Attachment 3 - Application Information and Certification Sheet

Legal Name of Proposer: West Central Coordinated Care Organization, LLC

Address: 601 SW Second Avenue
Portland, OR 97204

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

Contact Name: Sean Jessup **Phone:** 503.265.4748 **Email:** Sean.jessup@modahealth.com

Oregon Business Registry Number: 1526288-98

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 Executive Officer **Date:** 4/19/2019

(Authorized to Bind Applicant)

State of Oregon)

) ss:

County of Multnomah)

Signed and sworn to before me on 4/19/19 (date) by Robin Richardson (Affiant's name).

_____

Notary Public for the State of Oregon

My Commission Expires 2-8-22

OFFICIAL STAMP
ROZALYN K LARSON
NOTARY PUBLIC-OREGON
COMMISSION NO. 971465
MY COMMISSION EXPIRES FEBRUARY 08, 2022

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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.

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(Authorized to Bind Applicant)

State of Oregon)

) ss:

County of Multnomah)

Signed and sworn to before me on 4/19/19 (date) by Robin Richardson (Affiant's name).

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Notary Public for the State of Oregon

My Commission Expires 2-8-22

OFFICIAL STAMP
ROZALYN K LARSON
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COMMISSION NO. 971465
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Attachment 4 - Disclosure Exemption Certificate

Robin Richardson ("Representative"), representing **West Central Coordinated Care Organization** ("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 12 – NAIC Biographical Certificate NAIC Form 11	ORS 192.355(2)	**1.** Forms contain personal information that would constitute an invasion of privacy.
Attachment 7 – 12. f. 3. portion of response	ORS 192.345(2) Trade Secret	**2.** The number of pharmacies in our pharmacy network constitutes information that 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 disclose or use.
Attachment 7 – 12. f. 4. portion of response	ORS 192.345(2) Trade Secret	**3.** The number of claims our PBM system processed in 2018 and the performance information constitutes information that 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 disclose or use.
Attachment 7 – 12. f. 6. portion of response	ORS 192.345(2) Trade Secret	**4.** Certain terms within our PBM agreement constitute information that 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 disclose or use.
Attachment 7 – 12. F. 6. – NW Prescription Drug Consortium Pricing	ORS 192.345(2) Trade Secret	**5.** Pricing constitutes cost data that 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 disclose or use.
Attachment 7 – DSN Provider Report	ORS 192.355(2)	**6.** The report contains personal information that would constitute an invasion of privacy.

Attachment 5 - Responsibility Check Form

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

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

YES ☒ **NO** ☐.

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

How many contracts did not meet those standards? Number: **N/A** If any, please explain.

Response:	**Newly formed entity to serve Medicaid recipients in Lane County through CCO contract with OHA.**

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

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

YES ☐ **NO** ☒

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

Response:

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

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

YES ☐ **NO** ☒

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

Response:

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

YES ☐ NO ☒.

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

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

YES ☒ NO ☐

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

Response:

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

YES ☐ NO ☒.

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

Response:

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

YES ☒ NO ☐.

If "NO," please explain.

Response:

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

YES ☒ NO ☐ N/A ☐.

Submit a copy of the certificate with this form.

Response: We have included the certificate for Moda Health Plan in our response.

AUTHORIZED SIGNATURE

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

Applicant Name: **West Central Coordinated Care Organization**	RFA: **OHA–4690-19** Project Name: **Coordinated Care Organizations 2.0**

Signature: _____ **Title:** Chief Executive Officer **Date:** 4/19/2019

(Authorized to Bind Applicant)

Certificate of Completion

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

Chante Hillen

Has successfully completed the following:

DAS - CHRO - Overview of Pay Equity

On *2/13/2019*

Attachment 6 — General Questions

A. Background Information about the Applicant

1. Questions

In narrative form, provide an answer to each of the following questions.

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

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

West Central Coordinated Care Organization, LLC (WCCCO) intends to enter into an Administrative Service Agreement with one of its prospective members, ODS Community Health, Inc. Additionally, WCCCO intends to engage with ODS Community Dental, the ultimate controlling parent organization of ODS Community Health, Inc., as its Dental Care Organization.

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

No

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

Primary address: 601 SW Second Avenue, Portland OR 97204

Although WCCCO does not have an office within the proposed service area we have successfully demonstrated our ability to administer the CCO program in other geographies from a primary location outside of the service area.

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.

The proposed service area for West Central CCO includes all of Lane County. WCCCO will have contractual agreements in place with the Lane county public health department to provide point of contact services including but not limited to immunizations, disease treatments and family planning services. Additionally, WCCCO will contract with public health departments to provide well child care visits, school based clinic services and other services as they are available. WCCCO will have contractual agreements with the community mental health program that provide services within Lane County.

e. Prior history:

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

No

(2) If no to 1, is Applicant the Legal Entity that had a contract with

OHA as a CCO prior to January 1, 2019?

No

(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?

Yes

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

Not Applicable

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**
- **Oregon Educators Benefit Board**
- **Adult Mental Health Initiative**
- **Cover All Kids**
- **Other (please describe)**

WCCCO's affiliate ODS Community Health, Inc. (ODSCH) is an equity partner and administrator of the Eastern Oregon CCO (EOCCO) that has a contract with OHA for the Cover All Kids population under contract #156268.

WCCCO affiliate, Moda Health Plan, Inc., has held a contract with PEBB as a licensed insurer under contract #5300 since 1/1/2015 and OEBB under contract #107-1615-17 since 10/1/2008 for medical plan administration. Moda Health (formerly ODS) contracted with SEBB, BUBB, and the OEA Choice Trust prior to this. Delta Dental Plan of Oregon has held a contract with PEBB as a licensed insurer under contract #4700 since 1/1/2007 and OEBB under contract #107-1617-08 since 10/1/2008 for dental plan administration. Delta Dental (formerly ODS) contracted with SEBB, BUBB and the OEA Choice Trust prior to this.

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. WCCCO affiliate, Moda Health Plan, Inc., has offered Medicare Advantage since 2006. Our contract with CMS is current. Our PPO contract is state-wide.

h. Does Applicant have a current Dual Special Needs Coordination of Benefits Agreement with OHA to serve Fully Dual Eligible Members?

Yes. WCCCO's affiliate ODSCH is an equity partner and administrator of the EOCCO and has experience receiving Coordination of Benefits Agreement (COBA) crossover claims for Fully Dual Eligible Members with Traditional Medicare. WCCCO will obtain a COBA and will coordinate with COBA to receive direct crossover claims for Fully Dual Eligible Members with Traditional Medicare.

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?

Yes. WCCCO affiliate, Moda Health Plan, Inc., is a licensed health care service contractor in Oregon. Oregon Dental Service, doing business as Delta Dental Plan of Oregon, is also a licensed health care service contractor.

j. Does the Applicant (or an Affiliate of Applicant) hold a current contract effective January 1, 2019, with the Oregon Health Insurance Marketplace?

Yes. WCCCO affiliates Moda Health Plan, Inc. and ODS dba Delta Dental, have contracts with the Oregon Health Insurance Marketplace for 2019.

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.

WCCCO's affiliate ODSCH is an equity partner and administrator of the EOCCO and through this work has demonstrated experience and capacity for engaging community members and health care providers to improve the health of their communities. Below are a number examples for how WCCCO plans to work with providers and community members to improve health and address disparities that exist.

WCCCO is organized as a health plan/provider joint equity model that allows for true buy in and engagement in the success of WCCCO beyond just a provider contract. The following delivery systems within our geography intend to have an equity position and will have a vested interested in the success of WCCCO: PeaceHealth, McKenzie Willamette Hospital, Oregon Medical Group and Lane Independent Primary Providers (LIPP).

WCCCO will have a Clinical Advisory Panel (CAP) that services as a clinical matters advisory group for WCCCO. The CAP will help evaluate new clinical strategies directed at achieving the Triple Aim on behalf of all WCCCO communities.

WCCCO will provide quality measure bonus funding to primary care providers as a tool for incenting providers to continuously improve their performance.

From the community engagement standpoint WCCCO will form a Community Advisory Council's (CAC). The chair of the CAC will serve on the WCCCO board.

WCCCO will provide annual funding to its CAC so that members can address challenges

identified in their community health improvement plan.

WCCCO with the support of its affiliates will have significant data and analytics capacity and will regularly provide cost/utilization reports, incentive measure performance reports and will produce other ad hoc reports as needed. WCCCO's reporting will give providers and communities data to identify and help inform the development of initiatives to address regional, cultural, socio economic and racial disparities in health care that exist in each of WCCCO's communities. For example, WCCCO will provide county specific cost/utilization and quality metrics performance results and can further refine reporting using the race and ethnicity data provided by OHA. This information can then be used to inform the development of the WCCCO Community Health Improvement plan.

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

- **Chief Executive Officer**
- **Chief Financial Officer**
- **Chief Medical Officer**
- **Chief Information Officer**
- **Chief Administrative or Operations Officer**

(résumés do not count toward page limit; each resume has a two page limit)

Please refer to the Biographical Resume document included in our RFA response.

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 refer to the Contact List included in our RFA response.

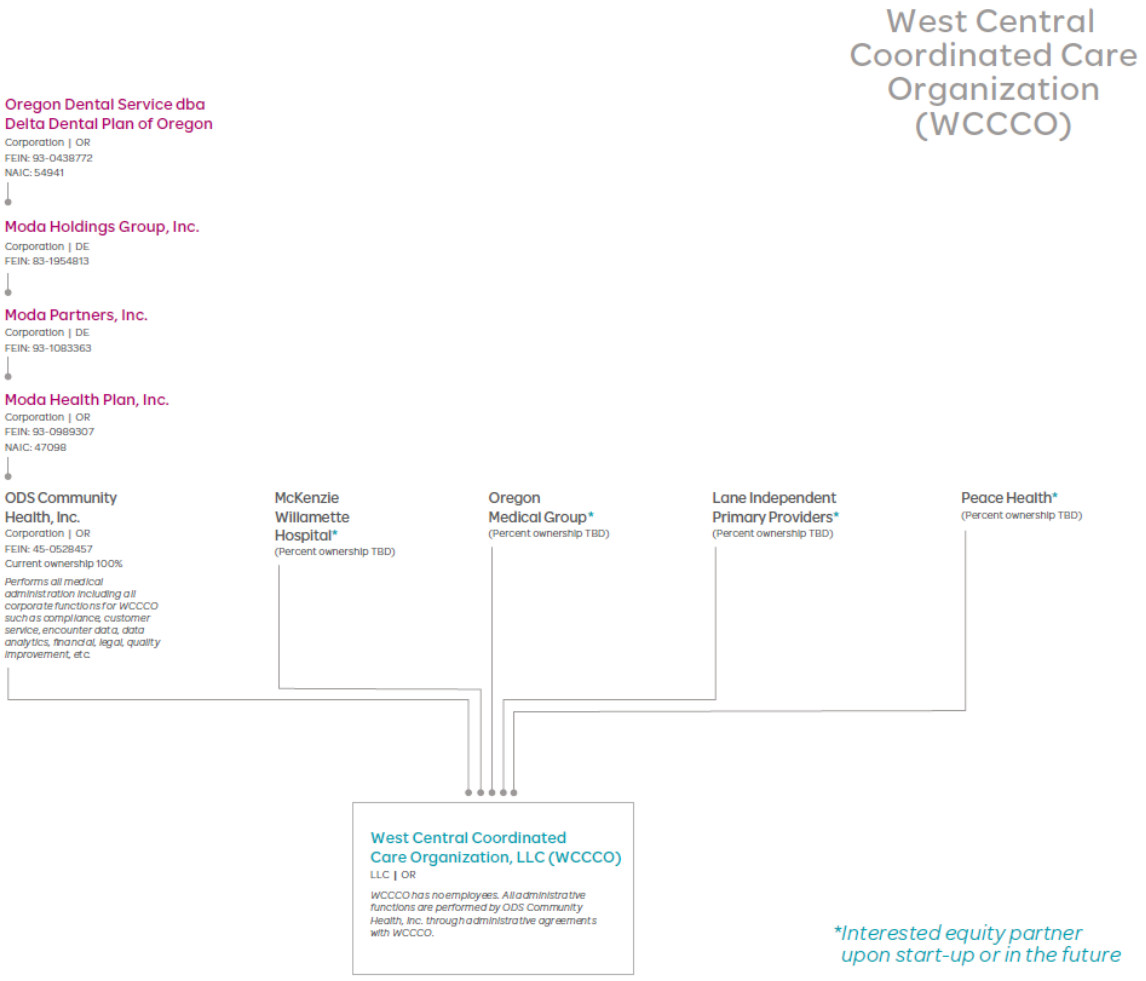
B. Corporate Organization and Structure

1. Questions

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 refer to the West Central Coordinated Care Organization Articles of Organization included in our RFA response.

b. Provide an organization chart listing of ownership, Control or sponsorship, including the percentage Control each person has over the organization.



c. Describe any licenses the corporation possesses.

WCCCO does not possess any licenses.

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.

WCCCO plans to enter into an Administrative Services Agreements with one its members, ODS Community Health, Inc.

C. Corporate Affiliations, Transactions, Arrangements

1. Questions

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.

Please refer to the Organization Chart included above and separately in our RFA response.

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.

WCCCO administrative functions will be provided by WCCCO affiliate ODS Community Health, Inc. (ODSCH).

ODSCH will perform all medical administration including all corporate functions for WCCCO such as compliance, customer service, encounter data, data analytics, actuarial, financial, legal, quality improvement, etc.

As WCCCO is a new entity no amounts have been paid to ODSCH to date.

