of PreManage. Specifically, for adult members with SPMI, JCMH and ColumbiaCare Services will get notifications when members 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 to reduce the length of time spent in the emergency room. The community-based treatment provider will also provide interim BH support between ED discharge and the first appointment with the member's provider. Further, JCC will ensure EDs and members are aware of the availability of crisis respite beds and urgent walk-in clinics, and how to access them.

For members with behavioral health disorders, JCC will use a robust strategy of care coordination offered by our integrated care coordination team. This multi-disciplinary care coordination team includes expertise in pharmacy, oral health, physical health, behavioral health, and population health. Referrals to the care coordination team 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.

ColumbiaCare Services and JCMH are well versed in the local continuum of care and 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, JCC has removed prior authorization requirements for most community-based services. JCC members will be able to access the following services without any prior authorization requirements:
- Subacute care for adults
- Respite for youth and adults
- Transitional housing provided by ColumbiaCare Services in two locations
- Supported housing
- Supportive housing
- ACT
- Intensive case management
- Early Assessment and Screening Alliance (EASA)

JCC 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, JCC 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 contract 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 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 JCC care coordination staff or a community provider.

JCC will also work with providers to build in same day access appointments to receive follow up or to establish care following an ED/hospital stay.

Lastly, we are evolving our work with Mercy Flights engage specially trained paramedics in connecting with high risk members before they are discharged from the hospital. The importance of engaging members face-to-face in the hospital, removing barriers to follow up care (sometimes that means empowering the member to select a PCP that will be a better fit for them), medication reviews with a pharmacist when the regimen is complex, and the great value of establishing a relationship of trust with a care team member who supports members during and after discharge from an acute care facility, has shown cost reduction while improving patient experience and outcomes. While not specifically targeting reductions in ED use, we are seeing the graduates of this program have dramatically lower rates of ED utilization.

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 have a JCC care coordinator assigned upon the initial referral. The JCC care coordinator will be part of the member's OSH care team and will be an active participant in:

- Long Term Care planning
- Coordination with the county CHOICE contractor (if outside of the CCO/health plan)
- Monthly IDTs at OSH
- RTT meetings
- Discharge/transition planning

The JCC 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 JCC care coordinator's primary objectives are to ensure:

- Member needs are met
- Member is placed in the appropriate setting and level of care
- 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 JCC Care Coordinator will work with all individuals involved in the member's local care including but not limited to:

- ColumbiaCare Services (LMHP)
- Jackson County Mental Health (CHOICE contractor)
- 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
  - MH Therapist, Case Manager, or treatment team

The JCC integrated care coordination team (including 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, JCC will continue to collaborate with the local CHOICE contractor through weekly 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 JCC approval is required for the referrals. As a result, we will work closely with the CHOICE contract to follow the course of treatment, the discharge timeline, and recommendations.

JCC will continue to contract with ColumbiaCare Services 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. JCC will contract with JCMH for ACT, which is offered to every member who is eligible for that program. When members are referred to adult foster care, ColumbiaCare Services will stay engaged as the treatment provider and assist with a smooth transition into the community. ColumbiaCare Services will create individualized plans for members with unique needs not easily met in the current continuum. JCC will continue to work closely with ColumbiaCare Services 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?
As part of JCC's outpatient mental health array of services, JCC will provide supportive employment services for our adult population with serious mental illness through our contract with ColumbiaCare Services. Supportive employment provides individual placement and support towards gainful employment. This is based on client choice and integration with other mental health services. Competitive jobs are the goal, with onsite support for the member at the place of employment, along with engagement with employers. Examples of specific services include work incentive planning, disclosure, ongoing vocational assessment, individualized job search and job development with employers.

Supportive employment services will be available to all members who are enrolled in mental health services with ColumbiaCare Services or another contracted behavioral health provider and who meet program admission criteria. Supportive employment services will be individualized and will assist individuals to obtain and maintain integrated and paid competitive employment. Supportive employment services will allow individuals to work the maximum number of hours consistent with their preferences, interests and abilities. Supportive employment 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
- Supportive employment is strengths-based and promotes growth and hope

ColumbiaCare Services' Supportive Employment program will follow a fidelity-based model based on standards set for the Oregon Supportive Employment Center for Excellence. The program will meet a fidelity score of at least 100, as measured by an OHA-approved fidelity reviewer. CCS is certified by OHA as described by OAR 309-019-0100.

A capitation payment model will be applied which will include mechanisms to increase capacity as demand increases, demonstrating JCC's commitment to ensuring access for our members. Payment for the program may increase incrementally as the census increases. For example, if enrollment exceeds the 20:1 staffing ratio, an additional staff person may be funded as mutually agreed by both parties.

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.
11.E.8.a. What Community resources will Applicant be using or collaborating with to support a fully implemented System of Care?

JCC is an active leader in the Southern Oregon Success (SORS), a Collective Impact Initiative committed to fully implementing an integrated System of Care (SOC) for children in Jackson and Josephine Counties. SORS includes representatives from a multitude of community resources and sectors, including the other coordinated care organization in our service area. The steering committee of SORS serves as the Executive Council within the SOC governance structure for Jackson County. It consists of the following partners: DHS Child Welfare and Self Sufficiency, Juvenile Justice, Southern Oregon Educational School District, Medford School District, Phoenix-Talent School District, Allcare Health, Options for Southern Oregon, Kairos, Youth Move, Jackson County Mental Health, the Addictions Recovery Center, Southern Oregon Early Learning Services, I/DD, Local Law Enforcement, Rogue Community College, Southern Oregon University, Children's Advocacy Center, Maslow Project, and WorkSource Oregon.

JCC's behavioral health manager sits on the SORS steering committee and JCC has been involved for the past several years. In the past year, SORS accomplished several initiatives, including:

- Convened the SORS youth development workgroup which helped bring $800,000 in grants to regional partner organizations
- Reached over 500 key leaders through holding events with national experts in resiliency building
- Held ACES trainings reaching more than 4600 participants, bringing the total to about 10,000 trained since 2016
- Facilitated the training of over 500 teachers in the PAX good behavior curriculum

11.E.8.b. Please provide detail on how Applicant will utilize the practice level work group, advisory council, and executive council.
By the end of 2019, all levels of the Jackson County System of Care (SOC) Governance Structure will have charters outlining their responsibilities, scope, and relationship to one another. The following generally indicates responsibilities within the Jackson County SOC:

- **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 known locally as the cross-systems review committee (CSRC)
    - 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 representatives. This is a sanctioned workgroup under the SORS steering committee that will:
    - provide ongoing assessment of the SOC
    - draft the 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:** The SORS steering committee referenced above (8a) serves as the executive council for the Jackson County System of Care. It 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

11.E.8.c. How does Applicant plan to track submitted, resolved, and unresolved barriers to SOC?
The practice level work group will track submitted, resolved, and unresolved barriers. A Jackson County System of Care (SOC) barrier submission form will be used to collect data that will then be catalogued on the SOC tracking sheet. JCC will submit an annual SOC report and updated SOC strategic plan to OHA. These reports will include evidence of JCC's commitment to upholding the principles of SOC, a summary of the local issues that have been addressed through the local governance structure, issues currently being addressed and priorities for the coming year. JCC 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 youth … 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?
As indicated above (8a), the SORS steering committee will use collective impact to ensure ample cross-sector representation within the SOC governance structure. Having achieved broad cross-sector representation, our objective next year will be to achieve 51% youth and family voice at all levels. To recruit youth and families to participate in SOC governance, JCC will engage in general youth and family outreach, as well as leverage partnerships with youth-related entities including local youth organizations, school governance groups, local youth advisory councils, parent advocacy groups, and peer support providers. Well-defined charters with clear membership expectations at every level will be developed to assist in recruitment. Once youth and family membership is achieved, consensus-based decision making will ensure representation of majority youth and family voice.

In addition, JCC will engage its Youth Advisory Council (YAC) to help ensure representation of youth voice. This council meets twice a month and consists of JCC members aged 14 to 20. It is linked closely with the JCC CAC and is a vehicle by which youth members will be heard and their thoughts considered when decisions involving youth are made. JCC will offer opportunities for YAC members to participate at various levels within the SOC governance structure.

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)?
JCC will contract with Jackson County Mental Health (JCMH) to provide wraparound services to our members. The contract will fund capacity for a specific number of slots and can be increased as needed to maintain the 1:15 ratio. 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.

11.E.9.b. How will Applicant communicate WFI-EZ and other applicable data to the System of Care Advisory Council?
JCC is currently chartering the newest iteration of the advisory council for the Jackson County System of Care. A main role of the advisory council will be to review data for trends that may indicate a problem, gaps in the system of care, or barriers to access. On a quarterly basis, JCC will share WFI-EZ data and other relevant data with the advisory council to ensure that we continue to

offer an evidence-based model to our members that meets fidelity and can be trusted to provide strong outcomes. The council will then make recommendations, based on review of the data, to JCC and directly to the wraparound program.

11.E.9.c. How does Applicant plan to receive a minimum of 35 percent response rate from youth?

Jackson County Mental Health (JCMH) will offer the WFI-EZ survey to youth, caregivers and team members after the youth has been wrap-involved for six months. WFI-EZs will first be offered through the wrap team meeting, where they will be administered and gathered by the family partner, the peer support specialist, the caregiver, or youth. The wrap care coordinator will leave the room while the survey is taken and collected. Forms will be sealed in an envelope and given to support staff to enter the data, without being seen by program staff, thus allowing for feedback to be uninhibited by staff presence. Forms are also offered individually to caregivers, youth, and team members when wrap meetings will not work due to time constraints. Data is tracked by JCMH support staff. When data is missing or when youth have not completed the survey, the care coordinators outreach to caregivers and youth for forms to be completed to ensure a minimum 35 percent response rate from youth.

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?

JCC currently contract with Jackson County Mental Health (JCMH) as the sole provider of wraparound services for its members and intends to continue this relationship into the new CCO contract period. JCMH has proven ability to provide wraparound facilitation and peer support and to work closely with relevant partners including treatment providers across the system of care, schools, child serving systems, and family members.

JCC Utilization Management and care coordination staff will work closely with the wraparound program 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 JCC behavioral health manager will be the liaison between the wraparound program and community providers and partners. The behavioral health manager will ensure that identified barriers are either addressed or brought to the practice level workgroup for consideration.

11.E.9.d.(2). How Applicant will ensure Wraparound services are provided to Members in need, through Applicant's Providers?

JCC, in partnership with JCMH and local child serving systems, has a high-functioning cross-systems review committee that will screen all referrals to the wraparound program. Community partners such as child welfare, juvenile justice, developmental disability services, homeless youth programs, treatment providers and schools have been trained on the referral process and eligibility requirements for wraparound and will be encouraged to refer members. JCC and JCMH will continue to provide refresher trainings to ensure the community is well educated about wraparound services and the referral process. Jackson County has identified youth engaged in both child welfare and juvenile justice as a high priority population and will maintain a strong collaboration among those systems to ensure these youth are able to receive Wraparound services.

JCC will fund wraparound services through Jackson County Mental Health. We will continually monitor access and capacity in monthly census reports submitted by the contractor to ensure wraparound services are available to be provided to members in need. In the event no space is

available, the JCC youth behavioral health care coordinator will step in to facilitate needed services and stay involved until a slot opens or the service is no longer needed for whatever reason. If data shows increased demand for services, JCC will work with contractor to increase capacity to meet the need.

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.
JCC will contract with Jackson County Mental Health 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, JCC will work with Jackson County Mental Health to expand the contract to add more slots.

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).
JCMH will employ youth and family partner and peer support specialists who will work with youth and families receiving wraparound services. JCMH's peer supervisor receives wraparound training and experience, so that the supervisor can support our youth and family partner and peer support specialists in their work. JCMH will employ clinical supervisors who have been trained in wraparound and who were once care coordinators; these supervisors have the knowledge and experience to coach the wraparound care coordinators and ensure fidelity. The program will be supervised by JCMH's program manager.

Community Engagement Plan

1. General Component
1.1. Table 1-Stakeholders Table: Please see tables following narrative 1.2. Table 2-Projects table
1.3. Describe (via narrative) 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);

JCC began as a community conversation that resulted in a stakeholder Board of Directors (Board), and stakeholder committees including Community Advisory Council (CAC), Youth Advisory Committee (YAC), Clinical Advisory Panel (CAP), Network and Quality (N&Q), Finance and Governance committees. Stakeholders include members, healthcare providers, other service delivery partners and other community partners. We have three foundational commitments that drive healthcare transformation for our community. (1) All healthcare is local. This shared belief reflects the Board's commitment to critical engagement with providers and members and the composition and agendas of the board, CAC, YAC, and CAP. (2) Nonprofit CCOs are the most ethical way to steward healthcare transformation as it allows commitment to member-focused mission-driven work and appropriate distribution of the taxpayer funded OHA risk funds. (3) We all (CCO, providers and members) serve as stewards of our public Medicaid funds. This means that any surplus is invested back into the community stakeholders (CCO, provider and member) and losses require support from these same community stakeholders.

The Board and its committees helped create JCC's mission/vision and are all active participants in strategic planning. CCO decisions over a threshold of $20,000 require approval from the Board. Delegated partners may make decisions without Board approval, but they must report utilization and financial data. As the parent company, Care Oregon is deeply invested in JCC's success and has complete transparency of financial and utilization data. Most decisions enacted at the JCC Board of directors require consensual decision making between CareOregon and community directors.

As an example, we are using the strategic priorities set by the CAP, N&Q, and Finance committees of the Board to co-create workplans with our largest provider systems. Shared workplans between JCC, our two large FQHCs, our two hospital systems, and our major behavioral health partners will be created from this alignment process and represent organizations that serve the majority of our membership.
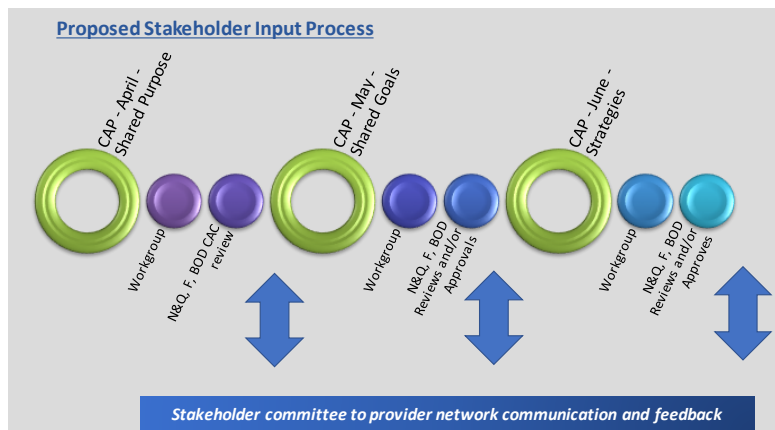
In a similar vein, the CAC is actively engaged in setting the CHIP priorities, which drive CHIP investment, strategy, CAP priorities and other work of JCC staff.

When decisions are made about significant program or service changes, information will be presented to the CAC, CAP, and N&Q committee to identify potential considerations for impact and make recommendations to ensure the best outcomes for our members and a healthy provider community. The CAC can provide member voice directly through its membership, being at least 51% OHP members. JCC has also found it effective to, at the CACs direction, conduct a narrow member survey to get input from a wider range of members.

There are a variety of collaborative forums in which JCC will continue to seek input from partners. Two examples include the Continuum of Care collaboration and the Early Learning Hub. At the monthly meeting with our local Early Learning Hub, we receive information about what is most needed among families the Hub network serves. This information is brought to JCC leadership to inform decision making. The Continuum of Care has recently reinvigorated to focus on addressing homelessness in our county. JCC participates in several of the workgroups, which allows for cross-systems collaboration. Please see Table 1-Community Engagement Plan for additional examples.

JCC will hold an annual conference that is open for all to attend. We approach the agenda for this conference as a two-way conversation, so that we are both providing an opportunity for our network of partners to highlight the success happening and to educate using member voice about challenges. This conference has proven to be an excellent opportunity for partners and community members to learn from one another, get re-energized about the work and voice their perspectives.

1.4. Describe (via narrative) how the Applicant will ensure the member voice is elevated;
JCC member voice is elevated in several ways. Information and recommendations raised by CAC members is followed up on by JCC staff. The two CAC members serving on the Board inform relevant decisions taking place at the Board or recommend additional attention to an issue. To elevate member voice overall, JCC staff have direct contact with JCC members through outreach, direct services and care coordination. Staff will continue to track themes in member feedback and elevate to leadership, CAC, and/or Board as needed. JCC's Member Services Department will provide information on feedback and grievances. It provides a dashboard summarizing member calls and grievances shared with the CAC monthly.

1.5. Describe (via narrative) potential barriers to community engagement and how the Applicant will address these barriers. The applicant will include: 1.5.a. 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);
The primary barrier to community engagement is opportunity, which encompasses challenges including transportation, costs, accessibility, childcare, language access, literacy and numeracy and gaps in information, all of which can prevent community members from engaging in JCC efforts. To truly hear from broad and representative members and to get broad community voice, we have to go to where people are, rather than expecting them to come to us or attend regular CAC meetings.

1.5.b. 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
JCC will seek to provide community engagement in locations where community members are already present and in locations/with service providers where the community is already comfortable. To address the challenges of engaging rural and non-English speaking communities, we will continue regular outreach and community engagement as we attend events in each community and

partner with organizations that have trusting relationships within these communities, such as Fiestas Patrias, Dia de Los Muertos and rural Point In Time Homeless Count outreach. We will continue to hold regular member meetings around Jackson County at locations familiar to community members. Our bilingual/bicultural staff will continue to engage directly with community members.

1.6. Describe (via narrative) 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.
JCC will have regular check in meetings with contracted partners and use formative evaluation methods to track progress, objectives and needed process improvements. Decisions are made jointly with our partners. Project and program updates are shared with stakeholder committees, such as the CAC, Clinical Advisory Panel, Network and Quality Committee, and Board.

2. CAC Component
2.1.a. N/A (applies only to applicants that are not existing CCOs)
2.1.b. 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.
- ***A description of how it defines its population, and***
- ***Any planned changes to CAC recruitment and engagement strategies to align CAC membership with that population and with CHP priorities.***

CAC Structure: Members of the CAC represent the diversity of the community including race/ethnicity, age, gender identity, sexual orientation, disability, and geographic location. There is at least one County representative and at least 51% of committee members will be classified consumers of OHP or uninsured. Community members are defined as individuals who bring strategic value to the committee composition but are do not fit the definition of consumer.

CAC Role: The CAC will advise and make recommendations on JCC's strategic direction. The CAC will partner with the Board to ensure that JCC remains responsive to member and community health needs. The CAC will empower JCC members to take an active role in improving their own health and that of their family and community members. CAC members provide expertise and insight in accessing and utilizing OHP services, SDOH, mental health, addictions, wellness promotion, education, housing, seniors' services, culturally specific health services, children and youth services, corrections and public safety, disability services and health disparities.

Specifically, the CAC is asked to provide the following critical input and support
- Identify and advocate for preventive care practices to be used by JCC.
- Maximize engagement of those enrolled in the Oregon Health Plan.
- Oversee the Community Health Assessment.
- Adopt the Community Health Improvement Plan to serve as a strategic population health and health care system plan for the JCC communities.
- Identify opportunities to improve population health, including the coordination of medical and non-medical services in order to improve health.
- Identify, implement and evaluate transformation fund initiatives, programs, services.

Population definition. JCC defines population as the demographics of our membership, with efforts to ensure that communities traditionally underrepresented have a voice on the CAC.

Planned Changes. JCC will continue to recruit more CAC members with a focus on members from communities traditionally underserved and who are representative of our overall membership. The CAC has recently added members who identify as Latino, homeless, and disabled. JCC will continue to recruit stakeholder partners who work in housing and early learning in alignment with focus areas for JCCs SDOH work and the priorities out of the 2018 CHA that will inform the 2019 CHIP.

2.1.c. All Applicants 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).
The CAC will meet at least quarterly or as often as it deems necessary to perform its responsibilities. Within this meeting framework, JCC has developed a strong structure for engaging OHP consumer representatives on the Board:

1. Two CAC Members sit on Board, one JCC OHP member, one community partner. A key aspect of CAC participation on the Board is to build leadership and empowerment among CAC members. All CAC members receive mentorship from a fellow Board member. It also provides a means for sharing member experience in Board discussions and decisions.
2. CAC members play a central advisory role for projects, member communications, community investments related to SDOH-HE, including budgets for SDOH interventions, recommendations for projects and member communications. The board also refers issues to the CAC for exploration and consideration of member experience. CAC members sitting on Board help flag when an issue might have a member impact.

To ensure that CAC members are meaningfully engaged, JCC provides support for CAC Members in their roles on the Board:

- Trainings in public speaking, meeting facilitation, community organization, overall healthcare system, and HR training offered by JCC or CareOregon.
- Send CAC members to conferences to encourage growth and leadership.
- Intentionally create a culture that supports a level of comfort to ask questions.

2.1.d. All Applicants will describe strategies for collaborating with CACs from other CCOs 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).
JCC will continue to support collaboration of our CAC with other CCOs in overlapping service areas. There will be significant collaboration and engagement of CACs through the CHIP and CHIP priority area workgroups. CAC members from each CCO will work together to develop strategies and involve community partners. We work with other CACs to engage isolated rural communities.

3. CHA/ CHP component:
3.1. Background information
3.2. Table 3: Please see tables following narrative
3.3. Table 4: Please see tables following narrative
3.4 Table 5: Please see tables following narrative
3.5. Describe how the Applicant's strategy for health-related services (HRS) community benefit initiatives will link with the Applicant's CHP.
JCC will align HRS community benefit initiatives with the CHP to pool resources with other partners for a larger impact. Depending on the strategies under each priority area (behavioral health, housing and parenting support/life skills), this effort could entail structuring the CAC-led CHIP grant to fund general strategies or funding a few smaller projects that all the partners support.

Table 1: Stakeholders to be included in the engagement process			
All applicants must complete this full table. Applicants may add rows as needed.			
OHP consumers (list in first column below)			
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	Community Advisory Council	OHP consumers on the CAC provide valuable insight that informs programmatic and funding decisions.	Continue to grow and diversify our OHP consumer membership on the CAC. Further clarify and strengthen the CAC's role to inform decisions of the Board of Directors and staff.
OHP consumers	Youth Advisory Council	Youth on the council provide valuable insight from lived experiences and	Increase opportunities for the YAC to inform organizational decision making.

		participate in the CHIP grant process with CAC.	
OHP consumers	Member Meetings	Regular meetings open to all JCC members to learn about services available to them and provide feedback on their experience of care.	Continue meetings with regularity and ensure time to hear from members.
Community-based organizations that address disparities and SDOH-HE (list in first column below)			
Community-based organizations that address disparities and SDOH-HE	RVYMCA and Ashland YMCA	Current strong partnership addressing healthy eating, physical activity, and social connectedness.	Committed to maintaining this strong partnership through renewing contracts and deepening shared missions by connecting even more resources, such as chronic pain management.
Community-based organizations that address disparities and SDOH-HE	Rogue Retreat	Current strong partnership providing housing and case management for those in recovery from addiction or chronic homelessness.	Committed to maintaining this strong partnership and showing impact on utilization and health outcomes through collaborative program evaluation.
Community-based organizations that address disparities and SDOH-HE	ACCESS	Partnership to provide cooking classes. As community action agency, ACCESS helps many OHP consumers connect to housing, utility assistance, food, medical equipment and more.	Maintain partnership for programs and increase connectedness for addressing SDOH through care coordination.
Community-based organizations that address disparities and SDOH-HE	Kid Time	Current strong partnership to connect our members and the community to quality early learning experiences. Contract to scholarship member participation and have provided grant funding for programs to increase access for children.	Will continue to deepen partnership by collaborating on outreach and connecting families to services to support their health.
Community-based organizations that address disparities and SDOH-HE	Maslow Project	Provides case management to youth and families experiencing homelessness.	Deepen partnership to wrap around shared members/ clients and support complex cases.

		JCC funded the establishment of a bilingual/ bicultural case management program.	
Community-based organizations that address disparities and SDOH-HE	Rogue Valley Transportation District	NEMT program is under RVTD. Work with them on transportation assessments, including food access. Serve on committees and coalition with them. Shared goals.	Grow our partnership to address the transportation needs of our membership and community.
Community-based organizations that address disparities and SDOH-HE	Housing Authority of Jackson County	Collaborate on connecting members to resources and gaining their expertise on housing issues and solutions.	Through the collaborative, in 2019 CHP will be engaging the housing authority on strategies under the housing priority.
Community-based organizations that address disparities and SDOH-HE	Continuum of Care (CoC)	Currently fund and participate on the CoC board and workgroups. Strong cross-sector collaboration to address homelessness and housing needs.	Provide leadership to increase focus of concrete solutions and align with the CHP.
Community-based organizations that address disparities and SDOH-HE	Southern Oregon Success	Support and JCC is an active member of the regional achievement collaborative. Backbone organization for ACEs and Trauma-Informed care training. Coordinating Systems of Care.	Continue to support and provide leadership on the steering committee.
Community-based organizations that address disparities and SDOH-HE	Schools	Strong partnerships with several elementary, middle and high schools to support health services and programing at schools and help families navigate the health care system, especially behavioral health.	Continue to deepen these partnerships and reach more families.
Community-based organizations that address disparities and SDOH-HE	Southern Oregon Head Start	Strong partnership to serve families and children. Support family health literacy programs. Director is a member of JCC CAC and N&Q committee	Continue to align health improvement strategies.
Community-based organizations that address disparities and SDOH-HE	The Family Nurturing Center	A longstanding partnership to support families facing crisis. JCC has supported food & nutrition programs as well as	Continue to collaborate on innovative approaches to wrapping around families including meeting housing needs.

		the implementation of a trauma informed model.	
Providers, physical health, including culturally specific providers as available (list in first column below)			
Providers, physical health	Providence	Second largest Hospital system for JCC membership in Jackson County and critical leadership partner	Participation in JCC BOD, CAP, Finance and N&Q committees Monthly Leadership meetings with multiple operational and executive staff to review shared workplan Participation in Cross System Care Coordination with JCC Regional Care Team and PreManage workgroup Participates in JCC Learning Collaboratives, Technical Assistance and APM programs
Providers, physical health	Asante	Largest Hospital system in Jackson County and critical leadership partner	Plans for participation in JCC BOD, currently participates in CAP and N&Q committees Monthly Leadership meetings with multiple operational and executive staff to create and review shared workplan Participation in Cross System Care Coordination with JCC Regional Care Team and PreManage workgroup Participates in JCC Learning Collaboratives, Technical Assistance and APM programs
Providers, physical health	La Clinica	Largest FQHC for JCC membership in Jackson County and critical leadership partner	Participation in JCC BOD, CAP, Finance, Governance and N&Q committees Monthly Leadership meetings with multiple operational and executive staff to review shared workplan Participation in Cross System Care Coordination with JCC Regional Care Team and PreManage workgroup Participates in JCC Learning Collaboratives, Technical Assistance and APM programs

Providers, physical health	Rogue Community Health	Second largest FQHC for JCC membership in Jackson County and critical leadership partner	Participation in JCC BOD, CAP, Finance and N&Q committees Monthly Leadership meetings with multiple operational and executive staff to review shared workplan Participation in Cross System Care Coordination with JCC Regional Care Team and PreManage workgroup Participates in JCC Learning Collaboratives, Technical Assistance and APM programs
Providers, physical health	Southern Oregon Pediatrics	Largest independent pediatric group in Jackson county and critical leadership partner	Dr Matt Hough, SO Peds Managing Partner participates in JCC CAP as CAP Chair Participates in JCC Learning Collaboratives, Technical Assistance and APM programs
Providers, physical health	Valley Family Practice, Family Practice Group, Shady Cove Clinic	Small private practice groups	Participates in JCC Learning Collaboratives, Technical Assistance and APM programs
Providers, physical health	Mercy Flights Paramedics	Largest paramedicine provider	Community Paramedicine provider participates in Cross System Care Coordination with JCC Regional Care Team and PreManage workgroup Participates in, JCC Technical Assistance programs
Providers, behavioral health, including culturally specific providers as available (list in first column below)			
Providers, behavioral health	Columbia Care	Largest Provider of Outpatient MH for adults and a critical partner.	ColumbiaCare leadership is represented at the JCC CAP, Participating in the Cross-System Care Coordination initiative, enhanced specialty workflow pilots, MTM consulting work, monthly leadership meetings, regular
Providers, behavioral health	Kairos	Largest Provider of Outpatient services for youth and a critical partner.	Participates in CAP, monthly leadership meetings, MTM Consulting work

Providers, behavioral health	On Track	One of two largest providers of outpatient SUD treatment as well as residential and transitional housing.	Participates in CAP, monthly leadership meetings and network meetings.
Providers, behavioral health	ARC	One of two largest providers of outpatient SUD treatment as well as residential, detox and transitional housing.	Participates in CAP, monthly leadership meetings and BH provider network meetings.
Providers, behavioral health	Jackson County Mental Health	Critical BH partner who holds many specialized outpatient BH roles.	Participates in JCC BOD and CAP, monthly leadership meetings, cross system care coordination initiatives, functions as CMHP.
Providers, oral health, including culturally specific providers as available (list in first column below)			
Providers, oral health	La Clinica	BH Integrated PCPCH clinics with referrals to oral health center; School based, integrated clinics with OH, farm workers clinic with OH, and mobile unit with OH to visit jail and homeless centers. Most have Latino/a bilingual/bicultural staff	JCC intends to build on our strong partnership with LaClinica to further and optimize opportunities within the health home concept for patients. La Clinica leadership, operational and clinical staff participate as above. Also Dental Director participates in JCC CAP
Providers, oral health	Rogue Community Health	BH Integrated PCPCH clinics with referrals to oral health center; School based, integrated clinics with OH. Most have Latino/a bilingual/bicultural staff	JCC intends to build on our strong partnership with Rogue Community Health (RCH) to further and optimize opportunities within the health home concept for patients. RCH leadership, operational and clinical staff participate as above.
Providers, oral health	Capitol Dental Care	JCC's largest contracted DCO with a network of primary and specialty dental providers. They also operate community- based programs within the county, such as school-based sealant programs.	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, oral health	Advantage Dental Services	JCC second largest contracted DCO with a network of primary and specialty dental providers. Also operate	Developing ongoing partnerships in medical-dental alignment, dental home development and strategic initiatives to

		community-based programs within the county, such as school-based sealant programs.	better integrate care across multiple disciplines by leveraging and developing cross-disciplinary systems.
Providers, oral health	ODS	JCC Contracted DCO with a network of primary and specialty dental providers	Quarterly joint CCO/DCO meetings with workgroups as needed
Providers, oral health	Willamette Dental Group	JCC Contracted DCO with a network of primary and specialty dental providers	Key strategic partner. Developing ongoing partnerships in Med-dental alignment. Quarterly joint CCO/DCO meetings with workgroups as needed
Providers, long term services and supports, including culturally specific providers as available (list in first column below)			
Long-term care	Aging and Persons with Disabilities (APD)	Active partnership since 2015 with MOU in place, leadership from APD and JCC meets twice yearly to review MOU, address barriers to meeting goals and objectives, and deepen partnership.	Continue twice monthly meetings for case managers and direct service providers from APD and JCC to ensure care coordination, and twice-yearly leadership meetings.
Providers, traditional health workers, including culturally specific providers as available (list in first column below)			
Providers, health care interpreters (list in first column below)			
Providers, health care interpreters	Linguava	Developing partnership to provide interpretation to members.	Continue to support Linguava in growing their capacity in Jackson County and collaborate to train providers on using an interpreter.
Providers, health care interpreters	Passport to Languages	Contracted to provide interpretation.	Continue to make available to providers.
Early learning hubs (list in first column below)			
Early learning hubs	Southern Oregon Early Learning Services	Strong partnership with monthly Hub/CCO meetings to advance shared priorities to improve outcomes for 0-5 pop.	Continue to meet regularly, will do focused work on select strategies together.
Early learning hubs	Family Connection Parenting Hub	Offer valuable parenting education in the community. JCC has funded.	Continue to strengthen partnership to break cycle of ACEs.
Local public health authorities (list in first column below)			

Local public health authorities	Jackson County Health & Human Services – Public Health	Jackson County Public Health (JCPH) is the Local Public Health Authority and plays an essential role for our community. It is important that JCC and JCPH remain aligned to: (1) provide direct services to JCC members, (2) generate a collaborative CHIP that meets CCO and public health accreditation requirements, (3) support the syringe exchange program, (4) build pathways to substance use and mental health treatment services for JCC members who engage with public health programs, and (6) ensure cohesion of our maternal child programs, especially for high risk JCC members.	JCC and JCPH already have a strong working relationship built on more than 6 years of partnership. JCPH has consistently provided staff resourcing and leadership for the JCC CAC and the Public Health Manager is currently a CAC co-chair. JCPH and JCC are also jointly providing staff resourcing and leadership tot eh collaborative CHIP. We are deepening our shared planning and resourcing for substance use treatment, particularly through the Bridge Clinic and syringe exchange.
Local mental health authorities (list in first column below)			
Local mental health authorities	Jackson County Mental Health	Jackson County Mental Health (JCMH) is the Local Mental Health Authority and plays an essential role for our community. It is critical that JCC and JCMH remain aligned to: (1) provide continuity of care for JCC members also engaged in the criminal justice system, (2) coordinate care for JCC members discharging from the Oregon State Hospital, (3) generate a	JCC and JCMH have a strong partnership built on more than 6 years of partnership. We have active contracts in place that cover provision of outpatient and some acute mental health services to JCC members, support for the crisis system, and funding of the mental health treatment court. We are in active collaboration on the CHIP. And we have an executed

		collaborative CHIP and community plan, and (4) ensure stability of the community mental health crisis system.	MOU codifying our commitment to strengthen our relationship.
Other local government (list in first column below)			
Other local government	City of Medford	Affordable housing	Strengthen our partnership by offering our voice in support of affordable housing projects the city is working on. Collaborate on growing political will.
Other local government	City of Ashland	Affordable housing	Strengthen our partnership by offering our voice in support of affordable housing projects the city is working on.
Other local government	City of Talent	Affordable housing	Strengthen our partnership by offering our voice in support of affordable housing projects the city is working on.
Tribes, if present in the service area (list in first column below)			
None			
Regional Health Equity Coalitions, if present in the service area (list in first column below)			
Regional Health Equity Coalitions	Southern Oregon Health Equity Coalition (So Health-e)	Collaborate, learn, support community efforts, promote best practices, and share resources to advance health equity in our region.	Maintain through continued leadership on steering committee and participation on workgroups. Also continue to collaborate on provider and community trainings.
Coalitions (list in first column below)			
Coalitions	Jefferson Regional Health Alliance	Collaborate and get input/ buy in from the major health care partners in the region.	Maintain through continued support, regular participation and leadership.
Add additional stakeholder types here (list in first column below)			
IPA	PrimeCare	Supports physicians in contracting and success in VBPs	Maintain through regular communication and annual conversations with PrimeCare Board of Directors

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 will 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 will 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.**
CHP Priority Area 1: Housing	Collaborate and Shared decision-making
CHP Priority Area 2: Behavioral Health	Collaborate and Shared decision-making
CHP Priority Area 3: Parenting Support & Skills (Breaking the cycle of ACEs)	Collaborate and Shared decision-making
Clinical/ benefits 1: Cross system Care Coordination modeling and implementation with PreManage	Collaborate and Shared decision making
Clinical/ benefits 2 Pathways to SUD Treatment	Collaborate and Shared decision making
Clinical/ benefit 3: HIT workgroup	Collaborate and Shared decision making
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. *Consult*: Obtain community feedback on analysis, alternatives, and/or decisions. Tools include issue briefs, discussion papers, focus groups, surveys, public meetings, and listening sessions. *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. *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. *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 <u>collaborator</u> 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 <u>not a collaborator</u> 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.***
Local public health authorities (list in column below)				
Jackson County Public Health	Collaboration	**Priorities from 2013 CHA/ 2014 CHP:** 1. Healthy Beginnings 2. Healthy Living 3. Health Equity **Priorities from 2018 CHA:** 1. Behavioral Health 2. Housing 3. Parenting Education and Life Skills Strategies are being developed for completed 2019 CHP by 6/30/19		Working towards even closer collaboration through the 2018 CHA and 2019 CHP

Non-profit hospitals (list in column below)				
Providence	Collaboration (2018 & 2019)	Priorities from 2018 CHA: 1. Behavioral Health 2. Housing 3. Parenting Education and Life Skills Strategies are being developed for completed 2019 CHP by 6/30/19		Working towards closer collaboration through the 2018 CHA and 2019 CHP
Asante	Collaboration (2018 & 2019)	Priorities from 2018 CHA: 1. Behavioral Health 2. Housing 3. Parenting Education and Life Skills Strategies are being developed for completed 2019 CHP by 6/30/19		Working towards closer collaboration through the 2018 CHA and 2019 CHP
Current coordinated care organizations, as of 2019 (list in column below)				
AllCare Health	Competition and Cooperation (2013 & 2014) Coordination (2018 & 2019)	**Priorities from 2013 CHA/ 2014 CHP:** 1. Healthy Beginnings 2. Healthy Living 3. Health Equity **Priorities from 2018 CHA:** 1. Behavioral Health 2. Housing 3. Parenting Education and Life Skills Strategies are being developed for completed 2019 CHP by 6/30/19	Developing shared CHP priorities that will hopefully lead to full collaboration within the three focus areas. Most work has been done separately to date.	Working towards closer collaboration through the 2018 CHA and 2019 CHP.
Primary Health	Competition and Cooperation (2013 & 2014) Coordination (2018 & 2019)	**Priorities from 2013 CHA/ 2014 CHP:** 1. Healthy Beginnings 2. Healthy Living 3. Health Equity **Priorities from 2018 CHA:** 1. Behavioral Health 2. Housing 3. Parenting Education and Life Skills Strategies are being developed for completed 2019 CHP by 6/30/19	Working towards agreements of shared work load and leadership.	Working towards closer collaboration through the 2018 CHA and 2019 CHP.