Compensation for service will be based on administrative fees calculated and paid to WCCCO by OHA for the services provided by ODSCH.

c. Describe Applicant's demonstrated experience and capacity for:

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

The WCCCO affiliate ODSCH, as an equity partner/administrator of EOCCO, has demonstrated experience and capacity for meeting minimum loss ratios and establishing reserves for claims payable based on actuarial data and specific large claims resulting in low prior year development.

D. Subcontracts

1. Informational Questions

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

WCCCO will enter into an administrative services agreement with ODSCH pursuant to which ODSCH will provide personnel and services to allow WCCCO to fulfill its responsibilities as a coordinated care organization, including, without limitation, administrative functions, healthcare services, operations, financial services and regulatory/compliance functions.

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)

WCCCO will delegate work to subcontractors. We have provided the list of subcontractors along with examples of the business functions they provide and how we monitor their performance in the document titled "Subcontractor Example" included with our response.

E. Third Party Liability

1. Informational Questions

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

To ensure prompt identification of members, WCCCO will utilize multiple methods to identify third party liability (TPL) information. One method will be extracting the TPL data provided on the 834 enrollment files. Also, TPL information will be self-reported from members and/or providers via phone, email, fax or in writing. An example of how this may occur is during a pre-authorization request where a provider sends in chart notes, faxed to WCCCO. Providers will also notify WCCCO via claims submission, of member TPL information. Additionally, WCCCO will utilize a coordination of benefits data mining vendor, which will match WCCCO members to other coverage. Finally, the claims processing system is configured to identify claims with diagnoses where TPL could be relevant. When TPL information is received through one of the channels above, the data is validated against our core operating system and discrepancies are reviewed for accuracy.

We utilize the TPL information in our claims processing system to accurately calculate provider payments and to identify claims that need additional review. WCCCO will have established review protocols where the subrogation department will review coordination of benefits or request additional information related to the claim. We will notify providers in writing who improperly bill WCCCO before the appropriate TPL source.

WCCCO will have TPL information available through the online member eligibility portal and by phone, when providers call to verify member eligibility. To ensure subcontractors are aware of any member TPL, this information is provided to them via eligibility files transmitted, if applicable.

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

In addition to the process outlined above, the WCCCO will utilize weekly reports for members that are turning 65 or have conditions that qualify them for Medicare. These report are validated to identify if any Medicare coverage exists.

F. Oversight and Governance

1. Informational Questions

Please describe:

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.

WCCCO's Board of Directors (Board) will function as the manager of the Company. The Board is comprised of Directors to meet all requirements of ORS 414.625."

b. Please describe Applicant's key committees including each committee's composition, reporting relationships and responsibilities, oversight responsibility, monitoring activities and other activities performed.

As a new organization WCCCO has not yet established all its committees. At a minimum WCCCO will form a Clinical Advisory Panel and will identify other needed committees as determined by the WCCCO board prior to January 1, 2020.

c. The composition, reporting responsibilities, oversight responsibility, and monitoring activities of Applicant's CAC.

The WCCCO Board will appoint a Community Advisory Council (CAC). The CAC will oversees and coordinate activities including the Community Health Assessments, Community Health Improvement Plans, and preventive care activities.

The WCCCO CAC will be composed of community members that represent the diversity of the communities they serve, including race/ethnicity, age, gender identify, sexual orientation, disability, and geographic location. A County Commission will review all applications and nominate members of the CAC, including members from county government. The chair of the CAC will service on the WCCCO Board.

The CAC will produce an annual report on WCCCO's progress with Community Health Improvement and present the report to the WCCCO Board.

Articles of Organization - Limited Liability Company

Secretary of State - Corporation Division - 255 Capitol St. NE, Suite 151 - Salem, OR 97310-1327 - sos.oregon.gov/business - Phone: (503) 986-2200

REGISTRY NUMBER: 152628898

FILED
FEB 14 2019
OREGON SECRETARY OF STATE

In accordance with Oregon Revised Statute 192.410-192.490, the information on this application is public record. We must release this information to all parties upon request and it will be posted on our website.

For office use only

Please Type or Print Legibly in **Black** ink. **Attach Additional Sheet if Necessary.**

1. **NAME OF LIMITED LIABILITY COMPANY:** (Must contain the words "Limited Liability Company" or the abbreviations "LLC" or "L.L.C.")

WEST CENTRAL COORDINATED CARE ORGANIZATION, LLC

2. **DURATION:** (Please check one.)
   - (•) Duration shall be perpetual.
   - ( ) Latest date upon which the Limited Liability Company is to dissolve is _____

3. **PRINCIPAL OFFICE:** (Must be a physical street address)

601 SW SECOND AVENUE

PORTLAND, OREGON 97204

4. **REGISTERED AGENT:** (Individual or entity that will accept legal service for this business)

THOMAS BIKALES

5. **REGISTERED AGENT'S PUBLICLY AVAILABLE ADDRESS:** (Must be an Oregon Street Address, which is identical to the registered agent's office.)

601 SW SECOND AVENUE

PORTLAND, OREGON 97204

6. **ADDRESS WHERE THE DIVISION MAY MAIL NOTICES:**

601 SW SECOND AVENUE

PORTLAND, OREGON 97204

7. **HOW WILL THIS LIMITED LIABILITY COMPANY BE MANAGED?**
   - ( ) This LLC will be member-managed by one or more members.
   - (•) This LLC will be manager-managed by one or more managers.

8. **IF RENDERING A LICENSED PROFESSIONAL SERVICE OR SERVICES, DESCRIBE THE SERVICE(S) BEING RENDERED:** ORS 58.015(5)(m)

9. **OPTIONAL PROVISIONS:** (Attach a separate sheet if necessary.)
   - ( ) BENEFIT COMPANY: The Limited Liability Company is a benefit company subject to sections 1 to 11 of chapter 269, Oregon Laws 2013. (additional requirements apply)
   - (•) INDEMNIFICATION: The company elects to indemnify its members, managers, employees, agents for liability and related expenses under ORS 63.160 - 63.170.
   - ( ) SEE ATTACHED

10. **NAME AND ADDRESS OF EACH PERSON WHO IS FORMING THIS BUSINESS:** (ORGANIZER)

THOMAS BIKALES

601 SW SECOND AVENUE

PORTLAND, OREGON 97204

LIST MEMBERS AND/OR MANAGERS NAMES AND ADDRESSES (MAY BE REQUIRED BY YOUR BANK)

11. **OWNERS: (MEMBERS)** (Names and Addresses)

12. **MANAGERS: (MANAGERS)** (Names and Addresses)

13. **INDIVIDUAL WITH DIRECT KNOWLEDGE** (Name and Address) List the name and address of at least one individual who is a member or manager of the LLC or an authorized representative with direct knowledge of the operations and business activities of the LLC.

SEAN JESSUP

601 SW SECOND AVENUE

PORTLAND, OREGON 97204

14. **EXECUTION/SIGNATURE OF EACH PERSON WHO IS FORMING THIS BUSINESS:** (Organizer)

I declare as an authorized signer, under penalty of perjury, that this document does not fraudulently conceal, fraudulently obscure, fraudulently alter or otherwise misrepresent the identity of the person or any members, managers, employees or agents of the limited liability company. This filing has been examined by me and is, to the best of my knowledge and belief, true, correct, and complete. Making false statements in this document is against the law and may be penalized by fines, imprisonment or both.

SIGNATURE:	PRINTED NAME:	TITLE:
Thomas J Bikales	THOMAS BIKALES	ORGANIZER

CONTACT NAME: (To resolve questions with this filing)

RYAN D. MAUGHN

PHONE NUMBER: (Include area code)

503 241-2300

WEST CENTRAL COORDINATED CARE O

152628898-19789707 NEWORG

Biographical Resumes

Chief Executive Officer

Robin Richardson, Senior Vice President (Moda)
robin.richardson@modahealth.com
503.243.4491

Currently, Robin is the senior executive responsible for leading Moda Health's major Government accounts, the Oregon Educator's Benefit Board (OEBB), the Public Employees Benefit Board (PEBB) and the Public Employee Retirement System (PERS) Health Insurance Program (PHIP) for Medical, Dental, Pharmacy and Vision services. He is also responsible for leading Moda's Medicaid initiatives, including its Eastern Oregon Coordinated Care Organization, (EOCCO). Robin's past experience and present leadership of a wide variety of areas within Moda provides him with a broad perspective of the changing and challenging dynamics of the market in this era of healthcare transformation.

Prior to joining Moda Health in 1998, Robin served as Executive Director of the National Home Infusion Association based in Alexandria, Virginia. Prior to that he served as Vice President for Home Health Care and Institutional Services for the National Community Pharmacists Association also based in Alexandria, Virginia.

Robin volunteers for the American Diabetes Association (ADA) where he has served in a variety of leadership positions at a local and national level including service on the National Board of Directors and on ADA's National Finance Committee. Locally, he served as Chair of the Community Leadership Board for Oregon and SW Washington. Robin recently completed a three year term of service to the ADA as Vice Chair, Chair Elect and Chair of ADA's National Board of Directors.

Currently, Robin is Chair of the Board of the Eastern Oregon Coordinated Care Organization. He is also a member of the Board of Directors of the Oregon Business & Industry organization (OBI). Robin is a current member and Past-President of the Oregon State University College of Pharmacy Advisory Council and was honored as an Alumni Fellow of Oregon State University. Most recently, he was named as an Icon of Pharmacy by the College of Pharmacy. Robin is also a former Board member and past two-term Chairman of the Board for the Foundation for Medical Excellence.

Robin is a graduate of Oregon State University. Robin is also a citizen of the Cherokee Nation.

Chief Financial Officer

Dave Evans, Senior Vice President and Chief Financial Officer (Moda)
dave.evans@modahealth.com
503.243.3952

As senior vice president and CFO, Dave is responsible for overseeing Moda Health's financial, treasury, regulatory, information services, underwriting and actuarial functions. He brings a

broad knowledge of financial planning and budget management to his role. For nearly a decade, Dave served as controller of Moda Health (then ODS), where he was responsible for day-to-day accounting and finance activities. Prior to joining Moda Health, he was an audit manager at PricewaterhouseCoopers, where he focused on financial services, including insurance and real estate.

Dave earned his bachelor's degree at Oregon State University. An active certified public accountant, he participates in the Oregon Society of Certified Public Accountants' mentoring program and is involved with the American Institute of CPAs. He is also active in the community, serving on the board of the Assistance League and two metro oversight committees.

Chief Medical Officer

Dr. Jim Rickards, Senior Medical Director, Population Health & Delivery System Collaboration (Moda Health)
jim.rickards@modahealth.com
503.243.3954

Jim Rickards, MD, MBA, is a board-certified radiologist who believes our health results from what happens in both the clinic and the community. He started out interpreting medical imaging studies such as CAT scans and MRIs. Over the course of his career, he has developed ways to move beyond helping individual patients to improve the health of populations and communities. In this work, he helped start one of 16 original Medicaid Coordinated Care Organizations (CCOs) in Oregon, the Yamhill CCO, and served as the organization's Health Strategy Officer. He has also helped develop and guide health policy and legislation at the state level during his time as the Chief Medical Officer for the Oregon Health Authority (OHA). He is currently Moda Health's Senior Medical Director for Population Health and Delivery System Collaboration, and is working to integrate value-based payment models and population health strategies for commercial insurance, Medicare and Medicaid populations.

Dr. Rickards holds an MD degree from Indiana University. He completed his radiology residency training at Cook County Hospital in Chicago, and finished an MRI predominate body-imaging fellowship at Rush University. He holds a healthcare-focused MBA from OHSU-PSU and is currently completing a Masters in Population Health through Thomas Jefferson University.

Chief Information Officer

Sue Hansen, Vice President, Business Operations & Enterprise Project Management Office (Moda)
sue.hansen@modahealth.com
503.265.5705

Sue Hansen is Vice President of Business Operations & Enterprise Project Management Office (EPMO). She is responsible for Moda's strategic technology development and implementation,

membership accounting operations and is accountable for corporate initiatives and project implementation through the Moda EPMO.

Sue joined Moda Health, formerly ODS, in 2004 as the Director, Information Services. In this role, she was responsible for the implementation of core administrative systems, including the Facets Extended Enterprise system. She also served as Moda's Chief Information Officer for more than ten years. Sue has over 40 years of experience in technology and the health insurance industry, and more than 25 years of management experience.

Chief Administrative or Operations Officer

Sean Jessup, Vice President, Medicaid Programs (Moda Health)
sean.jessup@modahealth.com
503.265.4748

For more than 20 years, Sean Jessup, Vice President of Medicaid Programs at Moda Health, has been a leader and an innovator in the ways in which healthcare is provided and paid for in Oregon. At Moda, Sean has held leadership positions in claims, customer service, provider contracting and benefits programming. Today, he uses these accumulated skills to oversee the operational and financial performance of the Eastern Oregon Coordinated Care Organization (EOCCO), a 48,000-member CCO serving members in 12 frontier and rural Oregon counties. In January 2019 Sean was named President of the EOCCO.

In this role, Sean works closely with local elected officials, public health advocates and EOCCO board members, as well as a wide range of hospital and provider partners, to implement innovative programs that reduce costs and improve care for people living and working throughout Eastern Oregon.

Sean maintains strong ties with key members of the provider community across Eastern Oregon and with state officials charged with overseeing Oregon's Medicaid program. These relationships position Sean to share insightful recommendations that both enhance access to care for members of the Oregon Health Plan and provide for them better health outcomes.

Prior to joining Moda Health, he worked for Quest Diagnostics Medical laboratory and for a medical billing company in Oregon. Sean is an alumnus of the Strategic Marketing Management Executive Program at Stanford University's Graduate School of Business.

West Central Coordinated Care Organization

RFA OHA-4690-19 Contact Chart

	Application	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com
	Executive Summary	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com
	References	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com
1	**Attachment 1** *Letter of Intent to Apply Form*	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com
2	**Attachment 2** *Application Checklist*	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com
3	**Attachment 3** *Application Information and Certification Sheet*	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com
4	**Attachment 4** *Disclosure Exemption Certificate*	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com

5	**Attachment 5** *Responsibility Check Form*	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com
6	**Attachment 6** *General Questions*	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com
7	**Attachment 7** *Provider Participation and Operations Questionnaire*	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com
8	**Attachment 8** *Value-Based Payment Questionnaire*	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com
9	**Attachment 9** *Health Information Technology*	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com
10	**Attachment 10** *Social Determinants of Health and Health Equity*	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com
11	**Attachment 11** *Behavioral Health Questionnaire*	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com
12	**Attachment 12** *Cost and Financial Questionnaire*	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com

13	**Attachment 13** *Attestations*	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com
14	**Attachment 14** *Assurances*	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com
15	**Attachment 15** *Representations*	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com
16	**Attachment 16** *Member Transition Plan*	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com
	Sample Contract *Exhibits A - N*	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com
	Membership and Enrollment	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com
	Readiness Review	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com
	Rates and Solvency	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com

West Central Coordinated Care Organization (WCCCO)

Oregon Dental Service dba Delta Dental Plan of Oregon
Corporation | OR
FEIN: 93-0438772
NAIC: 54941

Moda Holdings Group, Inc.
Corporation | DE
FEIN: 83-1954813

Moda Partners, Inc.
Corporation | DE
FEIN: 93-1083363

Moda Health Plan, Inc.
Corporation | OR
FEIN: 93-0989307
NAIC: 47098

ODS Community Health, Inc.
Corporation | OR
FEIN: 45-0528457
Current ownership 100%

Performs all medical administration including all corporate functions for WCCCO such as compliance, customer service, encounter data, data analytics, financial, legal, quality improvement, etc.

McKenzie Willamette Hospital*
(Percent ownership TBD)

Oregon Medical Group*
(Percent ownership TBD)

Lane Independent Primary Providers*
(Percent ownership TBD)

Peace Health*
(Percent ownership TBD)

West Central Coordinated Care Organization, LLC (WCCCO)
LLC | OR

WCCCO has no employees. All administrative functions are performed by ODS Community Health, Inc. through administrative agreements with WCCCO.

**Interested equity partner upon start-up or in the future*

Subcontractor Example

ODS Community Health, Inc. - Medical claim administration, medical customer service, medical and pharmacy utilization and case management, appeal and grievance adjudication, medical provider network and credentialing and overall health plan operations.

ODS Community Dental - Oral health claims administration, customer service, provider network management and credentialing.

Evicore - High tech imaging utilization management.

MedImpact - Pharmacy point of sale prescription processing.

Magellan - Dialysis management.

The WCCCO's Compliance Officer or delegated staff will monitor and audit WCCCO's subcontractors to ensure compliance with applicable laws, regulations and service levels with respect to its delegated responsibilities. These monitoring and auditing activities include:

Annual Risk Assessment, Compliance Audit and Policy Review: On not less than an annual basis the Medicaid Compliance Department will conduct a risk assessment, compliance audit and policy review of the subcontractor. The compliance audit will include a review and assessment of required policies and procedures. The risk assessment will take into account the types and levels of risk that subcontractors pose to the OHP program and to the WCCCO. Factors considered in determining the risks associated with the subcontractor include the amount of work completed by the subcontractor, complexity of work, training and past compliance issues. The formal risk assessment is not a static document and will be reviewed yearly to determine if priorities remain accurate in light of changes in OHA or CCO requirements.

Ongoing Monitoring: The Medicaid Compliance Department will use a quarterly reporting system to monitor operational performance of the subcontractor. Areas to be monitored and performance expectations will be agreed upon by WCCCO and subcontractor prior to implementation of monitoring program. Potential areas to be monitored include but are not limited to:

- Member access to care
- Customer service response times
- Claims and Encounter data timeliness
- Complaints, appeals and grievances
- NOABD turnaround times
- Credentialing policies and procedures
- Quality Improvement measures
- Compliance with State and Federal regulations

Subcontractors and Delegated Entities Report

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

Reporting Year 2020

Subcontractor/Affiliate Name	**Tax ID #** **(SSN/FEIN)**	**Correspondence Address**	
		Street Address / P.O. Box	*City*
ODS Community Health	45-0528457	601 SW 2nd Ave.	Portland
ODS Community Dental	93-0438772	601 SW 2nd Ave.	Portland
EviCore Healthcare	14-1831391	400 Buckwalter Place Blvd	Bluffton
MedImpact Healthcare System Inc.	33-0567651	10181 Scripps Gateway Ct.	San Diego
Magellan Rx Management	02-0676924	6870 Shadowridge Drive, Ste. 111	Orlando

CCO Name: WCCCO

Reporting Quarter 1

			Subcontractor/Affiliate Physical Address				
State	*Zip*	*Country*	*Street Address*	*City*	*State*	*Zip*	*Country*
OR	97204	USA	601 SW 2nd Ave.	Portland	OR	97204	USA
OR	97204	USA	601 SW 2nd Ave.	Portland	OR	97204	USA
SC	29910	USA	400 Buckwalter Place Blvd	Bluffton	SC	29910	USA
CA	92131	USA	10181 Scripps Gateway Ct.	San Diego	CA	92131	USA
FL	32812	USA	8621 Robert Fulton Drive	Columbia	MD	21046	USA

Parent Company Name *(if applicable)*	*State*	*Country*	**Service Type(s)**	**Subcontractor/Affiliate Owner(s) Business Name or Individual's Last Name**
Moda Health	OR	USA	Medical	Moda Health
Oregon Dental Services	OR	USA	Dental	Oregon Dental Services
Cigna Corporation	CT	USA	High Tech Imaging	Cigna Corporation
NA	CA	USA	Pharmacy	MedImpact Healthcare System Inc.
Magellan Pharmacy Services, Inc.	FL	USA	Dialysis	Magellan Health

Subcontractor/Affiliate Owner(s) Individual's First Name *(if applicable)*	**Percent Ownership**	**Payment Methodology**	**Payment Methodology: Other**	**Subcontract Month**
NA	100	100% of Admin Fee related to contracted services		September
NA	100	PMPM		January
NA	100	PMPM		January
NA	100	Flat fee per claim		January
NA	100	PMPM		June

: Begin Date		Subcontract End Date				
Day	Year	Month	Day	Year	Date of most recent Compliance Review	Downstream Delegation of Services
1	2012	NA	NA	NA	April, 2018	NA
1	2020	NA	NA	NA	April, 2018	NA
1	2020	NA	NA	NA	January, 2019	NA
1	2020	NA	NA	NA	December, 2018	NA
1	2013	NA	NA	NA	December, 2018	NA

Describe the work being Subcontracted or Delegated
Medical claim administration, medical customer service, medical and pharmacy utilization and case management, appeal and grievance adjudication, medical provider network and credentialing and overall health plan operations.
Oral health claims administration, customer service, provider network management and credentialing.
High tech imaging utilization management.
Pharmacy point of sale prescription processing.
Kidney dialysis management.

Attachment 7 — Provider Participation and Operations Questionnaire

1. Governance and Organizational Relationships

a. Governance (recommended page limit 1 page)

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

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

WCCCO's Board of Directors (Board) will function as the manager of the Company. The Board will be comprised of Directors to meet all requirements of ORS 414.625. All decisions regarding the management of WCCCO will be made by the Board of Directors.

(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 WCCCO Board will appoint a Community Advisory Council (CAC). The CAC will oversees and coordinate activities including the Community Health Assessments, Community Health Improvement Plans, and preventive care activities.

The WCCCO CAC will be composed of community members that represent the diversity of the communities they serve, including race/ethnicity, age, gender identify, sexual orientation, disability, and geographic location. A County Commission will review all applications and nominate members of the CAC, including members from county government. The chair of the CAC will serve on the WCCCO Board.

The CAC will produce an annual report on WCCCO's progress with Community Health Improvement and present the report to the WCCCO Board.

(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.

The chair of the CAC will serve on the WCCCO Board.

CACs are composed of community members and intended to represent the diversity of the communities they serve, including race/ethnicity, age, gender identify, sexual orientation, disability, and geographic location. The County Commissioner will review all applications and nominate members of the CAC, including members from county government. The names will be submitted annually to the WCCCO Board of Directors for final approval of CAC membership.

The CAC will produce an annual report on WCCCO's progress with Community Health Improvement and present the report to the WCCCO Board.

(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.

WCCCO will have a dedicated position on the Board of Directors for the Chair of the CAC. This person will be selected by the CAC and represent the interests of Lane County. CACs are comprised of a combination of OHP consumers and people representing various social, health and human service organizations. Members receiving DHS Medicaid-funded care will be represented through the charter, once established and through the review of applicants by the County Commissioner.

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

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

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

N/A

(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.

The WCCCO will adapt the same model as the EOCCO, which is described below.

Role: The Clinical Advisory Panel (CAP) will report directly to the Board and serve as a clinical advisory group led by the WCCCO's Medical Director. The purpose of the CAP is to assist in evaluating new clinical strategies directed at achieving the Triple Aim, including provision of stewardship of the WCCCO delivery system transformation; monitoring implementation and performance of WCCCO risk contracts; monitoring incentive measure performance; annually proposing a Quality Bonus Payment formula to the board; serving as a "Delivery System Review Group" (including reviewing WCCCO's Physical/Behavioral/Dental care integration progress, WCCCO claims and clinical policies, and WCCCO clinical decision tool utilization); and annually producing a Clinician Summit.

Relationship to the CCO governance and organizational structure: The CAP will be chaired by the WCCCO Medical Director who prepares a summary of each CAP meeting for the Board. The Board will be responsible for final decisions on CAP recommendations. It is monitored by the WCCCO Medical Director, the WCCCO Clinical Consultant (if applicable), the WCCCO COO, and the WCCCO Board. Additional activities will be determined by the WCCCO Medical Director.

The CAP will be tasked to ensure the healthcare transformation of the WCCCO is influenced by a clinical perspective.

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

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

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

N/A

(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.

The WCCCO will execute MOUs with the APD offices within the service area and follow the same model of a Collaborative and Multidisciplinary Teams (MDT) used by EOCCO. The MDT will be designed to meet the needs of WCCCO Members with extreme complex care coordination needs. WCCCO care management leadership will meet with the APD leaders in Lane County. The collaboration between the entities will follow the requirements of a Memorandum of Understanding that will be established by all parties. Members can be referred to the MDT by WCCCO employees, APD employees, or any member of the medical community such as physicians, nurses, DC planners and community health workers.

Once referred, the MDT will access current documentation relating to the patient and collaborate the interventions that have already been completed for a member. The collaboration at this level will reduce the time and redundancy of case research. The MDT then determines next steps, assigns the appropriate staff to follow-up, and documents the plan. This process is followed until the desired outcomes are reached.

The CCO Collaborative and MDT will have specific goals. WCCCO anticipates they will include:

- Improving HIPAA related compliance by only discussing WCCCO Members with stakeholders and state workers who have a vested interest in the particular Member
- Identifying barriers to care coordination that can be resolved in partnership
- Assisting the local medical communities with finding safe, appropriate, and expeditious levels of care and services for each Member
- Reducing administrative time and burden via secured and private collaborative emails and bi-weekly meetings

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

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

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

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

WCCCO has met with leadership from Lane County Health and Human Services (HHS) and looks forward to completing an MOU with the department. We have discussed our shared goal of developing a truly collaborative community partnership in which we leverage Health and Human Services' expertise and intimate knowledge of providers, local conditions and the existing delivery system with our expertise and success in implementing a ground-up CCO model elsewhere in the state.

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

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

WCCCO plans to work closely with community partners utilizing a number of different relationships, both formal and informal. Contracts will be utilized when the relationships involve funding mechanisms. MOUs are used to outline responsibilities where different organizations are contributing different resources to projects or programs. Committees, meetings, and other events are also utilized to build relationships and streamline processes.

With Moda as our equity partner, WCCCO is strongly positioned to truly integrate behavioral, dental and physical health services for CCO members in Lane County. This opportunity grows out of Moda's long history and experience of integration our commercial lines of business,

dental lines of business, as well as Moda's existing relationships with social and support services in the area.

WCCCO plans to implement a Community Benefit Initiative Reinvestments (CBIR) program, which can establish long standing relationships with multiple community organizations. Partner organizations are able to identify projects and programs that will impact the Triple Aim. Through funding support, partners will be able to establish a program that is sustainable and beneficial to the community. Our goal will be to implement these partnerships as the work done by the community within the community will ultimately help to drive by-in and continued healthcare transformation.

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

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

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

Member communication and engagement will begin with onboarding newly enrolled Members, through the mailing of the Member welcome packet and Member handbook. The handbook will been reviewed for health literacy standards and is available in multiple languages.

Within the member mailing will be instructions on how to select a Primary Car Provider (PCP), the role of their PCP, Member and Provider rights and responsibilities and how to engage in the development of the Member's treatment plan with their PCP.

WCCCO will promote the engagement and activation of Members through various channels, including the CAC, focus groups and health fairs.