Federally recognized tribes that have or are developing a CHA/CHP (list in column below)				
None				

**
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</u> or <u>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** …* ***N/A***	*Part 4a. Applicants **without an existing CHA and CHP or that intend to change their service area*** ***N/A***
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.					
None					
All regional health equity coalitions (RHECs) present in the service area (list in column below).					
So Health-e	Strong partnership collaborating on the healthy equity priority of 2014 CHP. Have partnered to offer trainings to the community and providers. Reproductive health workgroup of So Health-e overlaps both the health equity and healthy beginnings priorities of the CHP.	The CHA and CHP process could benefit from a stronger equity lens.	Have been asked to support and partner on the 2019 CHP.	**N/A**	**N/A**

Local government, including counties				N/A	N/A
Jackson County Health and Human Services	A primary partner on the CHA and CHP.			N/A	N/A
Organizations that address the four key domains of social determinants of health* (list in column below).					
Southern Oregon Success	Provides ACEs trainings addressing a CHP priority	Opportunity for more focused program alignment with measurable outcomes.	Will be a central partner in the parenting support priority of the 2019 CHP to break the cycle of ACEs		
SOELS Early Learning Hub	Align efforts under the Healthy Beginnings priority area of the CHP	Opportunity for more focused program alignment with measurable outcomes.	Will be a central partner in the parenting support priority of the 2019 CHP	N/A	N/A
Schools	Programing that has contributed to the Healthy Beginnings priority area of the CHP		Will be a contributor in the parenting support priority of the 2019 CHP	N/A	N/A
Southern Oregon University	Support Academia Latina program to support youth engagement in higher education and greater health literacy		Will be a promising contributor to the life skills priority of the 2019 CHP	N/A	N/A
Rogue Community College	Support programs to encourage youth engagement in higher education and greater health literacy		Will be a promising contributor to the life skills priority of the 2019 CHP	N/A	N/A
YMCAs	Strong partnerships to advance strategies under Healthy Living priority including member engagement in their health	Could benefit from even stronger connection to BH providers.	Deepen role of wellness programs to address social isolation and promote mental well-being to support priority	N/A	N/A

			area of Mental health and SUD.		
Rogue Retreat	Providing housing and case management to address the CHP priority under SDOH+HE	Would benefit from engaging with more healthcare partners.	Will be a central partner in the housing priority of the 2019 CHP	**N/A**	**N/A**
Traditional Health Workers (THWs) affiliated with organizations listed in OAR 410-141-3145 (in this column).					
Starting Strong Program	The JCC perinatal incentive program employs a CHW to improve maternal-child health outcomes. The program has a strong network of community partners that employ THWs to connect families to resources that increase stability and engagement in preventative care.	Need a bilingual CHW for the program	JCC plans to hire an additional staff	**N/A**	**N/A**
RVYMCA	Supported the training of CHWs and contract supports their work to support members in achieving a healthy weight through diet and physical activity.			**N/A**	**N/A**
RVYMCA	Supported the training of CHWs and contract supports their work to support members in achieving a healthy weight through diet and physical activity.			**N/A**	**N/A**

Rogue Community Health	Collaborate on projects with CHWs and provided them with training on health equity.	Need to engage RCH THW program to address CHP priorities.	RCH is on the CHP steering committee and workgroups.		
Culturally specific organizations and organizations that work with underserved or at- risk populations (list in column below).					
Maslow Project	Provided grant funding to establish a bilingual/ bicultural case management program to support families and youth experiencing homelessness.				
Kids Unlimited Academy	Support youth programs at this school serving high number of Latino families.				
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. <u>Housing must be included as one of the SDOH-HE spending priorities.</u>		
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 <u>health</u> <u>outcome goal</u> (i.e. addressing food insecurity to address obesity as a health issue) *or* <u>priority</u> <u>populations</u> (i.e. addressing early childhood education for children as apriority population) *or* <u>other</u>.
Healthy Beginnings	Jackson Care Connect CHP 2014	Priority population
Healthy Living	Jackson Care Connect CHP 2014	Health outcome goals
Health Equity	Jackson Care Connect CHP 2014	Health outcome goals (reducing health disparities) *Housing has been included in this priority as a SDOH+HE
Behavioral Health	Jackson and Josephine County Collaborative CHP 2019	Health outcome goals
Housing	Jackson and Josephine County Collaborative CHP 2019	Health outcome goals
Parenting Support and Life Skills	Jackson and Josephine County Collaborative CHP 2019	Health outcome goals and Priority population
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.		

JCC is collaborating with regional partners (hospitals, public health, CCOs) to complete a CHP around the three priorities of 1) Behavioral health 2) Housing 3) Parenting Support and Life Skills. These priority areas will be further defined during the process outlined below to develop strategies. The CAC will continue to be involved throughout the timeline. This process is being led by Jefferson Regional Health Alliance, Jackson County Public Health and the CHA/ CHP Steering Committee that JCC serves on.

Jan-Feb 2019
- Partnership name selection
- Visioning
- Select & narrow priority areas
- Form work groups

March-April 2019
- Select goals & population outcome measures
- Initiate selection of strategies
- Initiate drafting of CHIP document

May-June 2019
- Complete selection of strategies
- Complete initial draft of CHIP document
- Review, revise, & finalize CHIP document
- Internal CHIP document approval by partner organizations
- Submit to OHA by June 30th

2019 and beyond:
- Develop action plans
- Initiate and continue the action cycle
- Implementation and monitoring of CHIP action plan and population outcome measures. Includes:
  - Regular work group & committee meetings
  - Reports on progress
  - Continued recruitment new partners into CHIP partnership work
- Review & revise action plan

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

Attachment 10 - Social Determinants of Health and Health Equity

10.A.1.a. Did Applicant obtain Community involvement in development of the Application?

JCC values community involvement so that we can develop and deliver coordinated health care that responds to community needs, reduces disparities, and improves health outcomes. In developing this application, we specifically sought and received input on the application from providers, SDOH-HE partners, members, and other stakeholders by attending community meetings, presenting content of the application and/or specific issues (i.e. dental care). This input was then integrated into the application.

JCC solicited input to the development of this application from the following partners:
- **Community Advisory Council (CAC)**: 3 meetings. These meetings are open to the public. Because the CAC is focused on community input, we facilitated additional discussion and brainstorming around member engagement, how to communicate with members in culturally and linguistically appropriate ways, and how members want to be partners in their care.
- **JCC Board of Directors**: 2 meetings. These meetings are open to the public and attended by providers, community-based organizations and 2 CAC members.
- **Network & Quality Committee (N&Q)**: 2 meetings. Input gathered from health care providers and other service providers.
- **Clinical Advisory Panel (CAP)**: 2 meetings. Input gathered from clinical leaders.
- **JCC Governance Committee**: Input gathered from JCC Board members.
- **Dental Care Organization**: Input gathered from dental care organizations.
- **Community Health Improvement Plan (CHIP) Stakeholder Meeting**: This set CHIP priorities and was attended by physical health and behavioral health providers, community-based organizations, members, the Regional Health Equity Coalition and public health.
- **Community Health Assessment (CHA) – Community Engagement Meetings**: JCC held five meetings attended by members, providers, and community-based organizations. These meetings provided essential background data for plan development.

JCC also held numerous formal and informal one-on-one partner meetings with community-based organizations and providers to gather input on community strengths, care needs, and goals.

10.A.1.b. Applicant will submit a plan via the RFA Community Engagement Plan for engaging key stakeholders,
10.A.2. Requested Documents: RFA Community Engagement Plan and attaching 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.

To date, JCC has made investments in community capacity to address the priorities of our 2014 Community Health Improvement Plan: Healthy Beginnings, Healthy Living and Health Equity. Over the next several years, our SDOH-HE funding will shift to reflect priorities identified in our 2018 Community Health Assessment; housing, behavioral health, and parenting support and life skills. We currently have MOUs or agreements in place with the following entities:

Housing
- **Rogue Retreat**: housing and case management for members in recovery; expanding to support movement along a continuum of housing and self-sufficient stability. We evaluate health-related outcomes and the impact on cost and utilization. This partnership is also

supported by a CareOregon grant piloting housing for members undergoing Medication Assisted Treatment. JCC also funds access to showers, a laundry facility and drinking water.
- **Jackson County Continuum of Care**: improvements to decrease the average length of homelessness, increase efficiency in linking homeless members to support services, increase the number of shelter beds and housing units, and provide Homeless Management Information System (HMIS) so homeless members receive fair and equitable assistance.

JCC also has non-contractual relationships with local housing providers including Jackson County Housing Authority (which has representatives at JCC's CAC and Board) and The Maslow Project.

Behavioral Health
- JCC has contracts with Jackson County Mental Health (LMHA) and a host of organizations providing behavioral health, mental health and substance abuse services. See Attachment 11.

Parenting Support and Life Skills
- **Rogue Valley Family YMCA (RVYMCA) and Ashland YMCA**. (1) scholarships for YMCA memberships to support more than 2000 members' access to physical activity and healthy connections. (2) *12 Weeks to a Healthier New You* group-centered nutrition, fitness, health coaching, and personal training. Medical providers refer members; new component for chronic pain. (3) *Junior Wellness* program (RVYMCA) and *Youth Fitness* program (Ashland YMCA) support youth members who want to achieve a healthy weight. (4) Wellness staff are trained as Community Health Workers and in trauma-informed care.
- **ACCESS Cooking Classes.** Monthly cooking classes at the RVYMCA. JCC members learn to create healthy meals and change diets to improve their chronic health conditions.
- **Southern Oregon Success (SORS), collective impact collaborative.** (1) Raise awareness of the impacts of Adverse Child Experiences (ACEs), with training to more than 11,600 community members. (2) Coordinate regional programs that improve self-regulation and resilience with K-12 school districts and community groups. (3) with ACE Interface, complete regional strategy map to ensure effective coordination with JCC's Community Health Improvement Plan and other major regional initiatives.
- **Kid Time:** Low-cost memberships to non-profit children's discovery museum to engage members with young children to access early educational opportunities.

JCC also has agreements with organizations who have applied for and received Community Health Improvement Plan (CHIP) grants awarded by JCC's CAC. These organizations will vary from year to year. Current grantees (2018-19) include the following:
- **Addictions Recovery Center.** Residential substance use disorder treatment program for new and expectant mothers.
- **Reclaiming Lives.** Recovery Café provides long-term sobriety and personal growth support, reduces social isolation and builds community in a coffee shop environment.
- **Age Friendly Innovators.** Provides home safety assessments, improvements and installation of safety equipment for older adults on limited incomes and for disabled adults.
- **Head Start.** Health literacy training for parents, emphasis on families who are experiencing poverty, homelessness, have special needs, or are dual language learners.
- **Jackson Elementary.** Ready for Kinder Home Visiting program addresses school readiness for kindergarten-age students to eliminate disparities in equity and access for children.
- **NOWIA Unete, Center for Farm Worker Advocacy.** Familias Sanas (Healthy Families) provides educational classes for youth, focusing on healthy eating and food preparation, environmental concerns, and traditional Latino culture.

- **Siskiyou Community Health Center.** Free and voluntary home visiting to at-risk families to monitor child development, teach positive parenting, monitor home safety, and help families connect to medical care and community services.
- **Southern Oregon University Youth Programs.** Latino Pathways Enhancement Project prepares 120 Latino students for high school success and college readiness through academic support, mentorship and family support.
- **Spartan Boxing Club.** STEER (Staffing To Expand Earned Revenue) mentors and coaches underserved youth, helping youth learn the value of healthy, constructive exercise.

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.

JCC currently employs a variety of evaluation metrics to assess the performance of SDOH-HE programs and partnerships. The evaluation is to determine the effectiveness of each program against program goals and build process improvements. Partnerships are structured with an LOA or MOU outlining objectives, deliverables, and reporting timeline. The elements of evaluation will continue to include gathering information relative to each program, designing the appropriate evaluation, collecting and analyzing data and reporting the results. JCC will continue to align with a logic model process, outlining anticipated investments in time, money, staff or other inputs against the proposed activities, target population(s), short-, medium- and long-term outcomes or impacts that we expect.

Outlined in the table below are some of the programs for which JCC has been collecting member level data and the metrics used to evaluate the programs.

Project	Brief Description	Metric
Rogue Retreat	Stabilize members facing homelessness through housing and case management	Changes in self-sufficiency scores Medical costs Relapse rate
YMCA Membership (Ashland YMCA & RVYMCA	Engage members in healthy life style activities	Percent of total membership engaged Demographics engaged Do those engaged have lower health care utilization
YMCA Wellness	Support health outcomes	Number of engaged members Demographics engaged Behavior changes – pre & post intervention surveys Health indicators (BMI, A1C, blood pressure, etc.,) Health care utilization
Starting Strong	Engage pregnant members and those parents with children 0-4 in preventative health	Percent of members who gave birth who were engaged Demographics engaged Continuity of coverage Utilization of preventative care

While JCC does not yet have SDOH-HE performance milestones/metrics in place for our clinic network partners, we are currently developing a health equity component with measurable milestones and metrics for our primary care value based payment model (VBP) to be implemented in 2020. This will help clinics reduce health disparities by consistently providing culturally responsive, inclusive, and trauma-informed care. We anticipate that the VBP component will begin as a narrative or attestation report and then subsequently build to include an objective, quantitative measure of performance. We will seek to align with any equity-related measures developed by OHA and have already been focusing on disparities identified in the current CCO Incentive Metrics:

Focus/Background	Future Steps
Colorectal Cancer Screening - One in three (36%) Oregonians ages 50-75 are receiving recommended colorectal screening, and only one in five Latinos were screened (21%) in 2015. We have been monitoring screening rates by ethnicity and have seen the gap narrowing incrementally every year	Goal for 2019: Increase screening rates across the population by 3% and continue to narrow the ethnic disparity.
Effective Contraceptive Use - Jackson County has had a persistent disparity in adolescent pregnancy rates, with higher rates for Latinas. In 2018, through the Latino Network, we offered trainings on patient and family-centered, culturally appropriate, contraception care for adolescents. One FQHC had their entire clinical staff trained; representatives from 4 other clinic systems were trained.	In 2019, JCC plans to engage our Youth Advisory Council to learn their insights, and share this with our network partners to identify interventions to pilot. In addition, our bicultural Community Engagement Coordinator does specific Latino outreach to both parents and adolescents.
ED Disparity Metric - JCC employs PreManage to reduce ED utilization for the ED Disparity cohort. Since 2017, JCC has convened community partners to advance implementation. Improvements in care coordination are suggested in the data we are tracking.	We have seen ED Utilization among members with Mental Illness decrease from 104 (per 1000 MM) in January/2018 to 88.8 in October/2018; we will continue improvement work

In addition, JCC will be piloting a new component of the primary care payment model with pediatric clinics. While the component is classified in the cost of care domain, it will focus heavily on SDOH-HE, ACEs, and resiliency. The reporting milestones will focus on:
- Screening for medical and social complexity
- Segmentation of the population based on medical and social complexity factors
- Ability to generate member level and aggregate population report on patient complexity
- Internal and external resources available to patients with elevated complexity
- Processes for connecting patients to resources
- Using population-level complexity information to inform staffing models
- Building staff competency for trauma-informed care

Based on the initial data collection, we will develop reporting requirements that will push our pediatric network along the continuum where we identify opportunities for improvement. We anticipate spreading this concept to the full primary care network after a preliminary period.

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.
JCC has a clearly defined process that engages CAC members in identifying our SDOH-HE priorities, even though we do not have a written policy. The CAC plays a pivotal role in our Community Health Assessment, oversees our process for awarding grant funds based on addressing CHIP priorities, and decides how to award the funds. Since 2016, the CAC has distributed $830,000. Beginning in 2019, JCC is involving the CAC in more broadly in SDOH-HE efforts. Staff will provide SDOH-HE program updates at least quarterly and engage the CAC in developing recommendations to JCC Board about funding allocations of the SDOH-HE annual budget.

10.B.1.(d). Please describe how Applicant intends to award funding for SDOH-HE projects, including:
10.B.1.(d).(1). How Applicant will guard against potential conflicts of interest;
All CAC, Board, and committee members overseeing funding or programmatic decisions related to funding SDOH-HE projects will be asked to identify their relationship and declare any conflicts of

interest at each meeting. For grant funding, if a member has a conflict, they will be excused from reviewing that grant application and may be completely excused from voting on grant awards.

10.B.1.(d).(2). How Applicant will ensure a transparent and equitable process.

JCC ensures transparency and equity throughout the funding process. This starts with widely announcing the RFP for funding availability via emails lists, social media, a press release, our website and at community meetings. The award is structured to increase equity because it provides one-time funding for organizations and as such, is available to a broader range of community organizations. All funds awarded to SODH+HE projects through the CHIP grant are decided upon by the CAC, which holds meetings that are open to the public. Further, the grant review process evaluates each proposal based only on the 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.

JCC will conduct an annual program evaluation of every SDOH+HE funded program to assess impact /reach, and identify process improvements. For each project, we identify metrics and reporting mechanisms to evaluate and communicate impact. The metrics are tracked and shared with the CAC, JCC Board, and relevant JCC partners. We also share the outcomes of projects with our members and the community at large by posting stories on our website and social media and sharing at our annual Spring Conference. Our objective is to broadly disseminate information about our SDOH-HE priorities, projects and outcomes so that our community is aware of and can engage with us in reducing disparities and improving health. Lastly, we hold multiple meetings on an annual basis that bring together the Board and its committees (including CAC), where projects are highlighted for outcomes and improvement learnings.

10.B.1.e. For the statewide housing priority only: please provide proposed metrics for assessing the impact of investments in this area.

The adverse impact of homelessness on the health of individuals, families, and communities has been widely documented. Housing insecurity contributes substantially to health disparities, including increased vulnerability to illness and trauma, and rates of mortality are found to be three to four times higher among the homeless than in the general population.