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

- **Encourage Members to be active partners in their health care, understanding to the greatest extent feasible how the approach to activation accounts for the social determinants of health;**
- **Engage Members in culturally and linguistically appropriate ways;**
- **Educate Members on how to navigate the coordinated care approach and ensure access to advocates including Peer wellness and other Traditional Health Worker resources;**
- **Encourage Members to use effective wellness and prevention resources and to make healthy lifestyle choices in a manner that is culturally and linguistically appropriate;**

- **Provide plain language narrative that informs patients about what they should expect from the CCO with regard to their rights and responsibilities; and**
- **Meaningfully engage the CAC to monitor and measure patient engagement and activation.**

WCCCO will deploy tools, programs, and processes to engage and activate members, and their families and support networks. Here are some examples:

- Direct communication to Members, parents and caregivers tailored to the Member's situation and disease state. This includes information regarding self-management for specific conditions such as alcohol use and liver disease, mood and depression, chronic pain, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD) and others. WCCCO will attend health fairs to engage members and provide educational resources.
- New Member packets will contain a Health Risk Assessment (HRA) used for determining what the Member feels are their biggest concerns with respect to managing their health. The HRAs will then be used to determine if a Member is eligible for Health Coaching services. The HRAs will be available in both English and Spanish.
- WCCCO plans to implement specialized programs engage members during certain episodes of care. One possible example of this is the RGA Rosebud program for babies undelivered and delivered, focused on high-risk pregnancies and infants. The case management services provided for perinatal and neonatal members include resources for additional clinical opinions – perinatologists, neonatologists and specialized nurse consultants are available for consult through RGA Reinsurance Company, Moda's reinsurance partner. WCCCO would identify the high-risk pregnancy members and refers them to RGA for perinatal case management. Rosebud RN's begin outreach and engagement right away and assess needs and perform ongoing outreach, keeping WCCCO informed along the way. For babies born at 34 weeks and under, WCCCO would refer them to the Rosebud program's neonatal team while the baby is in the hospital and after discharge.
- Members would be engaged in quality improvement activities using various tools such as gift card incentives for compliance with preventive screening measures, or direct telephonic health coaching to those who self-identify as tobacco users, or those who have been denied authorization for a procedure due to their tobacco use.
- Member communication will be extended to all Members, not just those accessing services, but in addition, we will provide comprehensive Member detail to primary care physicians, including Member contact information, which facilitates provider outreach to engage Members in wellness and preventive visits to close gaps in care.
- WCCCO and its provider partners will develop collaborative teams with the communities in the service area. These teams will incorporate Traditional Health Workers, community partners and providers.
- Quality Improvement Specialists will interact directly with the CAC, providing data regarding progress toward incentive measures. These conversations will provide the opportunity for ideating member engagement solutions focused on enhancing member engagement and incentive results.
- WCCCO plans to offer funds through a CBIR program and through the reimbursement of Traditional Health Workers.

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

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

a. Patient-Centered Primary Care Homes

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

(1) Describe Applicant's PCPCH delivery system.

WCCCO will support the PCPCH model, as defined by Oregon's statewide standards. WCCCO is working to secure contracts with clinics certified as PCPCHs due to their ability to advance the goals of the Triple Aim. WCCCO is providing financial incentives to providers who obtain PCPCH certification and for provider to maintain and increase their tier level certification.

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

WCCCO will utilize a transition of care model that ensures members are identified at admission to LTC providers. This will be accomplished by prior authorization review of transfer requests, nurse assessments during IP stays, and ER alerts for trigger diagnoses. When a member is identified as needing LTC services by any level of review or contact, a notification will be sent to Case Management. At that point, notification will be provided to the appropriate county APD office and the regional MDT (Multidisciplinary Team). This will allow for case collaboration with physical and behavioral health case management and the local APD transition coordinator.

(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.

Due to portions of our service area being rural, we have FQHC, RHCs, SBHCs, migrant health clinics or safety net providers. WCCCO will work to contract with all of the FQHC and RHCs in our services and to provide assistance and support in obtaining their PCPCH certification, if not already certified. FQHCs, RHCs, SBHCs, migrant health clinics and school based health centers play a crucial role in providing access to the Medicaid membership.

b. Other models of patient-centered primary health care

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

N/A

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

N/A

4. Network Adequacy (recommended page limit 3 pages)

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

a. Evaluation Questions

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

WCCCO will regularly perform detailed, formal assessments of the adequacy of its WCCCO network against rigorous standards that exceed regulatory requirements. Bi-annually, WCCCO will assess more than 50 specialties in every county in the service area to ensure Members have sufficient provider access. On a bi-annual basis we will assess access to PCPCH, Primary Care, Pediatric, Behavioral Health and other high volume specialties currently accepting new patients using the Medicaid specific time and distance standards shown below and ensure that for 90 percent of WCCCO members, travel time or distance to a provider is within the defined access standard (see below).

- Urban: 1 in 30 miles, 30 min
- Suburban: 1 in 30 miles, 30 min
- Rural: 1 in 60 miles, 60 min

For behavioral health providers, geographical access analysis will be performed when adding a substantial block of new business and otherwise at least annually to assess compliance with availability standards (see below) for the number, type and geographical distribution of Practitioners and Facilities.

- 1 Physician(s) (MD/DO) per 2,000 members.
- 1 Doctoral-level, non-MD practitioner(s) per 2,000 members.

- 1 Non-doctoral level, non-MD practitioner(s) per 1,000 members.

WCCCO and its subcontractors will review the maximum member enrollment limit by evaluating the service area membership and the number of contracted providers within the time/distance standards to ensure adequate access to providers of the appropriate type and number. WCCCO will utilize reports to analyze the ratio of Members to Providers. Also, WCCCO will collect data on an annual basis, which includes the number and type of practitioners employed at each organizational provider within network. Provider to Member ratios will based on data obtained during delivery service network assessment.

WCCCO will continuously communicate with Providers to ensure the appropriate Member assignment. The communication will include the number of new Members each Provider can accept, if the Provider is accepting new Members or only established Members, and any restrictions the Provider has regarding the type of Members that they can see (for example, a pediatrician would only treat children).

WCCCO will provide financial incentives for Providers to obtain or maintain PCPCH certification and for Providers to maintain and increase their tier level of certification. The financial incentives will include an enhanced per Member per month case management payment that increases with tier level. Additionally, we anticipate WCCCO's CAP to be available to provide one-on-one training to provider practices seeking initial certification or higher levels of certification on an as needed basis.

WCCCO's primary goal will be to increase the number of currently certified PCPCH's to achieve tier 4 and higher while also working with smaller practices to obtain PCPCH certification.

(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.

WCCCO will use the following data sources to review and assess network development needs:

- Geographic location of participating Providers and Medicaid enrollees including distance, travel time, means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities.
- Data on complaints and grievances.
- Data on accessibility of appointments and appropriate range of preventative and specialty services for the population enrolled or expected to be enrolled.
- Reports from Member Services, Care Management or other areas indicating that the needs of an identified Member(s) are unable to be met.
- Data on the anticipated Medicaid enrollment and anticipated enrollment of Fully Dual Eligible individuals.
- Membership profile, as developed and periodically updated under the auspices of the Quality Improvement Committee. This profile, which may be divided into account or product-line specific sections, includes the below information on WCCCO’s membership:
    - Identified cultural, racial, ethnic, linguistic, demographic, and risk characteristics.
    - Recognized clinical risks including physical or developmental disabilities, serious mental illness, multiple chronic conditions and severe injuries.

    - Expressed special and cultural needs and preferences.
- Expected utilization of services, the characteristics and healthcare needs of enrollees.
- Numbers and types (training, experience, specialization) of providers required to furnish the contracted Medicaid services.
- Number of network providers who are not accepting new Medicaid Members.
- The Provider Network sufficiency in numbers and areas of practice and geographically distributed in a manner that the covered services are reasonably accessible to enrollees as stated in ORS 414.736.
- Ability of care to be integrated and coordinated (i.e. availability of PCPCHs, CCBHCs).

Through the credentialing and re-credentialing of Practitioners and Facilities, WCCCO will request for information on the following:

- Identified clinical, cultural, linguistic, demographic, or risk characteristics.
- Recognized clinical risks including physical or developmental disabilities, serious mental illness, multiple chronic conditions and severe injuries.
- Expressed special or cultural needs or preferences.
- Existing treatment programs designed to meet the needs of patients with specific clinical, cultural, linguistic, demographic, or risk characteristics.
- Staff resources and experience in providing care based on a patient's demographic composition and their specific healthcare needs.

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

WCCCO will create a Quality Improvement Work Plan through a Quality Improvement Committee. The committee will periodically analyze data and refers any identified access issues to the Credentialing Committee for consideration and action. Some of the data expected to be reviewed:

- Data on complaints and grievances.
- Data on the accessibility of appointments by level of urgency.
- Data on availability of Practitioners and Facilities.
- Evaluation of out of network claims.

WCCCO plans on pursuing contracts with available providers for behavioral health, specialty and routine services when a need for increased capacity is identified, based on the data sources reviewed. Not all services are available locally for Members who reside in rural parts of the counties. Members will be referred to contracted Providers who can deliver the level of care required and are most conveniently located from the Member's residence. When necessary and on a case-by-case basis, WCCCO and its Provider partners may allow the referral of an WCCCO Member to a non-contracted provider for needed care.

(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.

WCCCO will use a variety of mechanisms to monitor access and access to WCCCO services, including member complaints, surveys (Oregon Health Authority annual Consumer Assessment

of Healthcare Providers and Systems survey, internal member or provider survey) and/or practitioner office site surveys triggered by member complaints on access.

A WCCCO provider credentialing representative will conduct a practitioner office site survey when two member complaints that are related to any single or combination of the following office-site criteria have been received within a consecutive six month period: physical access; access to emergency, urgent, routine care; physical appearance; adequacy of waiting and exam room space; and safety.

The site review is scheduled within 60 days upon receipt of the second complaint. The site review tool includes access standards to appointments. The survey passing score is 80%. Practitioners who do not pass the audit are requested to submit a corrective action plan within six weeks of receipt of the score and are re-audited within six months. A pattern of scores below 80% may be ground for denial of recredentialing.

WCCCO will notify Providers of the primary care, dental care, and behavioral health access standards in respective Provider manuals.

Additionally, data will be collected quarterly from contracted Providers related to wait times. Templates will be given to providers that automatically calculate access percentages and access standards are built into the templates. This data is collected on emergency, urgent, and non-urgent care. This data is anticipated to be presented to the WCCCO Quality Improvement Committee.

(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.

WCCCO will require Providers to notify us of any change to Provider network. DCO capacity will be monitored monthly and WCCCO will send reports to the DCOs to ensure proper capacity and to check for any updates. Additionally, if not all dental services are available locally for members who reside in the WCCCO service are, Members will be referred to contracted Providers who can provide the level of care required and are most conveniently located from the Member's residence. When necessary and on a case-by-case basis, WCCCO may allow the referral of a WCCCO member to a non-contracted Provider for needed care.

WCCCO will review complaint analyses and if we find that a delegate's provider received two member complaints about DCO access (physical access, access to appointments, wait times) within a consecutive six month period, WCCCO will request that the delegate conduct a practitioner office site survey. The delegate has the option to use WCCCO's practitioner office site survey tool.

WCCCO will measure the access to dental care through the Quality Improvement Work Plan, which the Quality Improvement Committee analyzes. The dental access requiremets, outlined below are requirements of our DCO partners.

1. Emergency dental care is provided within 24 hours
2. Urgent dental care is seen within 1 to 2 weeks or as indicated in the initial screening

3. Routine dental care is seen within an average of 8 weeks and within 12 weeks or the community standard, whichever is less, unless there is a documented special clinical reason which would make access longer than 12 weeks appropriate.

(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.

The Network Management Committee meets once per month to discuss new provider applications, changes to contract, and pending issues related to network adequacy and contracted Providers. The committee is comprised of subject matter experts from a variety of fields with direct access to service providers and provides crucial feedback on any items they have heard or witnessed in the community that may compromise network adequacy.

Additionally, not all services are available locally for members who reside in rural parts of the counties. Members are referred to contracted providers who can provide the level of care required and are most conveniently located from the Member's residence. When necessary and on a case-by-case basis, WCCCO and its provider partners allow the referral of an WCCCO Member to a non-contracted Provider for needed care.

b. Requested Documents

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

Please see the CCO 2.0 WCCCO DSN Report included in our submission.

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

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

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

All complaints, appeals, expressions of dissatisfactions and hearing requests are logged into a single database, including subcontracted activities. The issues are categorized and reviewed for trends quarterly. The quarterly report is reviewed with WCCCO's Quality Improvement Committee to identify persistent or significant appeals or complaint issues. These reports include number of complaints/appeals, completeness and accuracy of responses, persistent or significant complaints/appeals, trends in issues raised, and timeliness of receipt, disposition and resolution. Quarterly reports, as prescribed, are also submitted to OHA. Areas for improvement are identified and appropriate interventions are recommended. As needed, we provide member or provider education and/or implement internal system improvements. Also, employee education is provided to reaffirm or update internal processes for our grievance system.

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

WCCCO expects to contract with every major hospital and clinic system in its service area. WCCCO will also work to increase home nursing visits through the local health departments to improve access to services.

Our Quality Improvement Committee will review provider network adequacy for physical, oral and Behavioral Health, to ensure that WCCCO members will have access to a wide range of specialists. This will include a review of all out-of-network claims to identify providers we can recruit for participation by attempting to secure contracts with them. We will also allow members to see out-of-network providers when a network provider is not available. WCCCO and its provider partners will monitor the number of available providers to ensure adequate capacity to meet the needs of WCCCO members.

To provide additional solutions for these access challenges, WCCCO will apply for a Health Recourses and Services Administration (HRSA) grant for direct to patient tele-behavioral health services. This will allow members to receive behavioral health services anywhere they have cellular or internet access.

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).

Authorization requests will be managed in a time sensitive, systematic process where submitted clinical documents are reviewed by Utilization Management Coordinators who base authorization decisions utilizing consistent MCG criteria, OARs, and current WCCCO policies and procedures to determine medical necessity. Medical Necessity Criteria will be reviewed and approved annually by the Utilization Management Medical Director. When review of medical necessity criteria is not met, a Physician Reviewer will review and make a determination. All authorization decisions to deny, reduce or suspend services will be made by a Physician Reviewer prior to the delivery of a Notice of Action Adverse Benefit Determination (NOABD). NOABD notification letters will be formatted and pre-approved by the Oregon Health Authority to meet state, federal and NCQA guidelines. NOABD notifications will be automatically generated through the authorization software system and sent within required timeframes to the Provider and Member. When an appeal is initiated, the review is conducted by a different Physician Reviewer who was not involved in the initial ABD decision. The Utilization Management Department will conduct an Interrater Reliability Test using the MCG Interrater Module at least twice a year. Appeals are reviewed in order to identify trends or opportunities to improve upon.

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

a. Care Coordination:

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

WCCCO accepts the challenge of integrating behavioral health and addictions services with

and between multiple agencies and funding streams in the WCCCO area. WCCCO is cognizant of the need to support the flow of information between all of the human service providers in our service area. Through the Choice Model, WCCCO will monitor, coordinate and inform partners, as related to all admissions and transitions between levels of care, including OSH. WCCCO will communicate discharge planning from day one. Through the MDT, WCCCO will meet with ADP six times each month through regional MDTs. WCCCO and its providers will utilize EDIE/PreManage to track clients at all levels and each CMHP will have access to EDIE/PreManage.

WCCCO will have the communications platforms, software tools, confidentiality expertise and training protocols, as well as the local experts and clinicians available to continue to support this crucial exchange of information between all of the payment models and providers in our systems of care.

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

WCCCO will have support staff who engage in community partnerships throughout the region. We will work to build strong partnerships with CMHP, early learning hubs, tribal nations, educational services districts, schools, juvenile and adult justice (state and local), DHS and others. These partnerships lead to coordination of services and opportunities to leverage resources to improve health outcomes for populations spanning the developmental pathway. For Wraparound, in each community we have a review committee, practice level workgroup, an executive steering committee.

We will invest in prevention activities in each community through the CAC. Examples include health screening days for adolescents, colorectal screening and other community events that promote overall health. We also have a youth and family grant program supporting prevention efforts in targeted communities.

We will invest in Oregon Recovers to promote building a strong cadre of people with lived experience to support each other in developing advocacy and awareness capitol throughout the region.

(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.

To ensure effective communication between providers and Members, WCCCO will provide a vendor contract to all providers for translation services.

The Care Coordination program will be built on the National Standards of Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. We will have a strong cultural and linguistic training program for our provider network, and we will provide ongoing support for any questions around cultural and linguistic concerns providers may have. WCCCO will develop a flyer/brochure in plain language about Care Coordination and how to access Care

Coordination services. This tool will assist the provider in educating the member about Care Coordination services.

(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.

WCCCO will provide technical assistance and facilitate access to Arcadia for all providers in our network. Arcadia is a powerful platform that allows providers to pull reports on high utilizers including people with multiple healthcare and service needs

WCCCO will have dedicated staff to promote the use of EDIE/PreManage by providing training, technical assistance and best practice examples to our providers. Lane County Behavioral health is currently using EDIE/PreManage, as well as hospitals and a large number of primary care clinics, making it easy to identify members attempting to access services in multiple healthcare settings. Through the use of EDIE/PreManage providers can obtain real-time information about ED utilization activity. Users with access to EDIE/PreManage can view the information on demand for patients in their care, including those with multiple diagnosis. Users can find up to date information on current providers and care recommendations from Hospitals, PCP providers, and CMHPs. EDIE/PreManage provides a place where users can contribute critical information about high risk patients to assist ED providers in patient care and treatment. This includes members with multiple diagnosis and those receiving care from multiple health care provides.

Lastly, WCCCO will provide detailed analytics in the form of monthly reports that are distributed to providers. These reports include a list of chronic member conditions, risk score, medications, gaps in care, etc. These are standard reports that are available monthly.

(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.

WCCCO will identify Members requiring ICC through a variety of mechanisms, including referrals from PCPCHs, CMHPs, community partners including Developmental Disability Programs and brokerages, and computer generated reports that alert for high or rising risk utilization. Upon receipt of a referral, WCCCO will assign the Member to an ICC professional who collaborates and coordinates with the Member's care givers to assure Member needs are addressed.

The WCCCO ICC professional will act as a centralized point to help assure that all of the Member's needs are being addressed and information shared between various entities. Much of this work will occur through referrals, which are then followed-up to assure services were delivered and the Member's needs were met. If needed, the WCCCO ICC will refer to complex care management who will work directly with Member to determine needs and arrange for services.

Regular Multi-disciplinary Team (MDT) meetings occur, which include representatives from the CCO and ADP with engagement from local provider groups to assure care is coordinated, and problem solving occurs for complex cases.

(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.

All members identified with complex needs, including members with SPMI, will be referred to the WCCCO multi-disciplinary care coordination team (MDT) and will be discussed at a bi-weekly meeting until issues are resolved. For many members with SPMI, care coordination is provided by their local CMHP, and WCCCO's role will be more supportive than hands-on. Documentation will be maintained to assure all members working with the Member have access to the information needed to assure care coordination goals are being met. Members of the MDT team will meet regularly with representatives from APD staff to further coordinate care and the delivery of services.

(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.

WCCCO will build off of EOCCO's experience in Eastern Oregon. It provides enormous experience finding innovative ways of reaching Members who are simply difficult to reach, or who cannot or choose not to avail themselves of services that are necessary. EOCCO has a team dedicated entirely to meeting the complex care management standards outlined by the National Committee for Quality Assurance (NCQA). Members are referred to this care coordination team through referrals, trending reports, or special circumstance alerts. The team works with the Member's providers and local community supports to address the Member's specific needs. Our providers have found ways to 'meet people where they are' and not exclude or close anyone from services simply because they refuse to access care in traditional ways. WCCCO looks forward to modifying the approach in collaboration with local partners in its service area.

WCCCO will fund Traditional Health Worker capacity in the WCCCO region for the purpose of care coordination and to reach underserved populations. Traditional health workers are a valued component of multidisciplinary care teams that will serve WCCCO members. Behavioral health providers will be contracted to provide peer support through Peer Wellness Specialists and Peer Recovery Specialists with the community mental health program or substance abuse provider. Client choice in creating an individualized service plan that incorporates peer-delivered services is primary in determining the integration of these supports into treatment and recovery from behavioral health disorders.

WCCCO will support clinics utilizing CHWs to provide evidence-based interventions within their enrolled populations through referrals by primary care providers, including but not limited to individuals experiencing chronic conditions, those who could benefit from preventative care

and screening, and individuals requiring support to access social services programs. This growing workforce has also been supported through a contract with Oregon State University's Professional and Continuing Education (PACE) program, which provides distance education and support to state certification to prospective rural and frontier Community Health Workers, reducing unnecessary travel for new professionals entering the health care field.

WCCCO will use EOCCO's experience implementing the Evidence –Based Wraparound model in every county in Eastern Oregon, by following the Wraparound Best Practices Guideline. Included in this model are arrangements for services for ICC youth who decline or who do not meet criteria for Wraparound. Because EOCCO's rural counties are smaller in population, EOCCO providers have been required to be creative with their limited workforce, requiring their Wraparound Care Coordinators to also serve high-risk youth in families with ICC services, without breaking the 15:1, client:coordinator requirement. Included in this Best Practices Guideline are requirements that every youth in Wraparound or ICC have access to a Family Support Partner and/or Youth Support Partner. These positions are also in the process of being certified as THW's. WCCCO expects four (4) Family Peer Support Specialists – specialty code (606); and two (2) Youth Support Specialists – specialty code (607).

WCCCO is committed to providing a holistic approach to members in services including access to social supports. In accordance to OAR 309-019-0115(1)(c) all individuals receiving services have the right to Peer Delivered Services. All contractors shall ensure that members are informed of their benefit to access and receive peer delivered services from a Peer Support Specialist, Family Support Specialist, or Youth Support Specialist as applicable to the member's diagnosis.

All contractors shall ensure that SOC Wraparound services and supports include Family Support Specialist(s) (Family Partner(s)), and Young Adult Support Specialist(s) (Youth Partner(s)), as appropriate. Such Family Support Specialist(s) and Young Adult Support Specialist(s) must have experience navigating the mental/behavioral health, child welfare, or juvenile justice system with a child or youth, and be active participants in the Wraparound process. Family Support Specialist(s) shall engage and collaborate with systems alongside the family/parent/guardian.

WCCCO will implement a direct-to-member tele-behavioral health software platform that allows members to receive care from the privacy of their own homes (or the location of their choice). This software can also be utilized to connect members with THWs, other peer specialists, culturally or linguistically appropriate providers, or other support staff that maybe harder to connect with due to transportation or lack of local availability issues).

Through our CBIR program we will fund projects in the service area that are based on the specific needs and health disparities in each county. These CBIRs are able to affect the triple aim and establish a program that is sustainable and beneficial to the community. Our goal is to continue these partnerships as the work done by the community within the community will ultimately help to drive by-in and continued healthcare transformation.

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

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

WCCCO will send members a new member welcome packet, including a member handbook within 14 days of member eligibility. In the member handbook, it will describe how a member should begin to seek services and select a PCP and how their PCP will help coordinate care. The welcome packet will include a PCP selection card with a self-addressed stamped envelope and other ways to notify WCCCO of their PCP selection. If a member does not select a PCP, a PCP is selected for them at 30 days after enrollment. This is based on the geographical region and members are assigned to the highest tier PCPCH with capacity.

We expect that at times a provider will notify WCCCO that one of their patients enrolled with WCCCO through a referral and/or authorization request. This happens prior to the member calling to select a PCP. Our staff is trained to send the PCP request to be updated in the system when this occurs.

WCCCO will screen and send an assessments to those individuals who have been identified as needing intensive care coordination (ICC). The ICC initial assessment will be initiated within 30 days of the date a member is identified for ICC and completed within 60 days of that date. WCCCO will assign a care coordinator to engage each member newly identified for ICC. The care coordinator will initiate telephonic contact with the member within ten business days of case assignment. The care coordinator will make two telephonic attempts on different days and times of day; and one attempt by mail.

(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.

As the state of Oregon's population continues to become more diverse, WCCCO network providers will serve members from diverse cultural and linguistic backgrounds. Providing linguistically appropriate healthcare in both verbal and written forms plays a crucial role in effectively delivering healthcare services. WCCCO will arrange for both telephonic and in-person interpreter services at members' medical provider appointments at no cost to the member. WCCCO Member handbooks and participating Provider manuals will include instructions on how to request these services. WCCCO will develop initiatives to increase education and awareness, improve our understanding of the diversity of our member population, develop standards for plain language and cultural competency, and implement staff cultural competency training. WCCCO's equity partner, Moda has a diversity council that is an interdepartmental leadership committee who is responsible for the development of infrastructure to ensure equitable healthcare for all members and the communities that we serve. WCCCO will also implement workplace diversity and cultural competency employee trainings for all new and current staff that are member facing.

WCCCO will also provide demographic data to primary care clinics via monthly provider progress reports. These reports include member level information on race/ethnicity in the form of a roster, data on claims based incentive measure performance, follow-up lists, an MED roster, and a list of patients enrolled in health coaching. Providers will use this information to assess performance and reach out to patients. WCCCO will continuously assesses the cultural, ethnic and linguistic makeup of our health plan membership to ensure the availability of practitioners to meet identified cultural and linguistic needs. Our assessment will include analyzing the utilization of interpreter services and member complaints for language, ethnic, racial and cultural barriers in accessing care. We also will survey our primary care providers to identify providers with non-English language capabilities and include this information in our online Provider directory and in the Provider directories given to members.

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

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

WCCCO will utilize EDIE/Pre Manage to notify of hospital discharges related to diagnosis with high re-admission rates or high needs. Outreach to these members is completed by and ICM (intensive case manager) to follow for a minimum of 30 days. This is to ensure follow up with PCP or Behavioral Health provider, medication reconciliation and disease education regarding symptoms. Members admitted to a skilled nursing facility are all referred to the county MDT for care collaboration.

(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.

WCCCO will meet biweekly with Lane County's APD offices to discuss transitions of care and complex cases. This will be accomplished with our MDT program, and each APD office will have the direct contact information for all WCCCO supervisors and coordinators to ensure rapid communication and triaging of needs. A daily email distribution list will notify APD of their members who have transferred to LTC services, and facility contact information will be provided to the DT coordinators at transfer. In addition, leadership from physical and behavioral case management and APD offices will meet quarterly to discuss the successes of the MDT program, as well as identify areas of improvement to best communicate our member's needs.

(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.

WCCCO's tracking system will allow for a central location that is able to track member's transition from one care setting to another. Members enrolled in case management will be noted within our systems. As members move from one care setting to another these services will be tracked and noted within our systems. This process is completed for all members. Care Coordinators and case managers will meet weekly to discuss members in an inpatient facility. Case managers will engage the member and family as appropriate. Members will receive notification of all service approvals and denials via mail.