We have developed the following metrics to track impact of our work over the last 5 years of building a continuum of housing services. For supportive and transitional housing, JCC proposes the following metrics based on those currently tracked in our partnership with Rogue Retreat:
- Utilization of health services (physical and behavioral health care),
- Utilization of preventative care,
- Stability as tracked through the self-sufficiency case management matrix,
- Average length of stay, and
- Maintained stability after program graduation.

Additional metrics will be added that are relevant for the collaborative CHIP strategies developing in our region. While not yet finalized, these are projected to include:
- Size of chronically homeless population,
- Number of affordable housing supportive policies in each regional jurisdiction (*e.g.*, construction excise tax funds, multi-unit zoning),
- Amount of affordable housing stock, and
- Proportion of rent burdened population.

JCC has already begun developing a continuum of housing services for our most complex members. We are employing metrics to evaluate the impact of housing services on health-related outcomes, cost and utilization. Our metrics will evolve from wisdom gained through our partners:

- **Rogue Retreat** to provide a wide range of housing support and case management. The continuum of housing opportunities supported by JCC include:
    - Kelly's Shelter – emergency shelter
    - Hope Village – shelter and case management
    - Recovery Housing – for men and women
    - Housing Retreat – subsidized rent
    - Restart Retreat – rebuilding rental history
    - Housing unit for individuals and their families who are being prescribed medication assisted treatment in their substance use recovery
- **ColumbiaCare Services** to provide a wide range of housing supports for members with behavioral health conditions including:
    - 10 beds of short- and medium-term transitional housing for adults with mental illness or substance use disorders.
    - 15 Rental Assistance Program (RAP) beds for transition age youth and Veterans with OHP. RAP reduces barriers by subsidizing rent, helping with move in costs, and accessing other housing resources.
    - 5 permanent housing units for members with SPMI in need of intensive treatment to support housing stability.
- **The Maslow Project** to provide social connections, case management, and resources for homeless youth.

10.B.2. Evaluation Questions
10.B.2.a. Please describe the criteria Applicant will apply when selecting SDOH-HE partners.
JCC will use the following criteria to select SDOH-HE partners:
- Mission that aligns and complements JCCs mission and the partnership goals;
- Demonstrated success providing services of the sort proposed in the partnership;
- Programs that serve those living in poverty;
- Demonstrated approach to their work through an equity, diversity and inclusion lens;
- Ability to provide and share data to collaboratively complete program evaluation;
- Staff with the skills needed to provide quality services;
- Required insurance consistent with the level of liability of the program; and
- Ability to follow provisions of HIPAA rules if member level data is tracked and exchanged.

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.
JCC's intent is to broadly share information regarding SDOH-HE spending priorities, availability of funding, application process and decision process. To reach the widest possible audience, JCC will send a press release announcing funding priorities and grant application process, post on our website, post on social media, share at public meetings, share through workgroups with partner organizations, share at CAC (open to the public), and share with variety of email lists. In addition, we highlight our community-based work at an annual conference held in April.

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.

JCC creates an annual budget for SDOH-HE spending based on community priorities and available funding. This is reviewed and approved at a high level by the Finance Committee and the Board of Directors. The CEO reviews and approves a more detailed version of the SDOH budget. Each SDOH program is assigned a project code used to track spending in the accounting system. Managers and staff receive the budget and project code list so they can identify the appropriate code when they request a payment. Each payment request is reviewed and approved by a manager, who confirms that the payment meets the strategic aims of the particular SDOH program. Accounting produces (1) a budget variance report by program for JCC management to review monthly and (2) a higher-level SDOH budget variance report for the Finance Committee & Board to review monthly. We will also provide an annual analysis to the Board of Directors and CAC.

The Board designates an annual fund to the CAC for CHIP investments. The CAC is responsible for all fund decision making and performance accountability. Staff track the financial components.

For member-specific SDOH-HE programs, JCC will collect data from our partners monthly, quarterly, or annually, depending on the cadence appropriate for the program. The system for sharing data depends on the type of data and the level of protected information. For partners providing case management, platforms are being explored to enable real-time data sharing between partners and internal staff. This will enable JCC to analyze demographics of members engaged, scope of engagement, medical utilization, diagnosis, and other risk factors.

10.B.2.d. Applicant will submit a plan for selecting Community SDOH-HE spending priorities 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.

All the partnerships JCC has developed to address SDOH+HE (described previously) are HRS community benefit. JCC staff are conscious of using these funds to build community capacity to achieve intended outcomes, rather than building dependence on OHP funding. Even programs that operate through member specific contracts with partners, such as Rogue Retreat and the YMCA, create organizational capacity to serve the broader community. This capacity development includes staff trainings, technical assistance, evaluation support, and ability to leverage additional funding.

Our community Board of Directors, which includes providers, CBOs and two CAC members, approves the allocation of funding for SDOH+HE, including the CHIP grant fund allocated to the CAC for distribution in alignment with the CHP. The CAC releases a request for proposals 2-3 times annually with specific criteria matching CHIP priorities. Nonprofit organizations are eligible to apply. The CAC and the Youth Advisory Committee (YAC) are responsible for reviewing applications and making funding decisions. (See above CHIP grant process and eligible entities.)

There was broad community input in the development of the original CHP that guides the funding priorities of healthy beginnings, healthy living, and health equity. The 2019 CHP in process is already engaging even broader community input (including both local hospitals, public health, FQHCs,

regional CCOs, 1,200 community members and 170 multi-sector organizations) and will inform the HRS community benefit investments going forward.

10.D. Community Advisory Council membership and role
10.D.1. Informational Questions. 10.D.1.a. Please identify the data source(s) Applicant proposes to use when defining the demographic composition of Medicaid Members in the Applicant's Service Area.
JCC will integrate 834 enrollment data within our enterprise data warehouse (EDW); this provides the basis of demographic information for our members. In addition to demographics, this data file includes valued information (eligibility, rate codes, etc.) which is integrated within the EDW at a member-level detail. This information is further refined as we connect with members (via customer service, care coordination, and community outreach programs) and we ingest data through other HIE activities (*e.g.,* Reliance, PreManage).

JCC 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. The Population Segmentation tool will be used to analyze claims data to categorize our population into risk categories (healthy, low risk, rising risk, and high risk) based on chronic conditions and past utilization. We will use this data to further understand utilization patterns within sub-populations and build better points of access to care. Further, the Johns Hopkins ACG system is applied on top of combined demographic and claims data to understand the health of our membership at an individual and population level.

JCC 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, JCC 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.

To analyze the interplay of medical and social factors that add layers of complexity to our members' health, JCC will use the health complexity data from OHA; we have used and 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. We also plan to use the aggregate information as part of the Maternal Child Health effort led by clinical staff.

Finally, JCC will use publicly available data provided by 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 JCC. These data will better allow JCC to respond to the needs of the whole community.

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, for engaging CAC representatives that align with CHP priorities and membership demographics, how it will meaningfully engage OHP consumer(s) on the CCO board and describe how it will meaningfully engage Tribes and/or tribal advisory committee (if applicable).
 Please see RFA Community Engagement Plan.

10.E. Health Equity Assessment and Health Equity Plan
10.E.1. Informational Questions. 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.

Improving health equity is a priority for JCC. Our work around equity, diversity and inclusion (EDI) is led by a cross-departmental Equity Action Committee. This committee's purpose is "To implement strategies aimed at reducing health inequities and healthcare disparities through shared learning and innovation, ongoing engagement, and diverse and inclusive leadership." It works to
- Reduce disparities in targeted metrics
- Improve language services and accessibility
- Maintain strategic and robust community-based, partnerships related to health equity
- Embed EDI in our CAC, board, and CAP
- Ensure use of equity and diversity lens in our hiring practices and on boarding
- Provide EDI support to our provider network/community partners
- Change organizational culture
- Uplift member voice

The Equity Action Committee has participation from representatives of the Board, CAC, and CAP. This committee leads the development of JCC's Health Equity Plan. The Equity Action Committee evaluates the effectiveness of its efforts by tracking deliverables in each area of focus with measurable indicators, such as number of interpretation appointments filled for language services.

In addition to the Equity Action Committee, JCC is committed to addressing health equities and raising awareness across our organization, our partners, and our community. Staff participate in the Regional Health Equity Coalition, which provides connection to trainings and resources. We also:
- Provide training to internal staff on specific topics and hosts a monthly staff "lunch and learn" series with an activity and discussion related to equity, bias, racism, and more.
- Offer trainings to provider network to address disparities, including on increasing effective contraceptive use among the Latino community in a culturally responsive manner.
- Require that our community-based partners complete trainings on health and health equity. The JCC Health Equity Integration Coordinator offers health equity trainings to support partners in their EDI goals. This ongoing technical assistance elevates the importance of the health equity lens in providing services to our members and community.
- Ensure contract compliance through regular check in meetings with partners to assess progress and the need for additional support.
- Provide trainings to providers through language service vendors.
- Ensure Equity, Diversity and Inclusion (EDI) trainings and activities are embedded into the CAC and board meetings as a means of providing ongoing training.

JCC provides the trainings using both internal staff and contractors with expertise in equity, diversity and inclusion. JCC tracks the number of staff and partner participants and effectiveness of training by tracking follow up items and increased capacity for implementing health equity goals.

10.E.1.b. Please describe Applicant's capacity to collect and analyze REAL+D data.
JCC 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, JCC 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, JCC 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.

JCC 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, JCC 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, JCC 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, JCC 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 JCC. These data will better allow JCC to respond to the needs of the whole community.

10.E.2. Evaluation Questions (Health Equity Assessment) See Health Equity Assessment Guidance Document
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.

JCC collects demographic, utilization and qualitative data that informs the development of culturally and linguistically appropriate services for our members. These include:

Demographics
- Please see above: 10.D.1.b and 10.E.1.b (REAL+D data).

Utilization
- JCC will merge member enrollment data with claims data to understand utilization trends for our populations and detect patterns of over- or underutilization or disparities in utilization which could point to access barriers.
- The Population Segmentation tool will be used to analyze claims data to categorize our population into risk categories (healthy, low risk, rising risk, and high risk) based on chronic conditions and past utilization. JCC will also use this data to understand utilization patterns for sub-populations and build better points of access to care for these populations.

Qualitative
- We gather qualitative data from our CAC, which consists of members who identify as Latino, disabled, LGBTQ, homeless, and senior citizens. The CAC members act as our "lived-experience advisors" and advise on how to more effectively provide culturally and linguistically appropriate services. JCC also gathers input from sub-populations through listening sessions engaging residents who are homeless, Latino, LGBTQ, and rural.
- We also gather information from our members through satisfaction surveys, the initial member screening, member service call logs, and from our community partners through our Annual Spring Conference and various community-based forums.

Fourteen percent (14%) of our members are Hispanic/Latino. Based on the demographics of our population, we have focused on developing capacity and programs that specifically address the needs of the Spanish-speaking, Latino population. Examples include:

- JCC has a bilingual/bicultural Community Engagement team that regularly reaches out and connects with people where they are. This team's work includes attending many culturally-specific events. Our team is adept at building trusting relationships with our members and helping them understand their benefits and how to effectively connect to services.
- JCC has implemented *Starting Strong* to improve maternal child health outcomes within the Spanish-speaking Latino community by intentionally increasing access to health care and social support services. Of the Latina JCC members who gave birth in 2017, 57% engaged with *Starting Strong*. This program gives women vouchers if they engage in preventative activities including WIC, pre-natal OB care, pediatrics, and home visiting programs. The women can exchange their vouchers at the *Starting Strong* store for car seats, diapers, formula, etc. The *Starting Strong* Program Specialist is a Certified Lactation Counselor and Community Health Worker offering education and resource navigation support.
- JCC has funded partners to add bilingual/bicultural staff to serve Spanish-speaking members, including the Maslow Project (for youth and families experiencing homelessness) and RVYMCA to help both English and Spanish speaking members connect to services.
- JCC has implemented preventive programs to increase engagement by specific segments of Latino population. For example, JCC identified a disparity in the colorectal cancer screening for Latino men. Through community listening sessions, we learned that Latino men would more likely to complete a home test. After implementing mail out home test kits we saw a significant reduction in this disparity.

Although we have a strong focus on programs to support of Latino population, we aim to provide culturally and linguistically appropriate services for all our members. Through CareOregon, JCC provides certified language interpreters to meet the need of Limited English Proficiency (LEP) members. These services are provided via face-to-face, telephonic, and on-line encounters at no charge to members. CareOregon monitors language usage, telephonic time to connect, member complaints and interpreter capacity by language to ensure high quality services. Through the 834 enrollment data described earlier, we monitor members who have a primary language other than English and are not using interpretive services. We engage in linguistically appropriate outreach to notify those members that interpretive services are available.

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.
Recognizing that hiring, retaining and promoting diverse staff is an organization-wide commitment, JCC implements multiple strategies as described below.

When hiring, we value the lived experience that people of diverse backgrounds, including bilingual/bicultural skills, bring to the work and the organization. We list our positions on job boards that promote diversity from within the community. We participate in job fairs throughout Oregon that promote equity and diversity. JCC has incorporated standard interview questions that inform prospective employees of our values around equity and diversity, and allow us to understand candidates' perspectives of the contributions their own experience will bring as an employee.

We also work to set an expectation of inclusivity in our operations. In the workplace, JCC intentionally cultivates a culture that values diversity of employees. JCC staff coordinate monthly EDI lunch sessions to have discussions and share information to raise awareness. As JCC employees, we operate on a set of "SPIRITED" values that drives our organization. One of these values is our organizational commitment to understand others, value differences, and move beyond

simple tolerance to embrace and celebrate the richness within each individual. We have an internal employee acknowledgement program that provides monetary and non-monetary recognition to individuals who demonstrate these values.

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.

JCC is dedicated to ensuring that members are aware of their rights for free, high-quality interpretation. We also recognize that there is additional work for us to do in this realm. Through its parent company, CareOregon, JCC has contracts with multiple interpretation vendors. 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 JCC's Language Access Workgroup monthly.

On behalf of JCC members, CareOregon oversees provision of both interpretation services through its customer service staff and translation of materials through its communications department. In collaboration with the DHS/OHA Assistors, JCC 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 Language Access Workgroup encourages providers to utilize interpreters (or bilingual staff). This committee will track 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 translated materials distributed; and funding for certification of local interpreters.

In addition, JCC will:
- Train staff who interact with members on how to effectively and appropriately use interpreters. Staff are trained on how and when to access contracted interpreters and to understand the need for meaningful language access.
- Send all notices in English and Spanish. 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.
- Offer Meaningful Language Access training to network providers emphasizing patient rights and ensuring that provider offices know how to access interpretation for JCC members.
- Enhance the customer service team with key language staff. We have added a policy to ensure a pay differential for bilingual staff and are formalizing our process for testing bilingual staff to ensure that they can communicate about complex health care benefit and service questions.
- Monitor the number of members who are limited English proficient and review that volume in comparison to the number of members getting interpreted visits to understand where to target additional education and capacity.
- Expand the data that we collect regarding interpreted visits by better understanding the needs and language programs of the clinics.

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.

JCC/CareOregon's provider agreements require and will continue to require compliance with non-discrimination practices including providing access to persons with disabilities. All new PCPs require site visits to ensure ADA compatibility of the office, including street level access or an accessible ramp and wheelchair access to lavatory.

Using the member appeal and grievance process, JCC, through CareOregon's Medical Management staff, will monitor and analyze all complaints and 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. If a member receives a denial of a service that could assist with their disabilities and is covered under another state program, JCC/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, Health Related Services may assist through coordination with the primary care team.

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. Informational Questions
10.F.1.a. Does Applicant currently utilize THWs in any capacity? Please describe how they are utilized, how performance is measured and evaluated, and identify the number of THWs in the Applicant's workforce.
Behavioral Health Network:
JCC actively supports the use of THWs by our members. We have direct experience showing the positive impact THWs have both for members who have received supportive services from a THW and for members who have gained employment as a THW. JCC and CareOregon staff both hold seats at a Sub-committee of the Traditional Health Worker Commission, and JCC staff serves as faculty at the Rogue Community College Community Health Worker program.

JCC directly employs a trained and certified THW in our S*tarting Strong* maternal child health program. This staff person addresses upstream issues by increasing participation in preventative care and connections to resources related to social determinants of health. The TWH also works with a network of clinical and social service organizations to establish the care need to help them achieve their goals. Currently this THW provides screening and navigation as part of the Accountable Health Communities project and is documenting work with members to share information with other internal care coordination team members.

Our behavioral health system utilizes the following THWs:
- **Kairos** outpatient services for youth: 3 FTE Family Support specialists and 1 FTE Peer Support specialist.
- **Jackson County Mental Health**: 2 part-time peers for the ACT team, 3 Family Partners for ACT, and 1 Youth Peer for the EASA program.
- **ARC** and **OnTrack**, both of our large substance use service providers, also use THWs (Certified Recovery Mentors).

- Currently **ColumbiaCare**, our main outpatient provider for adult MH, employs peers in their housing programs and plan to start a THW program in their outpatient clinic in 2020.

JCC also supports THW services in non-clinical settings such as our partnership with Compass House, an accredited Clubhouse Model providing psychosocial rehabilitation for members with SPMI who want rejoin society. This strength-based model offers mutual support by using peers, non-clinical staff support, pre-vocational training, social, and educational opportunities.

JCC has funded the training and positions of five Rogue Valley YMCA staff as THWs. These staff work as wellness coaches, interacting directly with members and their families, to set goals and attain needed resources. The staff at RVYMCA's membership desk are also trained as THWs; these staff assess members through conversation and provide information on beneficial resources in the community. As such, the YMCA functions as a community hub in a low-income neighborhood for connecting to resources and healthy habits. The outcomes of the programs are evaluated annually.

JCC's partner Rogue Retreat employs one Peer Support Specialist as housing case manager to work with members to maintain sobriety, access mental, physical and oral health care, and move towards stability. Rogue Retreat is planning to have more case managers trained as Peer Support Specialists.

JCC actively supports doulas as THWs. We work closely with the Oregon Doula Association to improve access to doula services among Medicaid enrollees. Our alternative payment models support clinics providing doula services to at-risk populations.

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.
JCC contractors utilize THWs in a variety of ways. The majority of funding is currently through grants, contracts, and value-based payments to our primary care or behavioral health network. The payment methodology used depends on the provider and type of service. Generally, those that provide services within traditional outpatient clinics are fee for service. Current state:
- **Fee for Service model**: Kairos, ARC, OnTrack, Rogue Valley YMCA, ColumbiaCare
- **Capacity Based contracts**: Jackson County Mental Health, WRAP teams, CompassHouse
- **Case Rate Contract**: Rogue Retreat

JCC has established an open-network for all doulas who meet OHA billing requirements to receive payment for services. We provide billing support to community and clinical partners who bill for OHA-approved doula services (*e.g.*, doulas who meet state criteria to bill for Medicaid).
We will update our APM funding to support primary care clinics integrating THW into their treatment teams. We can build from our current Behavioral Health Integration APM to build a THW/CHW APM providing startup funding and ongoing PMPM based on engagement levels and clinical outcomes. Finally, we will work to build sustainable funding models for community-based organizations that employ THWs but are not traditional healthcare facilities with billing capabilities.