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

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

WCCCO ICMs will communicate with members and their care givers to discuss enrollee's health concerns, social situations, and other concerns and questions the enrollee may not always think to discuss with their PCP or Behavioral Health provider. The WCCCO ICM will contact the enrollee's PCP or Behavioral Health provider with any concerns and inform the PCP or Behavioral Health provider of issues they may not be aware of. Multiple emergency room visits by an enrollee would elicit a call to the enrollee's PCP to notify them of the emergency room activity and to determine if the enrollee has been treated for the same condition or if the PCP is aware of the enrollee's condition. If needed, a referral will be given to a specialist or supplier. Claims will be monitored for activity, and contact with the enrollee will be continued until care coordination needs are complete. Care plans will be updated and revised when the enrollee has a change in medical condition, physical location, or when the enrollee expresses a change warranting care plan review. Care plans will be updated by the ICM and physician or Behavioral Health provider.

ICM's will be assigned to their case managed members in PreManage so that they are aware of any ER visits or Inpatient Admissions. Utilizing PreManage notifications, the ICM will then be able to coordinate with the PCP or Behavioral Health provider for follow up efforts.

Individual care plans will be established for all WCCCO members that are in Complex Case Management. The care plans will note that the self-management plan has been discussed with the patient and the date that has been done. It will also delineate whether a goal(s) is determined by

the member, care giver, family or ICM. Those goals are then prioritized and managed with input from the member at least monthly, to set interventions tailored to the individual needs of the member, care giver and the member's family and support system. Prioritization will also include the desired level of involvement of all parties.

WCCCO will monitor treatment plans to ensure that necessary services are provided by communicating with all providers and the enrollee to ensure that all providers are aware of the enrollee's care needs. When the WCCCO ICM assists an enrollee in finding care, claims will be monitored to see enrollee's visit activity. If there is a discrepancy in the care needs between the member and the provider, the ICM will reach out to the provider to assist in resources to help meet the service needs.

(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.

WCCCO will utilize the following standards to assess individuals for critical risk factors that trigger ICC for high needs; high risk reports, PreManage notifications, HRA's and other reports to identify members with intensive care coordination needs.

(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

WCCCO will meet biweekly with APD offices to discuss transitions of care and complex cases. This will be accomplished with the MDT program, and each APD office has the direct contact information for all WCCCO supervisors and coordinators to ensure rapid communication and triaging of needs. A daily email distribution list will notify APD of their members who have transferred to LTC services, and facility contact information will be provided to the MDT coordinators at transfer. In addition, leadership from physical and behavioral case management and APD offices will meet quarterly to discuss the successes of the MDT program, as well as identify areas of improvement to best communicate our member's needs.

(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.

WCCCO will reassess Members with high needs if significate changes are noted. PreManage alerts and high risk identification reports are also utilized to track any changes in Member status. If changes are noted the ICM will offer services.

(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.

Bi-weekly regional MDTs will provide opportunity to coordinate care for those members who are dually eligible. All WCCCO members, including those who are dually eligible, may be referred to the MDTs for care coordination needs.

Moda Health Plan, Inc. Medicare Advantage is the Affiliated Medicare Advantage plan partner. WCCCO Case Management staff will work within the same department, in the same location, as the case managers that work on the affiliated Medicare Advantage plan. When a WCCCO member is dually enrolled in both, the case managers will have an in-person consultation to assess and manage the member's overall health, including Behavioral Health issues.

(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.

Dental case management coordinates the dental services for WCCCO members who have complex medical needs, are aged, blind, disabled, have multiple chronic conditions, mental illness or substance abuse disorders and either 1) have functional disabilities or 2) live with health or social conditions that place them at risk, or developing functional disabilities, i.e., serious chronic illness or environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care. DCOs initiate targeted member outreach based on findings of dental assessments as well as on physical, behavioral health or dental provider, WCCCO or family/caregiver referrals.

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

WCCCO Case Manager will coordinate the dental needs between physical, oral and behavioral health through phone calls and/or emails, when a need is identified. This can be identified through a referral and/or authorization request, member or provider referrals, claims data, and other reports and/or notifications.

b. Care Integration (recommended page limit 1½ pages)

(1) Oral Health

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

WCCCO Case Manager will coordinate the dental needs between physical, oral and behavioral health through phone calls and/or emails, when a need is identified. This can be identified through a referral and/or authorization request, member or provider referrals, claims data, and other reports and/or notifications.

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.

WCCCO will evaluate members from enrollment through HRAs and throughout eligibility through hospital admission alerts and PA requests to identify members in need of dental services. If any concerns are found, referrals will be made to dental care coordination for member outreach.

(2) Hospital and Specialty Services

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

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

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

WCCCO will ensure that Member's PCPs are informed of member's specialist needs through mailed letters and/or phone conversations that include details of prior authorization requests and hospital admissions. Hospitals will also provide copies to visit summaries to PCPs after the Member is hospitalized.

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

PCPCHs and PCPs will be regularly engaged by various teams in the referral process for coordination needs as well as how to submit PA requests. Member specific discussions will be completed with providers to identify medically complex cases and assign them to ICMs.

(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.

With the use of PreManage and Arcadia, WCCCO will make the process of sharing records efficient to providers and ensures timely communication between clinics/facilities/WCCCO.

(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.

WCCCO will provide transition of care services after hospitalization or ED visits through ICMs as they engage with the member directly and work with providers and specialists to develop individual care plans for each member.

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

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

(1) Describe how the Applicant will:

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

WCCCO will meet biweekly with APD offices to discuss transitions of care and complex cases. This will be accomplished with our MDT program, and each APD office has the direct contact information for all WCCCO supervisors and coordinators to ensure rapid communication and triaging of needs. A daily email distribution list will notify APD of their members who have transferred to LTC services, and facility contact information will be provided to the DT coordinators at transfer. In addition, leadership from physical and behavioral case management and APD offices will meet quarterly to discuss the successes of the MDT program, as well as identify areas of improvement to best communicate our member's needs.

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

WCCCO will meet biweekly with APD offices to discuss transitions of care and complex cases. This is accomplished with our MDT program, and each APD office will have the direct contact information for all WCCCO supervisors and coordinators to ensure rapid communication and triaging of needs. A daily email distribution list will notify APD of their members who have transferred to LTC services, and facility contact information will be provided to the DT coordinators at transfer. In addition, leadership from physical and behavioral case management and APD offices will meet quarterly to discuss the successes of the MDT program, as well as to identify areas of improvement to best communicate our member's needs.

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

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

WCCCO will meet biweekly with APD offices to discuss transitions of care and complex cases. This will be accomplished with our MDT program, and each APD office will have the direct contact information for all WCCCO supervisors and coordinators to ensure rapid communication and triaging of needs. A daily email distribution list will notify APD of their members who have transferred to LTC services, and facility contact information will be provided to the MDT coordinators at transfer. In addition, leadership from physical and behavioral case management and APD offices will meet quarterly to discuss the successes of the MDT program, as well as to identify areas of improvement to best communicate the member's needs.

(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.

WCCCO will meet biweekly with APD offices to discuss transitions of care and complex cases. This will be accomplished with our MDT program, and each APD office will have the direct contact information for all WCCCO supervisors and coordinators to ensure rapid communication and triaging of needs. A daily email distribution list will notify APD of their members who have transferred to LTC services, and facility contact information will be provided to the DT coordinators at transfer. In addition, leadership from physical and behavioral case management and APD offices will meet quarterly to discuss the successes of the MDT program, as well as to identify areas of improvement to best communicate the member's needs.

(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)

WCCCO will meet biweekly with APD offices to discuss transitions of care and complex cases. This will be accomplished with our MDT program, and each APD office will have the direct contact information for all WCCCO supervisors and coordinators to ensure rapid communication and triaging of needs. A daily email distribution list will notify APD of their Members who have transferred to LTC services, and facility contact information will be provided to the DT coordinators at transfer. In addition, leadership from physical and behavioral case management and APD offices will meet quarterly to discuss the successes of the MDT program, as well as to identify areas of improvement to best communicate the member's needs.

(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.

WCCCO will meet biweekly with APD offices to discuss transitions of care and complex cases. This will be accomplished with our MDT program, and each APD office will have the direct contact information for all WCCCO supervisors and coordinators to ensure rapid communication and triaging of needs. A daily email distribution list will notify APD of their members who have transferred to LTC services, and facility contact information will be provided to the DT coordinators at transfer. In addition, leadership from physical and behavioral case management and APD offices will meet quarterly to discuss the successes of the MDT program, as well as to identify areas of improvement to best communicate the member's needs.

d. Utilization management

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

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

All members admitted to acute care facilities will be followed by our concurrent care coordinators. Complex members will be discussed in the weekly discharge rounds meetings. This meeting will include care coordination supervisors, concurrent review nurses and case managers. Members with over utilization will be identified via pre-manage and claim reports. Case management referrals for these members will be completed via a triage process. Health coaching will reach out to members regarding underutilization of services.

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

WCCCO and its delegated entities will have structured review mechanisms in place to detect and address over-and under-utilization of services. These mechanisms will include internal utilization management committees and case management or quality improvement teams that monitor utilization against practice guidelines and treatment planning protocols and policies, including members with special health care needs.

The utilization management committee is responsible to review and monitor data related to key utilization management indicators such as over and under-utilization and accessibility and availability of Behavioral health services. Quality Improvement Committees of our respective delegated dental care organizations monitor over-and under-utilization of services.

The case management team is responsible for monitoring data related to over-and under-utilization of services by WCCCO members, including those with special healthcare needs.

A facilitated workgroup includes representatives from physical, behavioral health and dental services to monitor data related to over- and under-utilization of services related to the Oregon Health Authority (OHA) CCO incentive metrics.

An interdisciplinary team of Medical Informatics and Population Health Management and Engagement representatives develop member and provider interventions as the result of monitoring targeted aspects of member care, including over- and under-utilization of services.

Examples of processes we use to monitor and detect potential over- and under-utilization of services include:

- Monthly or quarterly gaps-in-care reports to identify members missing preventive screenings or tests to manage chronic disease.
- Dental reports of referrals to specialty care and follow-up by the DCO to assess the status of the appointment

- Concurrent monitoring of behavioral health inpatient stays to ensure follow-up care by a behavioral health specialist or primary care provider within 7 days of dischargeMonthly case management reports on high risk members (data elements include diagnoses, living situation, cognition, mobility, bath/hygiene/grooming, Medicare status, behavioral issues, behavioral/emotional functioning).
- Inpatient discharge planning by the care coordination team to ensure discharge to the appropriate level of care
- Ongoing monitoring of emergency department utilization
- Monthly review of trigger diagnoses by our Medical Management teams
- Monitoring of readmission rates for all causes or by specific diagnoses
- Reviewing antibiotic usage for judicious and appropriate use
- Focused dental provider audits on potential over-utilization
- Monitoring of potential adverse outcomes and hospital-acquired conditions
- Inter-rater reliability testing for clinical staff to ensure consistency in decision making
- Medical management report of denial rates by procedure
- Quarterly analysis of utilization of out of network WCCCO services, including behavioral health services.
- Quarterly review of the cost and utilization dashboard that includes inpatient, outpatient, professional, mental health, dental, and pharmacy cost and utilization.

7. Accountability (recommended page limit 1½ pages)

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

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

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

subcontracted entities, and the timely and complete submission of reporting deliverables.

CCO 2.0 Accountability Standards include:

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

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

The WCCCO QIC will provide oversight to transformation, quality assessment and performance improvement activities to ensure that WCCCO Members receive high quality physical, behavioral and dental services. The committee will be a decision-making body that has the authority and representation to develop and implement integrated quality improvement activities it deems appropriate and necessary to improve the patient experience of care and health of the WCCCO populations, and to reduce the cost of healthcare. To track the quality measure performance across the CCO, we will deploy a variety of reports through our data analytics team in the form of provider progress reports, county-level progress reports, as well as a real-time view of metric performance through our HIE, Arcadia Analytics. This platform will be available to multiple clinic systems within our service area as well as our CMHP. Moving forward we will plan to continue to support this HIE as well as increase the number of those who are connected to the platform. This systems will allow for not only quality measure performance tracking but also overall population health management.

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)?

WCCCO's partner, Moda, participates in HEDIS reporting as well as all of the additional reporting requirements for health plan accreditation by NCQA. Moda was one of the first health plans in Oregon to voluntarily seek accreditation with NCQA. In addition, Moda participates in several CMS related reporting with respect to our Medicare Advantage line of business, our ACA market participation, and our engagement with other Oregon payers in the CPC+ initiative.

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

WCCCO providers will be required to meet Federal and State requirements related to quality and performance standards, which is outlined in provider contracts.

Through value based payment models that will be implemented, providers will be held to meet quality improvement activities and targets are subject to change each year, depending on areas of focus or need.

WCCCO providers will be required to submit reports and information on a monthly, quarterly or annual bases to assure that they are meeting contract requirements and quality of care standards. Examples of these reports include: access to emergent, urgent and routine care, utilization of restraints and seclusion, incident reports and near misses, financial reports, Wraparound, ACT, Choice and Supported Employment reports, interpreter logs and chart audits.

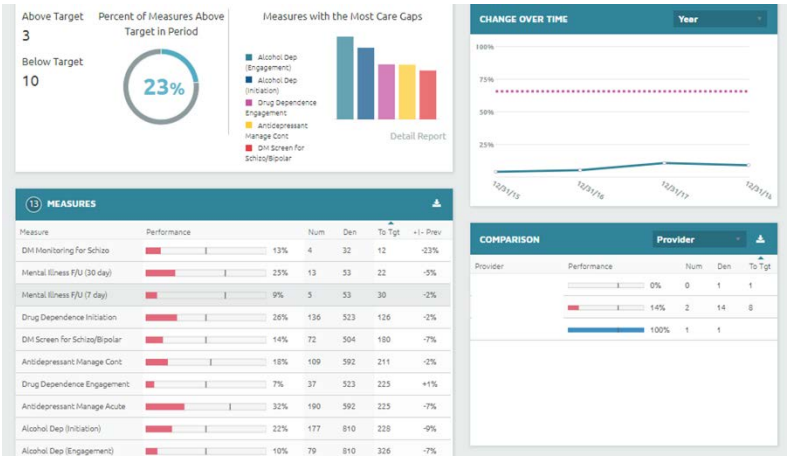
Also, the WCCCO Quality Improvement Committee will provide for a systematic structure for decision making, allocation of resources and implementation of integrated quality improvement and transformative activities with the goals of advancing the Triple Aim for WCOCCO members and meeting our objectives in the delivery and evaluation of the quality and safety of the care and services provided to WCCCO members.

The program will encompasses transformation and quality assessment and quality improvement activities for WCCCO. This will include monitoring and evaluating the quality and safety of care and services provided in ambulatory settings, hospitals, residential treatment and skilled nursing facilities; through home healthcare services, free- standing surgical centers and ancillary services; and by the CCO through member services, physical health, behavioral health and dental health services.

The objectives of the WCCCO QIC Committee will include:

- Establish and maintain organizational systems to ensure access to high quality, medically necessary, culturally competent and safe delivery of physical health, behavioral health and dental health services in the most appropriate setting.
- Transform the delivery of service to a model that is integrated and outcome-base
- Continuously improve the quality and safety of the care and service delivered to thereby:
    - Improve the health status of WCCCO population and their communities
    - Ensure member satisfaction with experience of care
- Ensure the delivery of cost-effective care and services
- Continuously evaluate the quality and safety of service delivery provided to members to identify improvement opportunities
- Promote communication and collaboration between WCCCO and our partners
- Support WCCCO practitioners and providers to improve the quality and safety of care and service delivered in their respective settings

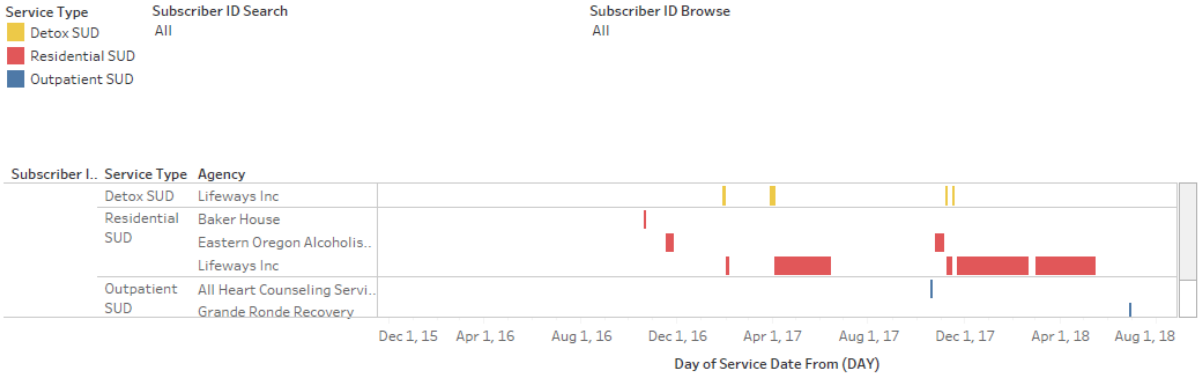
d. Explain the Applicant's internal quality standards or performance expectations to which Providers and Subcontractors are held.



WCCCO will share performance information through a number of mechanisms including: real time data available to all providers connected to the Arcadia Analytics platform (see example), monthly provider progress reports, Peer and Clinical Advisory Panel, Quality Improvement Committees, Board Meetings and the Community Advisory Council. WCCCO will also host a Clinician's Summit.

These data sharing avenues allow for review of previous performance and opportunities for the creation of quality improvement activities to address areas of concern or to continue performance improvement. With the performance data available real-time and/or monthly, quality improvement activities can be tracked regularly to note whether improvement is in fact occurring or if the project needs to be altered or abandoned.

Additionally, WCCCO data analysts can create custom reports for quality improvement tracking through their centralized database. These reports can be made available on an ad-hoc basis if the metric is not already tracked regularly. The example below shows a custom report to demonstrate a patient who has numerous SUD residential and detox services, but was not receiving much outpatient care. This data will be shared with the care team so they can better plan how to best work with this member and hopefully avoid the need for higher level services.



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

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

WCCCO through Moda will maintain the following activities and controls to identify potential fraud, waste, or abuse occurrences:

- Information system claims edits such as appropriateness of services and level(s) of care, reasonable charges, and potential excessive over-utilization;
- Post-processing review of claims and other claim analytics;
- Practitioner credentialing and re-credentialing policies and procedures, including on-site reviews
- Prior authorization policies and procedures (member eligibility verification, medical necessity, appropriateness of service requested, covered service verification, appropriate referral);
- Utilization management practices, such as prior authorization, concurrent review, discharge planning, retrospective review;
- Quality improvement practices;
- Dental/medical/pharmacy claims review such as appropriateness of services and level(s) of care, reasonable charges, and potential excessive over-utilization.
- As circumstances warrant, referrals from committees such as Quality Improvement Operations, Dental Quality Improvement, Credentialing, and Pharmacy & Therapeutics Committees;
- Practitioner and member handbooks language regarding the reporting of potential fraud, waste and abuse;
- Member and practitioner mailings to educate about potential areas of fraud, waste, and abuse and how to recognize schemes;
- Staff (including senior management and subcontractors) training regarding potential fraud, waste and abuse detection, reporting, and correction efforts. Such training occurs at least annually and is also part of new hire orientation for new employees.
- Monitoring of practitioner and member appeals and grievances;
- Encounter data validation. Confirmation with a statistically valid portion of the population that services as billed by the provider were actually received by the member. As part of this process, Contractor sends member verification letters to OHP members and performs follow-up if a timely response is not received.
- Monthly federal exclusion screening of all staff, providers and subcontractors. Excluded individuals will not be employed by the Contractor or its subcontractors.

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

WCCCO's Compliance Officer or delegated staff will monitor and audit Contractor's subcontractors to ensure compliance with applicable laws, regulations including Fraud, Waste and Abuse. On not less than an annual basis the Medicaid Compliance Department will conduct a risk assessment, compliance audit and policy review of the subcontractor. The compliance audit will include a review and assessment of required policies and procedures, including Fraud, Waste and Abuse policies and detection procedures.

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

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

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

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

WCCCO's Population Health Management and Engagement (PHME) team will include two areas of member outreach: one-on-one disease management & health coaching, and population-based quality initiatives. The overall goal is to achieve the Triple Aim— improve the patient experience of care, improve the health of populations and reduce the per capita cost of healthcare. PHME designs a comprehensive and integrated suite of programs and services for members at all stages of life and health status. Our programs and services cover a wide array of health topics to assist members in making informed healthcare-related decisions.

Quality is the foundation of all PHME activities. PHME staff will utilize the PDSA (Plan-Do-Study-Act) cycle to standardize the way we test change and monitor progress. Program performance will be evaluated by analyzing medical and pharmacy claims, member and clinic-reported clinical outcomes, Patient Activation Measure change and member survey data. The results will be documented and reviewed and provide the rationale for continuing current quality initiatives and starting new activities. WCCCO will measure the success of programs and initiatives comparing our plan-wide measure outcomes with state benchmarks and targets.

WCCCO will use clinical guidelines and best practices to design and develop programming. We will update the evidence-based guidelines to reflect any change in the national standards, and our medical directors and the Quality Council will review the guidelines biennially.

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.

WCCCO Quality Improvement Specialists will perform in-clinic technical assistance on quality improvement initiatives and routinely interact with provider partners via email, phone and webinar to promote and support upcoming and existing programs and improve population outcomes. Member rosters will be reviewed with clinic partners to promote clinic-based outreach and increase member engagement.

Additionally, WCCCO will work with community partners to facilitate Community Benefit Initiative Reinvestments (CBIR) that promote improved health outcomes and increased quality metrics. WCCCO staff will also implement member initiatives to promote health and wellness activities such as adolescent well care incentive programs, colorectal cancer screening media campaigns, and health education mailers.

Within our organization, WCCCO staff will also support various wellness initiatives to lead an active and healthy lifestyle. For example programs to encourage walking, eating healthy meals, and discount gym memberships.

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.

On behalf of WCCCO, Moda's analytics team currently consumes data from various sources to produce high-level dashboards that emphasize trends and opportunities in care delivery. For example, one recent report highlighted characteristics of Members who have not been using primary care services but rather emergency and specialty services. This data allows us to develop plans for impacting this member population and engaging them in primary care. Arcadia Analytics is another platform that consumes electronic data into actionable formats. This platform allows for review of Member gaps in care as well as services the Member may have received from another care provider in the system.

To ensure accountability we have an established shared savings model contract which includes shared risk and a quality bonus payment methodology for incentive measure performance. This shared savings model holds clinics accountable for continuous improvement in service delivery.

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.

WCCCO will process or import all referrals and prior authorizations into a central system. This system will also encompass our claims data. On a monthly basis, WCCCO will import all data into a central data storage solution. This includes documentation of all referrals and prior authorizations.

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

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

No. WCCCO is not under any sanctions by CMS.

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?

Moda Health Plan, Inc. Medicare Advantage is the Affiliated Medicare Advantage plan partner. WCCCO Case Management staff will work within the same department, in the same location, as the case managers that work on the affiliated Medicare Advantage plan. When a WCCCO member is dually enrolled in both, the case managers will have an in-person consultation to assess and manage the member's overall health, including Behavioral Health issues.

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

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

See Service Area Table below.

Service Area Table

County (List each desired County separately)	Maximum Number of Members-Capacity Level
Lane	95,000

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

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

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

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

(3) **The exception request is not designed to minimize financial risk**

and does not create adverse selection, e.g. by red-lining high-risk areas.

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

Service Area Table

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

In some areas the patterns of care may be such that Members seek care in an adjoining county. Applicant may choose to contract with Providers located outside the Service Area covered to ensure sufficient access to care for Members. The Service Area places no restriction on the location or distribution of an Applicant's Provider Network. The Applicant will receive rates for each county. If a prospective Applicant has no Provider Panels, the Applicant must submit information that supports their ability to provide coverage for those Members in the Service Area(s) they are applying. In determining Service Area(s) Applicants must consider the allowable driving distance and time to Primary Care Physicians (PCP) and any other Provider type outlined in contract or OAR 410-141-3220.

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

a. Standard #1 - Provision of Coordinated Care Services

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

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

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

comprehensive and integrated care management network and delivery system network serving Medicaid and dually eligible Members for the following categories of services or types of service Providers that has agreed to provide those services or items to Members, whether employed by the Applicant or under subcontract with the Applicant:

- **Acute Inpatient Hospital Psychiatric Care**
- **Addiction treatment**
- **Ambulance and emergency Medical Transportation**
- **Assertive Community Treatment**
- **Community Health Workers**
- **Community prevention services**
- **Dialysis services**
- **Family Planning Services**
- **Federally Qualified Health Centers**
- **Health Care Interpreters (qualified/certified)**
- **Health education, health promotion, health literacy**
- **Home health**
- **Hospice**
- **Hospital**
- **Imaging**
- **Intensive Case Management**
- **Mental health Providers**
- **Navigators**
- **Non-Emergent Medical Transportation**
- **Oral health Providers**
- **Palliative care**
- **Patient-Centered Primary Care Homes**
- **Peer specialists**
- **Pharmacies and durable medical Providers**
- **Rural health centers**
- **School-based health centers**
- **Specialty Physicians**
- **Substance use disorder treatment Providers**
- **Supported Employment**
- **Tertiary Hospital services**
- **Traditional Health Workers**
- **Tribal and Urban Indian Health Services**
- **Urgent care center**
- **Women's health services**
- **Others not listed but included in the Applicant's integrated and coordinated service delivery network.**

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

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

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

Service Category Description PCPP, SPP, PCPCH: Qualified to deal with the diseases and disorders of children and youth, including those who may be blind or disabled, have high health care need, multiple chronic conditions, and mental illness or substance use disorder. Some examples of the specialties or sub-specialties include pediatrics, cardiology, dermatology, neurology, occupational therapy, physical therapy, psychology, pediatric behavioral health, speech language pathology, otolaryngology, and oncology.

Service Category Description PCPA, SPA, PCPCH: Qualified to deal with the diseases and disorders of adults and geriatric patients, including those who may be blind or disabled, have high health care need, multiple chronic conditions, and mental illness or substance use disorder. Some examples of the specialties and sub-specialties include internal medicine, cardiology, neurology, gastroenterology, podiatry, pain management, rheumatology, urology, geriatric medicine, podiatry, oncology, infectious disease and endocrinology.

Service Category Description QHCI, THW, FQHC, RHC, Hospice, PC, SNF: Qualified to deal with all age categories and populations including those who may be blind or disabled, have high health care need, multiple chronic conditions, and mental illness or substance use disorder. Some examples of the specialties and sub-specialties include family practice, internal medicine, hospice and palliative care, skilled nursing, home health and preventive medicine.

Service Category Description DSPP, DSPA, OHPP, OHPA: Qualified to deal with all age categories and populations including those who may be blind or disabled, have high health care dental needs. Some examples of the specialties and sub-specialties include oral surgery, maxillofacial and dentistry.