10.F.2. Evaluation Questions. 10.F.2.a. Please submit a THW Integration and Utilization Plan
Please see **THW Integration and Utilization Plan**.

10.G. Community Health Assessment and Community Health Improvement Plan
10.G.1. Evaluation Questions. 10.G.1.a. Please submit a RFA Community Engagement Plan
Please see **Community Engagement Plan**

THW Integration and Utilization Plan

Applicant's proposed plan for integrating THWs into the delivery of services
JCC recognizes the value of traditional health workers for our members. THWs are a proven strategy for helping members engage in services by supporting effective access to health services. THWs can also increase the delivery of culturally and linguistically appropriate services and increase member retention.

JCC will continue to support integration of THWs within medical health systems such as La Clinica, Rogue Community Health, Asante Physicians Partners and Providence. However, we also recognize that if only the large health systems have THWs, there is limited access for other members who don't use those systems. Thus, JCC is exploring the potential to expand to additional sites or additional delivery models.

JCC 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 wraparound program includes youth and family peer support. Both of our large mental health providers for youth and adults have peer support specialists as part of the treatment team. In these settings, the peers are part of a multi-disciplinary treatment team and have a peer as their integrated supervisor.

JCC will continue to fund a clubhouse model of peer support, Compass House, which serves over 400 of our members with severe and persistent mental illness (SPMI) per year. This is a low-barrier opportunity for members to access support as often as daily, with integrated educational and employment services, transportation, skill building and social support.

In the substance use disorder (SUD) treatment network, JCC will support and fund recovery mentors to work with members prior to treatment, during treatment and into recovery. JCC is currently working with the Addictions Recovery Center to develop a funding model that will support pre-treatment outreach and engagement using recovery mentors. JCC is also working with a large group of community stakeholders and OHA to develop and implement a peer support component for low-barrier access to medication assisted treatment in emergency departments, hospitals and bridge clinics. Bridge clinics are a low barrier access point for someone ready and willing to begin buprenorphine and other medication assisted treatment (MAT) for opioid use disorder, without the traditional work-up and wait times. In Jackson County, the bridge clinic is co-located with the syringe exchange program as an attempt to meet people where they are and where they might be willing to get started on MAT (in other communities, this may be located in an ER, urgent care, primary care, specialty care, or similar location).

For community THWs, JCC may use two strategies:
1. Partner with an existing organization. This has the benefit of allowing JCC to work very closely with the organization on how the programs are implemented and influence quality. It will also allow JCC to provide THWs for any member, no matter which health system is providing care.
2. Hire THWs directly. This has the benefit of full control on implementation of the THW program, has a clearer route for data tracking and allows JCC to provide THWs for any member, no matter which health system in providing care.

How Applicant proposes to communicate to Members about the benefits and availability of THW services.
JCC will communicate directly to members about THWs through our website and potentially through information campaigns and the new member packet. We will encourage providers to refer members to THW as appropriate and will ensure that providers and community partners with THW will communicate with members about THW benefit and availability.

How Applicant intends to increase THW utilization
JCC will increase THW utilization throughout the region by purposefully integrating THWs into larger population health strategies and community health initiatives. JCC will designate a THW liaison as the central point of contact for THW integration, and who will primarily work to address the barriers to integration and utilization of THWs and their services. JCC will also use the OHA and THW Commission guidelines to establish sustainable payment models for THWs that will both encourage utilization and promote investment developing the THW workforce. JCC will collect data to measure the integration and utilization of THWs using the reporting template provided by OHA; we will use that data to understand the impact of THWs on the health of our membership and inform our approach to how to best utilize THWs to achieve the desired outcomes.

How Applicant intends to implement THW Commission best practices.
JCC will work in collaboration with the 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.

The actual practices will depend on the overall THW utilization strategy being implemented. Best practices cover a variety of THW settings including in a clinical setting, in community based organizations (CBOs), and in behavioral health.
- Most clinics and CBOs will need and receive technical assistance with implementing THW services, with the possible exception of mental health and SUD providers.
  - Health clinics will need and receive guidance on hiring, supervising and integrating THWs into their clinical care teams.
  - CBOs will need and receive guidance on hiring and supervising THWs.
    - Health systems will need to be educated on the use of THW in a CBO and how to work with THWs as part of the care team. JCC will emphasize and train on collaboration strategies.
- Entities employing THW will receive technical assistance in data tracking.
  - JCC will make sure that data is being collected for all measures in THW policy rubrics and for the CCO Utilization Template
- JCC will implement learning collaboratives to keep partners up to date on THW practices.

How Applicant proposes to measure baseline utilization and performance over time.
To gather baseline and over-time performance, JCC will require that THW services are tracked by every organization that is utilizing THWs. This data will be reported to JCC to allow for tracking baseline utilization and overall utilization going forward.

JCC will design specific performance measures for use of THWs.
- These measurements are still under development. Performance measures are expected to vary based on the setting in which the THW is utilized.

- Potential measures include number of interactions, specific types of interactions and outcomes of each interaction
- It is not expected that there will always be a monetary ROI that is easily reportable.
- Peer services could potentially be judged to be high performing based on participants evaluating the service as helpful.

JCC will also collect data to measure the integration and utilization of THWs using the reporting template provided by OHA. JCC will collect and submit the information collected for our service area by April 1 of each contract year for data collected in the prior contract year.

Data to be collected and submitted includes:
  (1) An assessment of member satisfaction with THW services;
  (2) Ratio of THWs to the total number of members;
  (3) Number of THWs employed by Worker Type (FTE/Contracted);
  (4) Number of requests from members for THW services (by THW types);
  (5) Number of engagements of THWs as part of the member's care team (by THW types);
  (6) Demographics of THWs and CCO membership: including race, ethnicity, language, disability; and
  (7) The number of clinic and community-based THWs.

JCC will collect data for each of the following THW types:
  (1) Community Health Workers
  (2) Doulas
  (3) Peer Support Specialists including Adult Addictions, Adult Mental Health, Family and Youth Support Specialists
  (4) Peer Wellness Specialists including Adult Addictions, Adult Mental Health, Family and Youth Support Specialists
  (5) Patient Health Navigators

JCC will document the number of interactions between THWs and members in each setting:
  (1) Clinic Setting
  (2) Non-Clinic Setting
  (3) Community-Based Setting

With proper reporting, it could be possible to do a "blind" study of the utilization costs of the members who accept THW intervention compared to those who decline services. This study will only be possible if the referral guidelines are adhered to, and data collection could be complicated by members that self-refer into THW services. If JCC undertakes such a study, we will ensure that reporting mechanisms are rigorously followed.

How Applicant proposes to utilize the THW Liaison position to improve access to Members and increase recruitment and retention of THWs in its operations.
 JCC will designate a THW liaison as the central point of contact for THW integration. The THW Liaison will be an employee who will act as the hub of information for THWs, consumers, and the community. This position will primarily work to address the barriers to integration and utilization of THWs and their services. In addition, the THW liaison will:
- Coordinate the CCOs THW workforce;
- Design THW integration and utilization plan within JCC's systems;

- Provide technical assistance to THW's provider enrollment within the JCC network;
- Assist in coaching and system navigation for THWs and members; and
- Support establishing THW's payments and rates, THW's utilization both in clinical settings and community-based settings, supervision and competencies, THW service delivery, and member accessibility to THW services within the CCO health care system.

Based on OHA and THW Commission guidelines, JCC will establish a payment model grid for the THW workforce, informed by recommendations of the Payment Model Committee of the THW Commission; the grid will be both sustainable and published. The JCC THW payment model grid will include various payment strategies, including fee-for-service, alternative payment models such as bundled payments and per-member per-month payments, direct employment, and other payment strategies. Sustainable rate shall mean strategies to pay for THWs services for long-term employment, as opposed to short-term grants or other forms of payment that result in underpay, underemployment or unemployment for THWs workforce.

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 HIT Commons MOU and fulfilling its terms?

JCC does not expect to have any challenges or obstacles in signing the HIT Commons MOU and fulfilling its terms. JCC 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)

JCC has been a leader in supporting EHR adoption and HIE platform creation and spread since the beginning of CCOs. We have actively participated in the OHA's various HIT committees and continue to promote adoption and best practice for HIT as a critical element to create shared actionable information to meet member, provider, population and plan need to drive value.

- *Member value*: Capture social determinants of health (SDOH) at the point of care, we envision optimizing EHR for better more effective integrated care, reducing risk and waste.

- *Provider value*: Optimize 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 specific patient and population health.

- *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 future efforts to bring value and improve health by supporting further adoption and spread of health information technology. As a reasonably small CCO serving rural communities, we benefit from our relationship with CareOregon which provides us with the sophisticated HIT expertise and resources of a large CCO that we could not otherwise afford. CareOregon serves approximately 250,000 Medicaid members across the state and has developed a comprehensive technology strategy to support its partner CCOs with member assignments and technology support functions. However, although CareOregon is the backbone for many of our infrastructure needs, our local JCC 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. Working closely with our regional partners, JCC will continue to improve our local health care system by investing in and spreading 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 Stakeholder HIT workgroup body created with charter Prioritized list of work identified and approved by stakeholder HIT workgroup	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 triple 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 EHR adoption and use throughout Oregon, including southern Oregon. This is true in our community, where the majority of our physical health providers have adopted Epic through our hospital partners Providence and Asante and through OCHIN, which hosts our two FQHCs, Rogue Community Health Center and La Clinica Health. Smaller clinics use a variety of CEHRT platforms.

In the future, given the high adoption rate in our community, JCC will focus on enhancing EHR utilization and functionality among clinics with existing EHRs. Our hospital partners may continue to support the smaller clinics adopting new EHRs. 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, JCC has and will continue to encourage and support adoption and use of EHRs in a variety of ways as described below:

By supporting PCPCH development and ongoing quality improvement - JCC supports Oregon's Patient-Centered Primary Care Home Program (PCPCH), which requires the adoption of an EHR for higher levels of PCPCH certification. Approximately 86% of our members receive care in a tier-3 or higher PCPCH including EHR adoption and meaningful use. JCC provides technical assistance to maximize EHR use through multiple modalities: continuous community-level learning opportunities through our coaching-led Patient & Population Centered Primary Care Learning Collaboratives (PC3), behavioral health peer-to-peer meetings, and clinic-based one-on-one coaching and other technical assistance support.

By supporting and incentivizing providers in population data and quality metrics achievement. Related to above, JCC partners with our clinical providers in achieving the OHA quality incentive metrics. Many of these metrics require EHR documentation and reporting. JCC 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, and 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 - JCC's care coordination staff 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 patient'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, JCC 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 - JCC supports an integrated, team-based model of behavioral health services in primary care. One payment model that JCC offers requires integrated behavioral health services to receive the enhanced alternative payments. In order to be successful, the data aggregation and care coordination activities required to receive the enhanced rates in the APM require use of the EHR**.** Clinics in JCC that have integrated behavioral health, include Providence, Asante, Rogue Valley Community Health, La Clinica, Southern Oregon Pediatrics, and Valley Family Practice. Clinicians in the FQHCs supported by OCHIN can document behavioral health directly into Epic.

By using value based payment (VBP) programs - JCC is increasingly engaging with its providers in forms of value-based payment, 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 payment incentivizes EHR adoption by giving additional dollars to clinics/systems that provide electronic CCO Quality Metric (eCQM) data. In the future, JCC's VBP models will likely include incentives that will require the use of EHRs, for example requiring providers to electronically submit their CCO Incentive Measure data to OHA's Clinical Quality Metrics Registry.

For the interventions listed above, we help clinics identify opportunities to more meaningfully use their EHRs to support their quality improvement and PCPCH enhancement goals. In addition, the past and current models for our alternative payment in primary care (PCPM and PCbehavioral health) bring resources for integrated care which are used for HIT technology, staffing and new care models using HIT in our provider clinics.

Examples of how we have helped our physical and behavioral clinics improve the use of their EHRs:
- Optimizing documentation of clinical quality metrics in EHR
- Data reporting capabilities (pulling reports)
- Referral documentation, reporting and closing loops
- Dot phrases for EHR efficiencies (*adolescent well check, depression, SBIRT, one key question, ACEs*).
- Medication reconciliation best practices
- "At the elbow support" with EHR vendors for optimization

By creating incentives for quality, robust APM models and at-the-elbow technical assistance, JCC continues to encourage adoption and optimization of EHRs.

<u>**Future Plans**</u>

By Contract Effective Date
The JCC Network and Quality Committee (N&Q) is a subcommittee of our Board responsible for providing clinical quality oversight and overseeing our regional network strategy and quality improvement initiatives. By contract effective date, we will create a workgroup structure of this committee (HIT Workgroup) to serve as the official body responsible for informing and monitoring

our HIT improvement efforts. Staff will work with this group to complete the 5-Year HIT Roadmap required by OHA to support our EHR optimization goals.

We will also initiate conversations with our CAP, Network and Quality Committee and other collaboratives 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 Epic 'dot phrases' for clinical metrics such as depression, best practice documentation for referral pathways for follow up after SBIRT screening, optimizing decision making for imaging, etc.

In Year 1, JCC will:

- **Create a HIT workgroup** comprised of key stakeholders to lead the development of our overarching HIT strategies with input from our Network and Quality Committee (N & Q), Clinical Advisory Panel (CAP) and other advisory forums. We will establish a charter for HIT workgroup, that includes identifying priorities and developing strategies for investing in EHR adoption and optimization.
- **Define EHR system needs -** Working with the HIT workgroup JCC 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 JCC Quality Improvement and Population Health targets and Incentive Metrics specifically. At a minimum, consider needs related to: Capturing data and reporting on existing and new metrics, accurate coding, including behavioral and oral health services provided in the primary care setting, cross system care coordination, screenings for preventive service and SDOH.
- **Conduct an environmental scan and identify gaps -** Assess current EHR prevalence, versions, capabilities and gaps for our primary care network. Evaluate specific capabilities for clinics striving to become robust, fully integrated primary care home that includes; oral, and health and behavioral health integration, 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 and PCPCH tier. We want our members to be cared for at the highest level of clinical quality. We will evaluate the value of providing ongoing subsidization of small clinics to adopt EHRs versus reassigning members to clinics with EHRs already implemented.
- **Create a plan -** Based on needs and gaps identified during the assessment process, the HIT Workgroup will develop a 5-Year HIT Plan that outlines the HIT priorities for JCC and its partners to support adoption and optimization of HIT among its community partners. The plan will be created in collaboration with JCC's CAP and Network and Quality Committee. We anticipate with the high rate of EHR adoption among our contracted physical health providers, JCC's plans will largely focus on helping providers more meaningfully use their existing EHRs and reassigning patients to higher quality clinics with EHRs.

  In the plan, we will align anticipated EHR needs that support JCC's four strategic priorities: integration and care coordination, clinical and quality excellence, member impact and financial stewardship and sustainability. We anticipate the plan will include both "new work" and prioritization of existing efforts and will address:

- Strategies to optimize value of current EHR investments, including workflow and system modifications to the EHR necessary to engage with Reliance, PreManage, and our GSI Care Coordination platform to improve 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 about organizations providing services related to SDOH, including those potentially identified through the HIT Commons. To support this work, we will seek input from our Community Advisory Council (CAC) and community providers about 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 including; our staff, CAP, N & Q, existing learning collaboratives (*e.g.,* behavioral health, MAT, PCPCH) and organizations that provide EHR technical assistance support to our clinics (*e.g.*, OCHIN, hospital system partners, vendors, etc.) to incorporate existing EHR optimization, quality improvement and workflow redesign into our new HIT workplan.

In Year 2, JCC will move to implement plans described in Year 1.

- Target training and technical assistance for different provider groups, particularly in the behavioral health world. Use current staff and advisory committees and learning collaboratives. Offer consultative services for care management services and patient care navigation.
- In collaboration with organizations providing EHR technical assistance to our clinic partners, deliver up-to-date functionality and workflows of current EMRs to include foundational and best practice standards within the EMRs related to treatment guidelines, decision support, and best practices at the point of care.

In Years 3-5, JCC will:

- Spread best practice, 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 will also,
  - Continue to support increased meaningful use of EHRs.
  - When, and if, infrastructure is available, we will 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. Few rural practices struggle to move to electronic health records in our region. With significant efforts in the last 6 years by OHA, hospital systems and CCOs to support EHR adoption through resourcing and technical assistance, the few clinics that remain on paper charts do so due to cultural resistance to change and not due to lack of resourcing. In the near term, we will continue to contract with them and continue to work with them to encourage EHR adoption. 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 for many behavioral health organizations that have implemented EHRs, they are not using their systems to report access to discharge/transfer reports, emergency department alerts, medications, lab results, 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. Below is a listing of modalities the JCC HIT committee and staff will use to support increased rates of EHR use for behavioral health providers.

Current EHR adoption

In our community, JCC's primary behavioral health partners are on or in the process of implementing certified EHRs. Kairos, ColumbiaCare and Jackson County Mental Health are on CareLogic and our substance abuse providers, ARC and OnTrack, are in the process of implementing Dr. Cloud. Approximately 70% of our outpatient behavioral health services are provided by these partners. JCC also has contracts with a number of small behavioral health specialists which are largely not on certified EHRs and we will assess their interest in adoption of EHR as part of the Year 1 environmental scan.

JCC has encouraged the adoption and use of EHRs among its contracted Behavioral Health providers:

- **By funding start-up costs.** JCC has supported spread of EHR adoption in our community by paying for EHR licensing fees and start-up costs for some of our behavioral health partners, including Phoenix Counseling, ARC, Kairos and Jackson County Mental Health. We support their further adoption of EHRs by encouraging applications for startup funding and providing networking opportunities for providers to learn from other providers about the benefits of electronic records and billing systems. We have also provided training on the benefits of using an EHR to assure compliance with Medicaid documentation requirements and EHR best practices.

- **By supporting PCPCH and behavioral health integration** As described above, the clinics associated with our two hospital systems and with the two regional FQHCs use EHRs that capture behavioral health data from their integrated behavioral health clinicians and have integrated work flows with support from years of JCC learning collaboratives. External partners in behavioral health are beginning their integrated data sharing and referral workflow process between Columbia Care Mental Health and pilots in our FQHC clinics. This work will continue in years 1-5.

- **By incorporating EHR use into care coordination activities**. As mentioned above, JCC's care coordination staff incorporates the use of provider EHRs into regular interdisciplinary care coordination and case conference meetings. Currently our behavioral health partners are not directly documenting into their EHRs during those sessions. However, we are supporting Columbia Care mental health provider for adults, and Kairos, mental health provider for children and adolescents, in their efforts to be able to employ concurrent documentation methods and techniques during the care coordination sessions to improve productivity and timely documentation. This promotes EHR use and consistent documentation across care settings.

Future Plans

In addition to continuing to support EHR adoption through the efforts described above, JCC 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 issues raised. JCC 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, JCC will:

- **Determine structure for behavioral health input** – HIT Workgroup and JCC staff will determine how best to structure development of HIT Workplan 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. We want our members to be cared for in the highest level of clinics possible. We will evaluate the value of providing ongoing subsidization of non-EHR behavioral health clinics versus reassigning members to clinics with EHRs. This may be constrained by availability of behavioral health providers in Jackson County.
- **Define behavioral health EHR needs –** Based on the input from the HIT Workgroup (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 plan -** based on needs and gaps identified during the assessment process, and input from the broader HIT Workgroup, JCC will develop a 5-Year HIT Plan that outlines the behavioral health HIT priorities for JCC and its partners to support adoption and optimization of HIT among its community partners. The plan will be created in collaboration with JCC's Clinical Advisory Panel and Network and Quality Committee. 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 JCC's organizational priorities per year that support JCC's four strategic priorities: related to integration and care coordination, clinical and quality excellence, member impact and financial stewardship and sustainability. The major components of the plan will address:
  - Strategies to optimize value of current behavioral health EHR systems including identifying key integration points with Reliance, PreManage, and our GSI care coordination system to improve care coordination among behavioral health providers, with physical medicine 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 be provided to other behavioral health providers.
  - Develop training programs to enhance claims and clinical quality measure data capture.
- **Support current efforts**
  - We will also continue to support work underway in the community to improve data sharing and referral processes between Columbia Care and the FQHCs. 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, JCC will begin to implement the plan developed and will:

- Continue to convene the group defined by the HIT Workgroup 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, Reliance and others in developing additional tools to assist in IT-enhanced patient care for the behavioral health population. These may include, but not be limited to:
    - Direct Prescription Drug Monitoring Program (PDMP) 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 with Reliance, PreManage and the GSI care coordination system where deemed effective and feasible.

In Years 3-5, JCC 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 HIT-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 and 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?

<u>**Current EHR Adoption**</u>
Currently CareOregon' s dental team leads our oral health strategy and manages the delegation of dental service delivery to our partner dental plans. JCC currently contracts with Advantage Dental, Capitol Dental, ODS Community Dental and Willamette Dental to manage the dental benefit, deliver clinical services, provide care coordination and outreach to members. JCC 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 encourage 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.

The FQHCs in our community offer dental services within their clinics. They are both utilizing Epic's Wisdom which enables shared multi-disciplinary documentation. To support integration between oral health and primary care, JCC will be optimizing medical-dental provider assignment alignment to these practices whenever possible.

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 Dental Care Organizations (DCO) 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 align 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. 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 will be priority goals.

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

In Year 1, JCC will:
- **Determine structure for oral health input** –With input from HIT Workgroup, DCOs and JCC staff, JCC will determine how best to structure development of 5-Year HIT Workplan to ensure 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 applied to oral health scenarios as appropriate and as needed.
  - Incorporate findings of the HIT Survey of 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 system, PreManage, Reliance and the JCC/CareOregon 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 group defined by the HIT Workgroup, the HIT Survey of DCOs, the assessment of referral processes, and input from the broader HIT

Workgroup, the HIT Workgroup or its designees will develop a 5-Year HIT Plan that outlines the Oral Health HIT priorities for JCC and its partners to support adoption and optimization of HIT among its community partners.

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

- Continue 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 Reliance, PreManage and GSI care coordination system where deemed effective and feasible.

In Years 3-5, JCC 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.
- Working 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: Investment in making the switch, costs, technical support, 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 large FQHC clinic systems or hospital delivery systems which provide upgrades and training support to further EHR adoption of providers employed or affiliated with them. In our rural area a few small, private practices clinics, who serve small numbers of JCC members still struggle to move to electronic health records. We believe current EHR adoption has been maximized in Jackson County due to the extensive technical assistance support provided by OHA and others. At this point non-adopters of EHR are resistant to EHRs because of cultural barriers, not financial or technical barriers. Further resourcing may be ineffective. Thus, in lieu of providing subsidization for these organizations, we may consider reassignment of those few members to clinics that provide higher value with EHR adoption, PCPCH programs and better quality outcomes.

Since the vast majority of JCC members are being served by larger clinic systems, we have shifted our focused from EHR adoption, to optimizing the EHR utilization within clinics. The challenge is that clinics have limited staff capacity and technical skill, competing organizational priorities and reluctant providers due to 'EHR burnout' making it difficult for these organizations to systematically optimize their EHR capabilities. Despite these barriers our regional hospitals, FQHC systems and larger private practices have shared our vision for maximizing EHR use and have dramatically increased the staffing and technical expertise as well as brought in new technologies to support data acquisition, analysis and reporting, like Tableau, and improved quality driven workflows with EHR systems. JCC continues to support these programs both with technical assistance, workflow and process improvement trainings, and financial stability through our APM programs for primary care. We will continue this strategy into the future.

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?

In 2012, a survey of behavioral health organizations' adoption of EHRs and readiness for meaningful use found that only 21 percent used EHRs. At that time, behavioral health providers' beliefs about both the efficacy of EHRs and the extra layers of privacy rights for behavioral health records were identified as contributors to slower adoption. Traditional beliefs about the importance of the patient-to-therapist relationship may also make it difficult to introduce EHR technology in the psychotherapy space. In a 2017 survey sponsored by OHA, behavioral health providers without EHR's identified the additional barriers to EHR adoption as cost, the small size of their programs, lack of technical infrastructure and staffing. Again, this is particularly true in rural communities.

Another barrier often cited among behavioral health providers is concern about electronic information sharing and associated privacy regulations such as 42 CFR Part 2 which requires addiction treatment providers to obtain written consent from patients in order to share any information with non-addiction clinicians except in the case of "true emergencies." Because most electronic health records are not able to accommodate separation of the substance-use records from the rest of the medical records, this regulation creates virtual care silos and hinders coordination of care efforts facilitated by EHRs and health information exchanges.

There has been recent activity in Congress to pass legislation that would allow authorization to disclose the records of patients with substance-use disorders without written patient consent to a covered entity, as long as it is in line with HIPAA, for treatment, payment purposes and healthcare

operations. We will track federal legislation and support any that reduce barriers for sharing of information essential to promoting coordinated care on behalf of our members.

As described above, JCC will create a plan to identify and address barriers and work with stakeholders, OHA, other state and national leaders to help educate providers about the benefits of EHRs to improve efficiency, safety and effectiveness of patient outcomes and identify strategies to overcome barriers. We will continue to engage in any state-led initiatives, such as the Behavioral Health Information Sharing Advisory Group, to help inform statewide strategies for furthering EHR adoption.

Barriers to primary care and behavioral health integration
From the research, clinics that provide both primary care and behavioral health services 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 other EHRs. Practices developed workarounds in response to these challenges, double documentation and 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, EHR upgrades and unified EHRs. [1] For example, behavioral health and specialty mental health services provided within the FQHCs can be documented in Epic through a behavioral health-specific navigator.

In our service area all of the PCP clinics with integrated behavioral health clinicians, promoted by the Primary Care Behavioral Health (PCBH) APM that JCC started in 2015, have adopted examples of 1and 2 above. This PCPH alternative payment model requires shared documentation, and coordination of care within an integrated team. Most of the clinic systems participating in the PCBH APM are connected through Reliance HIE.

Through its involvement in HITAG and HIT Commons state committees, JCC 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. JCC will also work 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:

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

- 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, solo 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. JCC will support its dental plan partners and providers in adopting certified EHRs as described in the oral health section above.

JCC 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 explore and understand current and future capabilities for extracting key elements from electronic dental 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 type 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 information. This HIE functionality is addressed elsewhere and will be critical 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 OMMTUP', possibly using funding related to addressing the opioid crisis. 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 metric and population health statewide target specifications and adoption (*e.g.*, OCHIN and PreManage guidance for metrics and population health targets, specs, and capacities). Thus, the vendor 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.

In Year 1 JCC plans to establish an HIT Workgroup that will oversee and advise on EHR adoption and optimization. This workgroup, as noted above, will work with staff and community partners to create our HIT plan and monitor success of ongoing strategies to improve EHR use, including continuing our technical assistance support to improve clinical outcomes and data integrity.

Our plan will be informed from data we regularly collect 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 each year 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.

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.
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 we plan to conduct each year to evaluate improvement and identify ongoing needs. Based on the outcome of these activities, we will set a realistic target 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.

JCC 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 electronic referrals or other means of transmitting relevant information even when electronic records systems are not feasible or practical.

9.C.   Support for Health Information Exchange (HIE)
9.C.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 a <u>*narrative as well as a roadmap that includes activities, milestones and timelines.*</u> (Please note: Roadmap attached as an Excel spreadsheet)

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.

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

Reliance HIE - JCC and its provider partners understand the value of HIE in facilitating care coordination, and creation of a community health record to improve quality of care for our members through aggregated data and analysis. Along with our partners, we have invested heavily in the formation and growth of Reliance, formally Jefferson HIE. As a founding partner for Jefferson HIE, JCC partnered to create the original charter, membership and funding mechanisms setting in motion a culture of open shared data exchange funded by hospital systems and health plans who derive value. We believe deeply in the importance of data as a community resource, data transparency and community funding to support HIE. JCC has contributed more than $2 million dollars in the form of granted start-up funding, subscription fees and onboarding fees on behalf of many physical health and behavioral health clinics in our network. Reliance facilitates the exchange of information among providers through 1) its community health record, 2) provider to provider referrals and 3) provider to provider secure messaging. As of April 2019, within Jackson County 31 clinics at 46 sites signed up to utilize their community health record (CHR) and 54 for eReferrals.

Currently, Reliance gives us valuable, timely clinical information from participating provider EHRs to support our patient outreach and clinic quality improvement efforts. As an example, the information we receive on new pregnancies among our member population allows us to identify members early in their pregnancies to ensure they are engaging in prenatal care. Similarly, we get information about members with hepatitis C, which allows us to reach out to member directly or inform their primary care clinic to ensure eligible members receive treatment. We also use the data from Reliance to track our performance on our quality metrics and inform our quality improvement strategies, including those related to diabetes management and depression screening. To support further adoption in our community, we educate our providers that have not contracted Reliance about the value of HIE and actively encourage them to consider the benefits of joining the HIE network. We are excited about the opportunity to continue our work with Reliance and will encourage our providers to take advantage of the technical assistance from Reliance in OHA's new HIE Onboarding Program. We envision an opportunity to produce SDOH data and reports through Reliance in the future as clinics become more adept at screening and documenting for SDOH in our community.

PreManage - JCC has also 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, between providers and JCC. Our entire community has prioritized reducing the disparate utilization of emergency departments by individuals with SPMI diagnoses, and we are seeing this work to be impactful in addressing this health inequity.

Beginning in 2017, JCC convened leadership from 13 network partners, including both local hospitals and AllCare, to develop a local plan to advance the adoption of the PreManage platform among primary, behavioral and oral health providers. This collaborative has now formalized into what we are calling our Cross-system Care Coordination Steering Committee. The committee has consistent participation from across these organizations and has proven to be of such value that even clinics who are not yet connected to PreManage attend to build care coordination relationships with their peers.

In addition to convening the steering committee, JCC helped remove barriers of 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 JCC include, Rogue Community Health, Providence, La Clinica, Columbia Care, Jackson County Mental Health, APD (with reading privileges only), Options, and all the DCOs (reading privileges only). We have coordinated with the emergency department medical directors at both 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.

- Support cross-system care coordination among our community partners: Several of our clinics 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. JCC contracts with Mercy Flights to provide support to members in the emergency department and as they transition out of the hospital. (See example below about Mercy Flights.)

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Mercy Flights Transitions Model

JCC contracts with Mercy Flights' paramedics to provide face-to-face discharge support for JCC members transitioning out of the hospital. JCC provides support to members transitioning between care settings in a variety of ways. For those members transitioning out of the hospital, JCC contracts with Mercy Flights' Community Paramedic Transitions. Mercy Flights is notified through PreManage when a JCC member is hospitalized. Prior to discharge, a Mercy Flights' paramedic engages with the member face-to-face to assess member's readiness for discharge, ensure appropriate supports are in place for a smooth transition and creates a plan to address potential barriers to follow up care (see more information in Attachment 7).
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Mercy Flights Mobile Integrated Health Proactive Model

JCC leverages Care Oregon's population segmentation tool to identify "rising risk members" who we believe would be most amendable to intervention and enhanced care coordination services to improve health outcomes. This cohort is crossed with the list of assigned but unengaged patients who are not actively engaged in primary care. PreManage uses this list, which is refreshed monthly, to prompt real-time auto notifications when any members from this list admit to the emergency department. Mercy Flights attempts to outreach these members, offer them care coordination support and attempt to engage them in primary care, dental and mental health specialty or SUD Treatments as well as any other needed services to address social determinants of health (SDOH) barriers (see more information in Attachment 7).
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- Support care coordination with our internal team: Referrals to our care coordination staff come from providers and from the JCC 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. In collaboration with AllCare CCO, our primary care network, mental health specialty network (including Jackson County Mental Health, Columbia Care MH providers), both hospital systems and community paramedics, Jackson Care Connect leads a workgroup and steering committee to advance the adoption of PreManage for cross-system care coordination. We have developed the following as a collaborative effort: a map of accountabilities across systems, a point person roster to increase communication and the co-authoring of care recommendations across systems as well as a guideline for best practice when developing care recommendations. The local hospital physicians have helped lead the charge in identifying what is appropriate to include in care recommendations to inform their intervention in the emergency department and promote continuity of care post discharge. As a CCO, we are able to monitor the volume of care recommendations developed by each system and offer technical assistance side-by side in each system to tailor the support to meet their specific needs, from workflow development to IT support to advance their adoption of the tool.

Support health equity: JCC has also adopted the use of PreManage and created cohorts that help monitor effectiveness and impact of various population and clinic-level strategies and interventions.

Epic Care Everywhere - The majority of contracted physical health providers in our service area are on Epic, including Asante, Providence and our two FHQCs. 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.

EDIE - All hospitals in our service area have adopted EDIE, which is a 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. As a result, emergency department physicians have subsequently reported finding significant value in receiving these notifications, which in addition to providing information about utilization, may include 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, JCC awaits the integration of PDMP into EDIE and will support the HIT commons workgroup to promote and prioritize this work. Once complete JCC will support its use as above.

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

JCC's provider network currently uses Reliance closed loop referrals system and will also expand the provider portal 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) and if this represents a redundancy with Reliance referral system. 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 from JCC, 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.

E-consults through RubiconMD - RubiconMD is an e-consult platform that providers 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, JCC 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 JCC. In addition, Rubicon now provides up to 20 hours of continuing medical education (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.

Project Echo - JCC 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.

Telehealth - JCC 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 address reduced access for specialty services as they arise.

GSI – Care Coordination platform - JCC has implemented a robust Care Coordination platform that has dramatically increased our efficiency. The platform provides greater access to comprehensive and tested assessments, uses standardized workflows to improve efficiency and avoid errors, and allows our care coordination team 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 the provider's EHR (when authorized). For those providers without secure messaging, JCC uses the provider portal to communicate the care plan and generate a care plan via Premanage for members with acute needs.

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

MyCharts - 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.

<u>In the future, we will engage our providers to:</u>

Support and expand existing technology solutions that provide timely information to providers and care coordinators by:
- 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 by:**
- Expanding closed loop referrals via our portal.
- Expanding closed loop referrals via Reliance.
- Researching and implementing a tool that allows us to capture and share SDOH (*e.g.*, Unite Us, Bertha, Clara) or by expanding use of Reliance's Community Health Record
- 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 JCC, OHA, research, etc. by:
- Supporting state-sponsored HIE Onboarding Program
- Evaluating tools that promote national standards for sharing information among different EHRs (*e.g.*, Carequality, CommonWell, etc.)
- Actively participating in state multi-payer data aggregation activities
- Researching bulk electronic communication between EHRs, JCC/CareOregon, and OHA. We are actively improving our capability to both ingest and produce data sets for clinical and community partners. Expected use 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 by:
- Promoting 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.

Support solutions that allows members to communicate with providers and JCC so they can better participate in their own care by:
- Enhancing member portal and evaluating benefits of mobile applications.
- Encouraging utilization of MyChart patient portal, JCC's patient portal, and associated mobile apps, if available.

Engagement 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 (CQMR-SME) workgroup – helps define rules and technical assistance for providers to electronically submit data to Clinical Quality Metric Registry in 2020.
- Oregon Health Leadership Council EDIE Steering Committee.
- HIT Commons Workgroup.
- Metrics & Scoring Committee.

By participating in these groups, JCC is able to learn best practices and bring these into our clinical strategy development pertaining to HIE within our region. This allows us to be early adopters in the exciting area of HIE. In addition, participation in these groups allows JCC 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.

Future Plans

By Contract Effective Date
By the contract effective date, JCC will define relationship and execute on engagement with state-sponsored partner (*i.e.*, Reliance) to ensure JCC providers have the opportunity to participate in the OHA HIE Onboarding Program.
We will continue with the eleven programs listed in 9C1a.

In Year 1, JCC will:
Assess the current state
- Meet with the HIE vendors providing service in Jackson County (Reliance and PreManage) to gain insight into:
    - Current level of adoption by HIE module.
    - Clinics that have not adopted HIE technology.
    - Clinics that have implemented but are under utilizing the available technology.
    - Future features and functions in development and timeline for availability in Jackson County.
    - How JCC will be informed about advances in HIE utilizaiton.
    - Obtain HIE vendors' input how to JCC 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 for providers currently using <u>and</u> 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).

Develop the Plan
Using the information gathered from meeting with the HIE vendors and state HIT representative and from the survey of Providers, JCC will develop a five- year plan consisting of 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 utilization of current HIE systems to clinics that have EHRs but have not adopted HIE technology. Within Jackson County this is believed to be a small number. But as HIE technology achieves its greatest value when the entire community participates, eliminating these gaps is worth the effort. Based on the results of these efforts, JCC will assess the option of implementing HIE technology incentives in quality metric and VPB strategies.

JCC will work with organizations creating IT solutions to support the electronic exchange of information collected by some of our providers using the Accountable Health Communities (AHC) screening tool to identify SDOH needs and connect them to needed services.

In Year 2, JCC 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 JCC HIE adoption efforts.
- Begin to evaluate, design and develop HIE interoperability solutions with Reliance, PreManage, Epic CareEverywhere and GSI Care Coordination platform where deemed effective and feasible.
- Continue to engage with state entities to ensure JCC efforts align with other initiatives.
- Evaluate Reliance referral module for referrals to JCC 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.

In Years 3-5, JCC will:
- Continue to engage and track HIE vendor plans and enhancements to ensure JCC 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 JCC 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. In the early years JCC promoted Reliance's behavioral health workgroup to research and adopt best practices for information exchange that has become Reliance's best practice. Currently, ColumbiaCare and Jackson County Mental Health, our primary behavioral health partners, are both registered on PreManage and beginning to create use cases. Columbia Care and Jackson County Mental Health will continue to participate with our JCC community wide PreManage collaborative and build capacity to participate in shared care plans.

The behavioral health organizations within JCC vary widely in their HIE needs, as well as in their capacity to develop the necessary infrastructure and workflows to support health information exchange. In the future, we are committed to develop strategies to expand HIE and information sharing among all provider types. To this end, our HIE expansion efforts outlined above for physical health in answer 9.C.1.a will be applied as much as possible to our behavioral health provider networks.

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

PreManage - As mentioned above, JCC led the creation of a multi-stakeholder collaborative to develop a community-based strategy and plan to implement and advance the adoption of the PreManage platform among primary, behavioral and oral health providers in our region. Through this work, we have developed best practices for care recommendations and mapped the roles and responsibilities of all participating partners before, during, and after an emergency department visit.

The population of focus for this collaborative work is members identified in the OHA MH disparity group which captures members who have a serious persistent mental illness (SPMI) and present to the emergency department for physical health reasons. JCC actively uses this cohort to ensure members needs are being meet and directly aligns with the work of our behavioral health partners, with the ultimate goal of reducing disparities for those with mental illness experience. PreManage enables our providers to conduct proactive outreach for members who may present to the emergency department with behavioral health concerns or in crisis. As able, our behavioral health partners arrange for peer supports to meet with the patient while they are in the emergency department and help them connect with services to better manage their behavioral health concerns.

JCC'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, JCC 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).

<u>Future Plans</u>
As we identify strategies for future HIE use with behavioral health providers, JCC will be particularly interested in a solution that builds on the current EHRs and HIE capabilities. We will assess with our providers the value and feasibility of sharing information through Epic Community Connect programs as an initial solution. 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, JCC will define relationship and execute on engagement with state-sponsored partner (*i.e.*, Reliance) to ensure JCC 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 JCC 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 Jackson County (Reliance and PreManage).
- 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 <u>and</u> 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, JCC may establish a sub-group to focus specifically on behavioral health workflows and privacy issues. This workgroup would participate in:
- Evaluating the Reliance Consent module and other HIE workflows.
- Ensure behavioral health providers are a priority in the JCC regional HIE Onboarding Program (HOP) including small providers use of HIE portals.

    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. JCC 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, JCC will determine if the barriers to HIE adoption for behavioral health providers differ significantly from those of the physical health providers. If so, JCC will develop a separate HIE adoption strategy.

In Year 2, JCC 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 JCC 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 that admit from an emergency department or hospital inpatient facility
    - Evaluate opportunities to extend telemedicine technology for members, including mobile applications that support member's ability to communicate with their care team. 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, JCC 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.

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 JCC'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. JCC 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 - JCC, 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, JCC 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 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, JCC, 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, JCC 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 JCC efforts align with oral health-specific initiatives.

In Years 3-5, JCC will:
- Support efforts identified in years 1 and 2 to further HIE between oral health and others.
- 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.

JCC 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 offices, public health authorities, pharmacies and other health plans.

For further details please see 9C1a

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.

JCC will expand the use of PreManage with contracted behavioral health providers to coordinate care for patients with complex needs. Specific actions will include:
- Educate behavioral health 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.
- JCC will place Peer support in emergency department to engage Members in the emergency department who are there secondary to a SUD-related issue. PreManage notifications will be the primary mechanism to identify and activate Peer support staff.

While not yet implemented, we will be modeling our provider technical assistance and support strategies after those already in place for our physical health care providers. These supports include learning collaboratives and clinic-based one-on-one coaching mentioned above.

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 assure they are aware of their dental benefits, selecting a provider and arranging 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 our implementation. We also monitoring, 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 where 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.

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.

We actively engage providers across our behavioral health, physical health, and oral health networks, both electronically and in person, to promote the value of 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.

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?

JCC requests assistance from OHA related to HIE use and setting targets for increased use of HIE in several ways, recognizing some of these may be more aspirational than others:

- We would like to understand what information may already exist about HIE utilization within state systems, including how it collected, and at what cadence.
- JCC service area shares a border with California. We would like OHA to work with California on interstate HIE integration. (with single sign-on).
- 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).
- 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.

JCC will:

- Collect HIE utilization data from PreManage and Reliance on a quarterly basis.
- Establish targets for HIE adoption and utilization, based on input from HIE vendors and their experience in HIE adoption.
- Establish prioritized list of clinic sites not utilizing HIE and establish a plan to provide technical assistance.
- Actively promote onboarding to 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 Behavioral Health provider's current usage state, identify gaps relative to key workflows, and have this inform our choice of suitable targets.

Since we have such a diverse provider and system environment at a very early stage of HIE adoption, an initial part of our plan will be to assemble and possibly automate the collection and visualization of usage data so it can inform our process improvement and change management efforts around HIE adoption.

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.

JCC 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 JCC 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 JCC 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.

Jackson Care Connect (JCC) 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).

JCC 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. JCC 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. JCC is committed to enhancing system-wide data with more of this information as it becomes available.

First, JCC 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. JCC has partnered with OCHIN to gain access to the OCHIN Acuere population health management platform. This access allows JCC to retrieve member-level EHR information for all JCC 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, JCC 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, JCC 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), JCC receives 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. JCC, 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.

Last, JCC, 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, JCC 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?

JCC 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 to address key triple aim objectives within the scope of their networks and provider relationships, while also sharing best practices that can be adopted system-wide as appropriate.

In addition to these key network and population management insights, JCC 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 which, when viewed system-wide, 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.

JCC 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 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 target interventions for engagement in appropriate medical and behavioral health care or create recommendations for alternative pharmaceutical options. As mentioned previously, JCC is currently assessing how best to integrate the OPIP Pediatric Health Complexity data from OHA with our medical claims data to understand how social complexity impacts medical service and emergency department utilization and as well as health outcomes among our population. Again, this will allow us to create regionally specific processes or programs that improve access and engagement for our members with elevated social complexity.

9.D.2.　Evaluation Questions
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.
(Please note: Roadmap attached as an Excel spreadsheet)

JCC 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.

JCC 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.

JCC'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:

JCC 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 relevant to individual programs, as opposed to broader performance metric sets. 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;

JCC 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, JCC 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.

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 <u>narrative as well as a roadmap that includes activities, milestones and</u> timelines.

As described in 9.D.2.b, JCC 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.

JCC 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:
JCC'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 <u>plans for start of Year 1 as well as plans over the 5- year contract, including activities, milestones, and timelines</u>. Include information about the following items:
JCC 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?
JCC 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)?

JCC 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)?

JCC 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. JCC 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?
JCC 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, JCC 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. JCC'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?
JCC 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 JCC 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. JCC 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. JCC 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, JCC will explore opportunities to integrate clinical data into our data aggregation and analytics platform that provides actionable information to both JCC 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

Form an HIT Workgroup — Roadmap in place ▲ (Q1 2020)

Initiate conversations with our CAP, Network and Quality Committee and other collaboratives about ways to systematically incorporate EHR optimization into our clinical initiatives and quality improvement processes

Physical Health

Define EHR system needs: Define current and anticipated future EHR capabilities (e.g., data extraction, data merging, data analysis and data reporting)

Conduct an environmental scan and identify gaps

Develop workplan

Targeted traning and technical assistance — △ Engagements Begin

Additional population management tools, 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 △

	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

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)

EHR interoperability solutions with HIE and care coordination platforms — Design / Development

Targeted traning and technical assistance — Engagements begin

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

First version — Refinements

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 identfy strategies that can be adapted to oral health

Create a workplan

Bring initial priorities to pilot or next stage — Design / Implementations begin

Implement best practices regarding Oral Health EDR use and configuration and monitor progress and impact

Gantt chart with timeline columns: By 2020 | 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)

Task	Timeline
Implement strategies identified during the plan development to increase EDR adoption	2021 Q4 – 2024 Q4
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	2021 Q3
Explore opportunites to integate EDR with HIE and care coordination platforms	2021 Q3
Require dental plans to capture and exchange population-level and member-level information from their providers' EDRs for quality measurements	2021 Q4 – 2022 Q2; milestones: Begin engagements with dental plans △, Contracts in place △
Working with the DCOs to integrate closed loop electronic referrals and/or preauthorization's within their providers' EDR workflows	2022 Q1 – 2024 Q4; milestone: Plan in place △
Identify opportunities for how EDR systems in oral health settings can be augmented to better support care coordination and information sharing with primary care providers	2022 Q1 – 2022 Q3
Work with DCOs on incorporating EDR-enabled VBP methodologies with their contracted oral health providers	2022 Q2 – 2024 Q4; milestone: Initial contracts in place △

Barriers and plans to address

Physical Health

Task	Timeline
Develop EHR optimization plan (same as in EHR Adoption roadmap)	2020 Q2
Identify key practices to address	2020 Q3
Perform detailed analysis of prioritized providers and EHR needs	2020 Q3
Work with partners to define the incentives and support requried and develop workplans	2021 Q1 – 2022 Q1; milestones: Initial workplan △, Revised workplan △

Behavioral Health

	By 2020	2020				2021				2022				2023				2024			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
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			▇	▇	▇	▇	▇	▇	▇	▇	▇	▇	▇	▇	▇	▇	▇	▇	▇	▇	

Oral health

	By 2020	2020				2021				2022				2023				2024			
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

Task	Timeline
Meet with the HIE vendors operating in JCC's service area	Q1 2020
Meet with members of the State's Office of Health Information Technology, CQMR SME workgroup	Q1 2020
Develop and distribute a survey tool for Providers currently using and not currently using HIE technology	Q1 2020
Deveop workplan	Q2 2020
Expand the functionality and utilization of current HIE systems among existing and new connections	Q2 2020
Continue to monitor HIE utilization and work with HIE vendors to achieve optimal adoption	Q1–Q2 2021
Compare quality and performance metrics of providers utilizing HIE technology to those providers that have not adopted HIE technology	Q1 2021

Develop Solutions

Task	Timeline
Evaluate, design and develop HIE interoperability solutions with Reliance, PreManage, Epic CareEverywhere and CareOregon's GSI Care Coordination platform where deemed effective and feasible	Q1–Q2 2021
Continue to engage with State entities to ensure JCC efforts align with other initiatives	Q1–Q2 2021
Evaluate Reliance referral module for referrals to JCC Care Coordinators	Q2 2021
Evaluate Reliance and PreManage analytics modules to determine ROI and appropriateness of each solution	Q2 2021

	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
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 JCC 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		█																		

	2020			2021			2022			2023			2024		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

Form workgroup to focus on behavoral health and privacy issues and build workplan

Evaluate Reliance Behavorial Health Consent Module

Develop and Expand Solutions

Continue to engage with State entities to ensure JCC 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

A Gantt-style roadmap with quarterly columns from 2020 Q1 through 2024 Q4:

Task	Timeline / Milestones
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	2020 Q1
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 (2020 Q3 – 2024)
Encourage utilization of one-way electronic referrals to CareOregon or DCO portals for improved care coordination	Outreach plan in place (2020 Q3 – 2021 Q3)
Promote further use of EDIE for emergency department and urgent care event notifications for oral health related diagnosis	Plan in place; Implementations in progress (2021 Q2 – 2024)
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 (2021 Q2 – 2024)
Expand existing electronic dental referral process with physical and oral health providers	Plan in place (2021 Q2 – 2021 Q4)
Working with OHA and HIT Commons, explore ways to integrate PDMP information into HIE services and downstream to Electronic Dental Record systems	(2021 Q4 – 2022 Q2)
Expand functionality to the dental services request process to support bi- or tri-directional communication	Outreach plan in place (2022 Q2 – 2024)
Explore closed-loop referral and authorization technology to support additional providers and clinical disciplines.	Plan in place (2022 Q3 – 2024)
Explore how to best align provider groups for cohorts of members	(2022 Q3 – 2022 Q4)
Work with the DCOs to integrate closed-loop electronic referrals and/or preauthorization's within their providers' EDR workflows	Vendor/ practice selected; First implementation (2022 Q4 – 2024)

	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			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

Physical Health

Task	Timeline
Incorporate hospital event notification access into environmental scan activities discussed earlier	2020 Q1–Q2
Include hospital event notification access in JCC's HIT workplan	2020 Q3–Q4
Continue PreManage license coverage for JCC's member population	2020 Q1 – 2024 Q4
Identify and prioritize organizations that are not currently using PreManage	2020 Q3
Continue working with organizations to spread use of PreManage	2021 Q1–Q3
Work to address funding model for PreManage based on state support plans	2021 Q1–Q3
Continue working with organizations to address issues and spread use of PreManage	2022 Q1 – 2024 Q4

Behavioral Health

Task	Timeline
Incorporate hospital event notification access into environmental scan activities discussed earlier	2020 Q1–Q2
Include hospital event notification access for behavioral health provdiers in JCC's HIT workplan	2020 Q3–Q4
Continue PreManage license coverage for JCC's member population	2020 Q1 – 2024 Q4
Identify and prioritize high-value behavioral health use cases	2020 Q3
Identify and prioritize behavioral health organizations that are not currently using PreManage	2021 Q1
Continue working with organizations to spread use of PreManage	2021 Q1–Q3
Work to address funding model for PreManage based on state support plans	2021 Q1–Q3
Continue working with behavioral health organizations to address issues and spread use of PreManage	2022 Q1 – 2024 Q4

Oral Health

Task	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4	2022 Q1	2022 Q2	2022 Q3	2022 Q4	2023 Q1	2023 Q2	2023 Q3	2023 Q4	2024 Q1	2024 Q2	2024 Q3	2024 Q4
Incorporate hospital event notification access into environmental scan activities discussed earlier	██	██																		
Include hospital event notification access for oral health provdiers in JCC's HIT workplan		██	██																	
Continue PreManage license coverage for JCC'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

	2020				2021				2022				2023				2024			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

HIT to Administer VBP Arrangements

Expand use of VBP administration system already in use — Expand to 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 platorm and services -- aligned with VBP strategy

Sustaining NEMT (4B)

Work with Primary Care to sustain 2C

Evaluate Primary Care data needs for 3B arragements

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 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)

	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 Care — Develop tools (2C) ▲ ; Tools and data in place (2C) ▲ (Q2 2022 – Q4 2024)

Pharmacy — Develop tools (2C) ▲ (Q1 2024)

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 — (periodic blocks across timeline)

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 JCC's care coordination system - acces care plans and population segmentation information — Access model in place ▲

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. — Assessment completed ▲

Task	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
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

Task	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 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 1 and III exchange capabilities to increase our ability to gather population health status outcomes					■	■	■	■	■	■	■	■								

Data Sources

Task	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
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

Task	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 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

Task	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
Maintain governance and customer feedback forums	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■

	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

Effectiveness of HIT supports

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 JCC and providers	First cohort live ▲ ████████████████████████████████

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.

Subcontractor/Affiliate Name	Tax ID # (SSN/FEIN)	Correspondence Address		
		Reporting Year		Reporting Quarter
		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
Rogue Valley Transportation District	93-0645766	200 S. Front Street	Medford	OR

CCO Name: Jackson County CCO, LLC, d.b.a, Jackson Care Connect

		Subcontractor/Affiliate Physical Address					Parent Company Name (if applicable)	
Zip	Country	Street Address	City	State	Zip	Country		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
97501 USA	200 S Front Street	Medford	OR		97501 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 Admnistra tion | 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	September	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		October	1	2014	Evergreen	

ate 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 JCC was July, 2018.	JCC 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 JCC including, but not limited to human resources and legal.

| 2019 | October, 2018 | N/A | JCC 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 JCC in any appeals of DCO's NOABD. |

| 2019 | October, 2018 | N/A | JCC 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 JCC in any appeals of DCO's NOABD. |

		JCC 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 JCC in any appeals of DCO's NOABD.
2019 October, 2018	N/A	
		JCC 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 JCC in any appeals of DCO's NOABD.
2019 October, 2018	N/A	
		JCC delegates the administration of the NEMT benefit to RVTD, including transportation network development, ride coordination, credentialing, and claims administration.
Jul-18	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: 857453-97
Type: DOMESTIC LIMITED LIABILITY COMPANY

Next Renewal Date: 05/18/2013

· 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
05/18/2012

Jurisdiction
OREGON

Name
JACKSON COUNTY CCO, LLC

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

ROBCON
ACK
05/18/2012

85745397

ARTICLES OF ORGANIZATION
OF
JACKSON COUNTY 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 Jackson County 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.
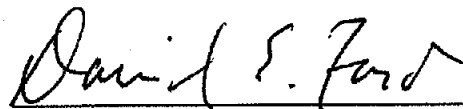
V.

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: May 18, 2012.

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**

Item	Contact	Telephone	Email
Application generally	Jennifer Lind	503.416.3683	lindj@careoregon.org
Each Attachment to the RFA (separate contacts may be furnished for parts	Erin Fair Taylor	503.416.1797	faire@careoregon.org
The Sample Contract generally	Monica Martinez	503.416.4934	martinezm@careoregon.org
Each Exhibit to the Sample Contract (separate contacts may be furnished for parts)	Monica Martinez	503.416.4934	martinezm@careoregon.org
Rates and solvency	Teresa Learn	503.416.1415	learnt@careoregon.org
Readiness Review (separate contacts may be furnished for parts	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
Describe the Applicant's Legal Entity status, and where domiciled.
Jackson County CCO, LLC, d.b.a. Jackson Care Connect (JCC) is a limited liability corporation (LLC) with the principle place of business at the CareOregon, Inc., headquarters, 315 SW 5th Avenue, Portland, OR 97204. JCC also maintains a local office in Medford, OR.

6.A.1.a. Describe Applicant's Affiliates as relevant to the Contract.
CareOregon, Inc. is the sole member of JCC. CareOregon is also the entity that performs most CCO administrative function, health plan operations, and benefit administrative functions. CareOregon maintains physical and behavioral health networks and oversees the benefit administration for these service types on behalf of JCC.

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?
JCC operates a local office at 33 N. Central Ave, Suite 320, Medford, OR 97501. JCC's community-based operations function out of the Medford office, including, but not limited to, member engagement, provider services, clinical integration support, and health equity work. Most of the back-office administrative work, including but not limited to claims administration, customer service, finance, communications and contracting, are all 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.
JCC proposes to continue serving all zip codes in Jackson County. Over the last 6 years, we have established a strong working relationship with Jackson County government, especially with the Departments of Health and Human Services (including Mental Health and Public Health) and Jackson County Community Justice. As documented in our MOU, JCC and Jackson County Jackson County Mental Health (the LMHA) have made extensive plans across a range of services to provide outpatient mental health services (with a particular emphasis on serving JCC members who are also engaged in the criminal justice system), special programs such as ACT and mental health court, and community-based services such as crisis services. We work together with both Jackson County Mental Health and Public Health on a collaborative Community Health Improvement Plan that will meet JCC's CHP requirement, Jackson County Mental Health's BIP requirement, and Public Health's credentialing requirements. Lastly, we will continue to work closely with the County to coordinate service delivery for our members who engage with the criminal justice system (including jail, law enforcement, parole and probation). These arrangements are codified in provider agreements, a Memorandum of Understanding submitted with this application, and collaborative work with County leadership at the Public Safety Coordinating Council.

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: JCC holds a contract to administer the Cover All Kids benefits to eligible enrollees.
•	Other (please describe)	No

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, 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. Also, 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.
JCC was initially awarded a contract in 2012 to operate as a CCO. In the intervening seven years, JCC has developed deep relationships with community members and providers in its service area to improve health and reduce disparities. JCC engages our community through:

- **Strong Partnerships:** JCC has a broad network of partners which share similar missions and goals for health care transformation, community health, and equity. Our staff serve on many coalitions and committees, which allows them to directly engage with partners in this work, and in the case of partner-led coalitions and committees, to support the partners in their work. Of note, JCC participates in the regional health equity coalition which specifically addresses regional, cultural, socioeconomic and racial disparities in health care.
- **Collaborative CHA and CHIP:** JCC leads the process to engage community members and partners in elevating SDOH+HE as a primary lens. This is done through the Mobilizing for Action through Planning and Partnerships (MAPP) process.
- **Community Advisory Council (CAC):** This group works to advise and make recommendations on JCC's strategic directions. Members of the CAC represent the diversity of the community including race/ethnicity, age, gender identity, sexual orientation, disability and geographic location. The CAC always has at least one county representative, and at least 51% of committee members are classified as consumers of the Oregon Health Plan or uninsured.
- **Board of Directors:** Made up of local stakeholders, the board provides overall organizational direction and oversight.
- **Clinical Advisory Panel (CAP):** Made up of clinicians, the CAP provides clinical input into JCC initiatives, opportunities to improve access, member engagement and quality.
- **Spring Conference:** JCC holds an annual conference that is open for anyone to attend. We approach the agenda for this conference as a two-way conversation so that we are both providing an opportunity for our network of partners to highlight successes and educating with member voices the challenges that persist. It has proven to be an excellent opportunity for partners and community members to learn from one another, get re-energized about the work and voice their perspectives.
- **Community Engagement Team:** This team carries out community engagement through programs and outreach and collaborates with partners to address SDOH+HE. The team includes bilingual/bicultural staff.
- **Trainings:** JCC offers trainings to our network to address regional, cultural, socioeconomic and racial disparities.

6.A.1.l. Identify and furnish résumés for the following key leadership personnel (by whatever titles designated):
- Chief Executive Officer: Jennifer Lind
- Chief Financial Officer: Teresa Learn
- Chief Medical Officer: Amit Shah
- Chief Information Officer: Nate Corley
- Chief Administrative or Operations Officer: Amy Dowd

(résumés do not count toward page limit; each resume has a two page limit)

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 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 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 Jackson County CCO, LLC, d.b.a. Jackson Care Connect (JCC). Since CareOregon, Inc. is a non-profit, public benefit corporation, it has no owners.
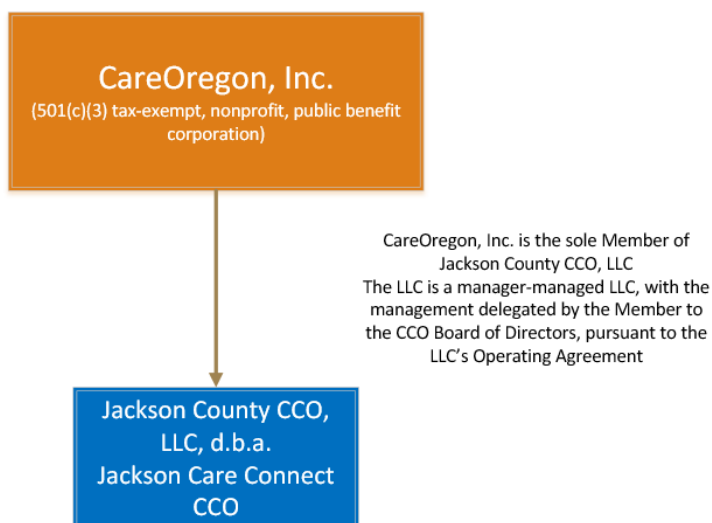
6.B.1.c. Describe any licenses the corporation possesses.
JCC does not possess any licenses.

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.
JCC only contracts with Affiliate, 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 Jackson County CCO, LLC, d.b.a. Jackson Care Connect. 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	93-0933975	524114
Jackson County CCO, LLC, d.b.a. Jackson Care Connect	Applicant	Limited Liability Corporation	OR	45-5499608	N/A

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.

JCC has three different financial arrangements with its Parent, CareOregon: a delegation agreement, a management services agreement and a gainshare arrangement. Under the delegation agreement, JCC delegates the physical health and behavioral health benefit to CareOregon. Delegation expense was $119.9 million and $108.3 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 $1.9 million and $1.6 million in 2018 and 2017 respectively. Under the gainshare arrangement, CareOregon shared a portion of its surplus with JCC, however as CareOregon's reserves on the JCC population dropped, JCC returned a portion of the gainshare. In 2018 and 2017 respectively, JCC returned $13.5 million and $0 in gainshare to CareOregon.

6.C.1.c. Describe Applicant's demonstrated experience and capacity for:
Managing financial risk and establishing financial reserves

JCC 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, JCC holds reserves to meet the OHA requirements. JCC has consistently met these requirements over its tenure as a CCO.

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

JCC has served as a CCO for six and half years and has consistently met the minimum restricted reserve and net worth requirements as outlined in the OARs. Even when JCC grew as a result of the ACA expansion, JCC made sure to increase its reserve requirements accordingly. JCC 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, JCC has the ability to look to CareOregon to meet reserve requirements if needed.

Managing financial risk and establishing financial reserves

JCC 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, JCC holds reserves to meet the OHA requirements. JCC has consistently met these requirements over the six and half years serving as a CCO.

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

JCC has served as a CCO for six and half years and has consistently met the minimum restricted reserve and net worth requirements as outlined in the OARs. Even when JCC grew as a result of the ACA expansion, JCC made sure to increase its reserve requirements accordingly. JCC 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, JCC has the ability to look to CareOregon to meet reserve requirements if 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.

JCC 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, JCC maintains a management services agreement with CareOregon to provide administrative functions such as Human Resources, Finance, Information Services 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)

JCC 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. JCC also expects to subcontract with Rogue Valley Transit District for the management of the non-emergent medical transportation benefit.

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 JCC board of directors, so that they are aware of any areas of risk or concern.

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?
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.

E.1.b. How will Applicant ensure the prompt identification of Members covered by Medicare across its Provider and Subcontractor network?
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. Care Oregon also contracts with a vendor to process MSP (Medicare as a Second Payer) files, and ensure this information is available in the claims processing system. In addition, Care Oregon performs an internal investigation in accordance with the Coordination of Benefits policy; this policy outlines CareOregon's procedure for 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.
JCC is governed by a board of up to 15 directors. There are currently 13 seats filled and one in open recruitment. In addition to the positions required on the CCO board, we have five founding board members, two CAC members (one is a JCC member), county Health and Human Services, Housing Authority, Early Head Start, Veterans Administration, safety net clinics, hospitals, and behavioral health.

The board exercises its oversight of JCC by meeting the duties laid out in the Operating Agreement. Board members are vetted and nominated by the Governance Committee, with an intention to balance diversity across stakeholders, community members and areas of expertise. CareOregon reserves two seats on the JCC Board as the sole member of its wholly owned LLC. As defined in the Operating Agreement, most decisions require the consent of both CareOregon's member directors and the Board of Directors. This requires consensual decision making with the potential for greater veto power than unilateral decision-making authority. The JCC Board recognizes that CareOregon reserved very few unilateral powers and as a result is deeply invested in their responsibilities as the local governing body.

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.

Board committees are responsible for vetting relevant issues and crafting recommendations for board action. All board decisions are based on recommendations that come out of one of the six committees: Clinical Advisory Panel, Community Advisory Council, Finance, Governance, and Network & Quality. These five committees serve at the will of the board and contain both board members and non-members. In summary, they are:

1. <u>Clinical Advisory Panel (CAP):</u> comprised of practicing clinicians across physical, behavioral, and oral health who recommend and oversee clinical initiatives. At least one CAP member also serves on the JCC Board.
2. <u>Community Advisory Council (CAC):</u> see 6.F.1.c. below.
3. <u>Governance Committee:</u> this committee is responsible for monitoring board composition, nominating new board members, maintaining committee charters and holding board members accountable to their duties.
4. <u>Compliance Committee:</u> the governance committee convenes as a compliance committee at least annually and more often as needed. They review and recommend the compliance program, review critical compliance reports and monitor critical internal and external audits (including EQR).
5. <u>Finance Committee:</u> comprised of board members, this committee is responsible for overseeing monthly financial performance and monitoring JCC's financial health.
6. <u>Network and Quality Committee:</u> comprised of numerous non-board members, this committee reviews APM programs and advises on quality pool programs.

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

- **Composition**: Members of the JCC CAC represent the diversity of the community including race/ethnicity, age, gender identity, sexual orientation, disability and geographic location. In accordance with OHA regulations, there is at least one county representative, and at least 51% of committee members are classified consumers of the Oregon Health Plan or are uninsured.

- **Reporting Responsibilities**: The CAC keeps records of all meetings. It develops recommendations for consideration by the board of directors and the CAC must report regularly to the Board and get approval at Board meetings when appropriate.

- **Oversight Responsibility and Monitoring Activities**: The CAC advises the JCC board of directors in (1) promoting the mission and goals of JCC, (2) ensuring engagement of members in healthy system planning, (3) advising on projects, member communications, community investments related to Social Determinants of Health (SDOH) and Health Equity (HE) and (4) collaborating with other regional CACs.

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

MEMORANDUM OF UNDERSTANDING
Jackson Care Connect CCO
AND
Jackson County Health and Human Services

This Memorandum of Understanding (MOU) between Jackson Care Connect CCO (JCC), and Jackson County (JCHHS) serves to document our commitment to work together to ensure coordination of care and improved health through shared behavioral and public health system planning and provision of clinical services.

Jackson Care Connect intends to submit an application to the Oregon Health Authority to continue serving as a CCO for all zip codes in Jackson County. As requested in the OHA application, the parties have engaged in developing shared expectations and commitments. The parties understandings are documented in this Memorandum of Understanding for the purposes of JCC's application to continue operating as a CCO for Jackson County.

I. **Term.** The understanding and commitments made by the parties in this MOU begin upon execution shall remain in effect until the parties enter into an agreement that supersedes this MOU, until December 31, 2019 if JCC is notified by OHA that JCC has not been awarded a CCO contract in Jackson County, or until December 31, 2024, whichever occurs first.

II. **Understanding:** It is mutually agreed upon and understood by and among the parties in this MOU that:

A. JCC will be submitting an application in response to RFA# OHA-4690-19

B. Both parties support and approve of JCC's submission of the application

C. In the event JCC is awarded a contract to continue acting as the CCO for Jackson County, the parties agree to undertake the obligations outlined below:

    1. As the Local Mental Health Authority (LMHA), Jackson County Mental Health (JCMH), a division of JCHHS, shall:

        a. Coordinate with JCC on the development of a comprehensive Behavioral Health Plan as described in the RFA# OHA-4690-19, Exhibit M, Section 3a(7). The plan will utilize data from the collaborative Community Health Assessment and will be aligned with the collaborative Community Health Improvement Plan scheduled for completion in 2019.

        b. Provide clinical services for JCC members in accordance with the Provider Contract that include:
            1. Outpatient Mental Health Services for Adults and Youth
            2. Assertive Community Treatment (ACT)
            3. Wraparound
            4. Early Assessment and Support Alliance (EASA)
            5. Crisis
            6. Mental Health Court Coordination

a. Coordinate with JCC on the development of the Community Health Improvement Plan for completion in 2019.
b. Provision of clinical services for JCC members in accordance with the Provider Contract that include:
    1. immunizations,
    2. reproductive health services,
    3. sexually transmitted infection services, and
    4. other communicable disease services

3. As an operating CCO, JCC shall:

a. Coordinate with JCMH and JCPHD on development of the collaborative Community Health Improvement Plan scheduled for adoption in 2019.
b. Coordinate with JCMH on the development of a comprehensive Behavioral Health Plan as described in the RFA# OHA-4690-19, Exhibit M, Section 3a(7). The plan will utilize data from the collaborative Community Health Assessment and will be aligned with the collaborative Community Health Improvement Plan.
c. Reimburse for all clinical services provided to JCC members in accordance with our existing provider contract.
d. Support the County role as LMHA and LPHD by sharing data, facilitating comprehensive needs analysis and planning.
e. Support JCMH to maintain the mental health safety net system including community crisis services in accordance with JCHHS's existing provider contract.
f. Reimburse JCPHD for critical public health services in accordance with all existing contracts.

Notwithstanding anything herein to the contrary, this MOU is a statement of intent does not and is not intended to contractually bind the parties. The parties shall not be contractually bound unless and until they enter into a formal, written agreement, which must be in form and content satisfactory to each party and to each party's legal counsel, in their sole discretion. Neither party nor any third party may rely on this MOU as creating any legal obligation of any kind.
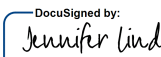
**Agreed to on behalf of
Jackson County**

Signature

Name: __Danny Jordan__

Title: __County Administrator__

Date: __4/18/19__

**Agreed to on behalf of
Jackson Care Connect**

DocuSigned by:
Jennifer Lind
9E9E0B3748FB44A...
Signature

Name: Jennifer Lind

Title: CEO

Date: 4/19/2019

CareOregon, Inc.
(501(c)(3) tax-exempt, nonprofit, public benefit corporation)

CareOregon, Inc. is the sole Member of Jackson County 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

Jackson County CCO, LLC, d.b.a. Jackson Care Connect CCO

Jennifer Lind

443 Liberty St ♦ Ashland, OR 97520 ♦ Ph: 541-200-9459 ♦ lindj@careoregon.org

Health and Policy Experience

Jackson Care Connect   **Medford, OR | 2012 - Current**

Chief Executive Officer
- Responsible for managing strategy development of Jackson Care Connect Board and strategy execution by staff.
- Member of CareOregon Executive Leadership Team

The California Endowment   **Oakland, CA | 2005 - 2012**

Program Officer
- Responsible for all strategy development and place-based grant making within the boundaries of TCE's Building Healthy Communities site of Merced.

Program Associate
- Responsible for grant review and analysis of financials, programmatic design, and potential for policy impact. Issue areas covered health care access, children's health insurance program, and social determinants of health.

Northern Sierra Rural Health Network   **Nevada City, CA | 2004 – 2005**

Programmatic Consultant
- Built business objectives and community stakeholder input related to telemedicine implementation across 9 rural northern California counties

LifeLong Medical Care   **Berkeley, CA | 2004 – 2005**

Financial Consultant
- Facilitated decisions by FQHC management and Board related to projected pharmaceutical expenses and development of in-house pharmacy.

Volunteer and Community Leadership

Jackson County Public Safety Coordinating Council	**2016 – Current**
Jefferson Regional Health Alliance Board Member	**2015 – Current**
Southern Oregon Early Learning Hub	**2014 – 2016**
Connecting to Care Board Member	**2012 - 2015**

Education

University of California, Berkeley   **Berkeley, CA | May 2005**

Master of Public Health Degree in Health Policy and Nonprofit Management,
Certificate in Business Administration: Haas School of Business

Southern Oregon University   **Ashland, OR | June 2000**

Bachelor of Arts in Applied Cultural Anthropology, Minor in Interdisciplinary Ethics
Churchill Honors Scholar

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.

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.

E DUCATION

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

Amit R. Shah
Care Oregon, Inc
315 SW Fifth Ave, Suite 900
Portland, OR 97204
503 416 1751
shaha@careoregon.org

PROFESSIONAL

3/16-present	Chief Medical Officer-CareOregon
3/15-present	Senior Medical Director-Network Services CareOregon
1/13-present	Quality Corporation Board member
12/12-present	Oregon HIMSS Advisory Board member
9/12-3/15	Care Oregon Medical Director
1/13-1/14	Interim Medical Director Neighborhood Health Center
7/13-1/14	Jefferson Health Information Exchange Board member
1/11-9/12	Care Oregon Board member
9/10-9/11	Northwest Regional Primary Care Association Board member
9/08-9/12	Medical Director Multnomah County Health Department
01/07-9/12	Laboratory Medical Director Multnomah County Health Department
02/06-9/08	Assistant Medical Director Multnomah County Health Department
02/06-9/08	Electronic Health Record Medical Director Multnomah County Health Department
1/06-9/08	Chair, Clinical Oversight Group Oregon Community Health Information Network
06/04-7/07	Clinic Lead Provider-East County Clinic
09/00-09/12	Physician Staff Multnomah County Health Department at East County Clinic and Westside County Clinic
09/00-present	OHSU Clinical Assistant Professor with Family Medicine Department
06/00-present	Oregon State Medical License
06/00-present	Board Certified Family Medicine

EDUCATION

03/13-present	Registered for Clinical Informatics Subspecialty Board examination Informatics
03/06-9/08	Oregon Health Sciences University Biomedical Informatics Certification
06/97-06/00	Family Medicine Residency at Northern New Mexico Family Practice Program; Santa Fe, NM
08/93-6/97	Drexel College of Medicine Philadelphia, PA MD
08/89-12/92	University of Rochester Rochester, NY B.S. Molecular Genetics

PROFESSIONAL SOCIETIES

12/12-present	Oregon HIMSS
7/00-present	American Board of Family Practice Board Certified
1994-present	American Academy of Family Physicians

LANGUAGES
Spanish fluent and proficient written

RESEARCH
Publications available upon request

REFERENCES
Available upon request

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