Service Category Description MHPP, MHPA, SUDPP, SUDPA, HPSY, AD, MHCS: Qualified to deal with all age categories and populations including those who may be blind or disabled, have high mental illness or substance use disorders. Some examples of the specialties and sub-specialties include psychiatry, psychology, and clinical psychology.

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

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

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

WCCCO's proposed service area includes three rural counties in Northwest Oregon. Counties include: Clatsop, Columbia and Tillamook.

WCCCO will have contractual agreements in place with Lane County public health to provide point of contact services including but not limited to immunizations, disease treatments and family planning services. Additionally, WCCCO will contract with public health departments to provide well child care visits, school based clinic services and other services as they are available. WCCCO will contract with the community mental health program that provides services within Lane County.

Publicly Funded Health Care and Service Programs Table

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

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

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

As a newly forming CCO, WCCCO is deeply committed to building profound partnerships with robust community engagement, and we understand that this is the key to a truly integrated model. As we will discuss throughout the application, and within Attachment 10, our primary equity partner Moda, has a track record of utilizing an active Community Advisory Council (CAC) structure in the administration of its program in Eastern Oregon with excellent results.

WCCCO is actively meeting with local providers and community groups to better understand the lay-of-the-land, identify local community expertise and understand the opportunities for collaboration and growth. WCCCO appreciates that the existing Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) for Lane County involved numerous stakeholders with key involvement from Lane County HHS. We look forward to supporting

"Live Healthy Lane (Lane County's Healthy Future), and understand that we will be the new partner in the process and look forward to the opportunity for collaboration and partnership with these important stakeholders. We look forward to learning from the community and adjusting our plans accordingly.

(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.

WCCCO intends to provide for continuity of existing services by supporting Lane County Behavioral Health in continuing to provide Intensive Care Coordination. This arrangement will preserve existing relationships and make use of existing expertise and infrastructure. WCCCO through Moda also has Registered Nurses who provide ICC for medical needs and they will work closely with Lane County Behavioral Health to coordinate for members with intensive medical and behavioral needs. We have extensive experience implementing and monitoring delegation agreements to comply with NCQA and CMS requirements.

Our contracts will include specific requirements for care coordination in alignment with OHA requirements. WCCCO will enforce contract requirements through regular reporting and by conducting annual reviews. Reviews include member-specific charts with attention to documentation (assessments – coordination of information to determine medical necessity, service plans – service interventions and coordination, service notes – delivery of services and coordination of care) as well as assessment of systems-level data and functions. Feedback on reviews will be given with potential for corrective action plans (CAPs), technical assistance, or additional monitoring.

(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.

WCCCO has met with Lane County Behavioral Health and has entered into a Letter of Agreement with Lane County Behavioral Health to contract with WCCCO effective 1/1/2020.

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.

WCCCO is able to provide culturally relevant coordinated care services to our AI/AN population through our experience obtained through EOCCO and the partnership and contract with Yellowhawk Tribal Health Center. This health center has fully integrated services inclusive of primary care, behavioral health, oral health, and pharmacy services. Additionally, EOCCO's AI/AN Members are able to be seen at either an IHS or any other contracted clinic outside of the IHS. This operational decision was made in partnership with the Confederated Tribes of Umatilla in order to ensure their members had complete access to healthcare services. Additionally, Yellowhawk Tribal Health Center has employed Community Health Workers to ensure care coordination for their Members.

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

(1) From among the Providers and facilities listed in the DSN Provider Report Template, please identify any that are Indian Health Service or Tribal 638 facilities.

There are two federally recognized tribes in Lane County: 1) The Coquille Indian Tribe live in the Tribe's five county service area including Lane County as well as Coos, Curry, Douglas, and Jackson counties; 2) The Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians are made up of three tribes (four Bands): two bands of Coos Tribes: Hanis Coos (Coos Proper), Miluk Coos; Lower Umpqua Tribe; and Siuslaw Tribe. The five-county service area is made up of Coos, Curry, Lincoln, Douglas and Lane counties.

WCCCO is committed to ensuring that Tribal members have access to services provided by American Indian providers, for both outpatient and inpatient behavioral health services. Since many of these services are located outside of the WCCCO region, efforts will be made to utilize tele-behavioral health if Members would prefer not to make the drive into Portland. WCCCO will continually monitor out-of-network utilization to identify opportunities to further contract with Native American providers being utilized by our Members.

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

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

WCCCO has experience through the relationship established between EOCCO and Yellowhawk Tribal Health Center. Details of the experience is noted below.

The relationship between EOCCO and Yellowhawk Tribal Health Center started by building a foundation of understanding on the needs of the clinic and facility. Through meetings and collaborative efforts, a contract was signed on July 1, 2014. Since that time, the clinic became certified as a Tier 3 PCPCH and has received enhancement payments for the certification. The clinic also participates in the Risk Model and Shared Saving agreements.

EOCCO has implemented special allowances for Yellowhawk, even as a contracted provider. This is to allow for access to healthcare that is culturally responsive and promotes member's choice to see both an IHS and/or a clinic outside of the IHS. Since the membership has the right to see providers at Yellowhawk, we systemically bypass the requirement that Yellowhawk be the assigned PCP on the member record. This allows for claims payment when members are seen at the IHS but assigned to a clinic outside of the IHS. However, many of the members are assigned to the clinic. Additionally, we process Yellowhawk authorizations that are sent in and once again waive the requirement of it originating from the PCP.

EOCCO also reimburses the Traditional Health Workers employed by the IHS, billed to EOCCO. The use of THWs help promote access to health care that is culturally responsive and addresses health disparities experienced by tribal members.

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

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

We are committed to delivering on the goals of CCO 2.0 by managing a pharmacy benefit that ensures culturally sensitive access while focusing on prevention, quality improvement and lower costs. WCCCO's pharmacy benefit will be administered consistent with the Prioritized List as determined by the Health Evidence Review Commission (HERC) for covered conditions and treatment pairs. Drugs used to treat mental health conditions such as depression, anxiety and psychosis and which are covered by the Division of Medical Assistance Programs (DMAP) will be coordinated by the same pharmacy team to ensure WCCCO members receive integrated and coordinated health care that focuses on improving quality, eliminating health disparities and ensuring healthy outcomes.

Our pharmacy program is delivered in partnership with the Oregon Prescription Drug Program (OPDP) to maximize purchasing power and align benefits that reduce costs. Consistent with the CCO 2.0 recommendations of the Oregon Health Policy Board, WCCCO is committed to program transparency, 100 percent pass-through of any savings, and affordable prescription drug coverage for members in our service area. WCCCO's pharmacy benefit includes the following:

- Use of OPDP as the backbone of our pharmacy network and reimbursement strategy to better manage prescription drug costs.
- Transparent pricing – services will be delivered for a low single administration fee per approved claim.
- 100 percent pass-through of pharmacy charges and payments – aggressive pharmacy network financial guarantees will apply for brand and generic drugs. Any network over-performance will be passed directly to WCCCO; there will be no spread retained by WCCCO's PBM.
- 100 percent pass-through of manufacturer rebates, which will help lower the total drug cost.
- No concealed markups by our PBM and no hidden administration charges or costs.
- An exclusive specialty pharmacy, Ardon Health, a Portland-based specialty pharmacy that works closely with providers throughout our service area and understands the unique healthcare needs of WCCCO members with complex conditions that require specialty medications.
- Local and experienced clinical pharmacists who oversee benefits and work directly with prescribers to ensure the right medications are utilized at the right time.
- A dedicated pharmacy customer service team.
- Personalized educational materials and tools for members available through our web-portal.
- A local customer support team that will work daily with WCCCO leadership to ensure the pharmacy program is targeted to perform against key objectives.

(2) Specifically describe the Applicant's:

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

WCCCO's drug formulary will be facilitated through OPDP and is the cornerstone of medication therapy, quality assurance and cost containment efforts for our pharmacy benefit. WCCCO will develop, maintain and administer a closed formulary which will limit coverage to the most clinically and economically valuable medications based on the Oregon Health Authority (OHA) Prioritized List of Health Services. The formulary is governed by our Pharmacy and Therapeutics (P&T) Committee, a group of community-based physicians and pharmacists, and includes FDA-approved drug products for each therapeutic class and at least one item in each therapeutic class of over-the-counter medications to ensure sufficient treatment access. WCCCO will work in collaboration with the OHA and other CCOs to develop strategies to maintain and manage Managed Medicaid formularies across Oregon. This includes participation in the CCO Pharmacy Director Meetings, Oregon P&T meetings, and the CCO Oregon Pharmacy Workgroup to provide input on legislative changes and incorporating OHA recommendations.

We evaluate new market entries on a weekly basis as new products are approved by the FDA. When new drugs are approved, our clinical pharmacy staff evaluate and prepare information for review and discussion by the P&T Committee to determine formulary placement. Our approach to formulary and utilization management reflects current evidence-based treatment guidelines produced by national organizations and HERC, as well as data from original clinical trials published in peer reviewed journals, systematic reviews (such as those from the Northwest Evidence-based Practice Center), and national drug compendia. Our P&T Committee meets quarterly to update and revise the WCCCO formulary.

In addition to formulary placement decisions, the P&T Committee evaluates utilization management edits, such as prior authorization (PA) guidelines, step therapy, and quantity level limits to ensure clinically appropriate and cost-effective use of medications, but also to ensure a mechanism for coverage of medications not included on the closed formulary. If a particular drug is not covered on the formulary, a formulary exception review is conducted by the clinical pharmacy team on a case-by-case basis to determine if an exception can be made and the product covered.

In addition to the clinical input provided by our P&T clinician members, we seek clinical input on our utilization management controls in a variety of other ways. Through the peer-to-peer process in our PA program, we continuously garner prescriber feedback. Additionally, we have access to an Expert Clinical Network of more than 120 specialists that includes expertise in almost every disease state, but is particularly beneficial for rare and orphan diseases where there are a limited number of providers in the entire country. We are able to access this group of providers for input and feedback on newly approved drugs, therapeutic categories, coverage criteria, and PA cases.

(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.

We propose OPDP's Pacific Value Network (PVN), which includes an extensive network of retail chain and independently owned community pharmacies to ensure broad availability and convenient pharmacy access for members. The PVN was originally created to meet the unique access and performance requirements of CCOs in Oregon and has been available through OPDP since 2014. The PVN pharmacy network is centered on the importance of providing an extensive network of pharmacies with a strong presence in Oregon to address the communities we serve.

[redacted]

Given the critical role that specialty medications play in health care today, our pharmacy network will include Ardon Health (Ardon), a dedicated Portland-based specialty pharmacy with strong regional expertise that offers a more personalized connection with patients and prescribers in the Northwest. Ardon is amongst a small number of pharmacies accredited for specialty pharmacy by both URAC and ACHC. In addition, Ardon holds ACHC Distinction in Oncology. A unique offering of Ardon is the ability to provide a single point of concierge services for onboarding members requiring access to Limited Distribution Drugs (LDD). This allows members and prescribers to use a single source for all their specialty pharmacy needs, including LDD medications.

Ensuring prescribers and members understand their formulary choices and the PA and step therapy requirements for prescribed medications is critical to administering WCCCO's pharmacy benefit. Positive formulary changes can occur quarterly after a product has been approved by the P&T Committee for inclusion in WCCCO's formulary. Negative changes can occur two times per year, in January and July. WCCCO will use individualized member communication strategies that effectively communicate formulary changes that adversely impact drug selection

and utilization. Member communication occurs no less than 30 days prior to a change, but we aim for 60 days advance notice, with additional mailings to support members that start the medication after the notification date. We will work closely with our provider community and community representatives to ensure written materials that communicate pharmacy plan changes are clear and concise.

Our electronic PA platform provides an efficient mechanism for provider offices to request PAs and submit required clinical information either through an electronic health record system or a web-based portal. Through this process, providers receive real-time validation of member eligibility, as well as coverage criteria questions specific to the member and the member's plan. Once responses to the criteria question set is submitted by the provider they may get an auto-approval within a few seconds, if criteria are met, or the case may be pended for further review. For all submitted requests, a provider office can check the outcome or status of a request online. The electronic PA process provides an accessible, efficient, and transparent process for coverage determinations and can lead to shorter time-to-treatment for members when clinically appropriate.

(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.

WCCCO will use a proprietary, integrated claims adjudication platform to process all pharmacy claims. Our claims processing system has been in place since 1989 and is time-tested in the PBM market, [redacted] This single platform creates a universal system with real-time information that can be shared across all applications. The claims adjudication platform includes thousands of edits to determine if a claim should be paid. The support requirements are flexible and can support custom configurations while maintaining very high performing adjudication results [redacted] This platform enables individuals to access claims history so that relevant clinical and historical data elements can be made available and queried to investigate specific claim questions.

Coordination of Benefits (COB) is supported when a member has healthcare coverage under more than one plan. If a member is covered by more than one pharmacy plan, WCCCO coordinates benefits with other insurers to help the member receive the full benefit of those plans. By coordinating benefits, WCCCO may be able to reduce the overall cost incurred for covered services.

Upon enrollment and annually thereafter, WCCCO will request information from each member regarding any other health insurance coverage they may have to verify any changes that may have happened during the year. In order to prevent a claim from being delayed or denied, members alert WCCCO if they or anyone in their family have any other current pharmacy coverage, including Medicare, that has existed in the last 12 months. Members let us know by completing a Coordination of Benefits form and returning it to WCCCO.

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

Our dedicated government operations and clinical staff process and review all PA requests for WCCCO members, including monitoring PAs on weekends and holidays to ensure members and providers receive timely and accurate determinations. We continuously monitor turn-around times to ensure consistent standards of performance.

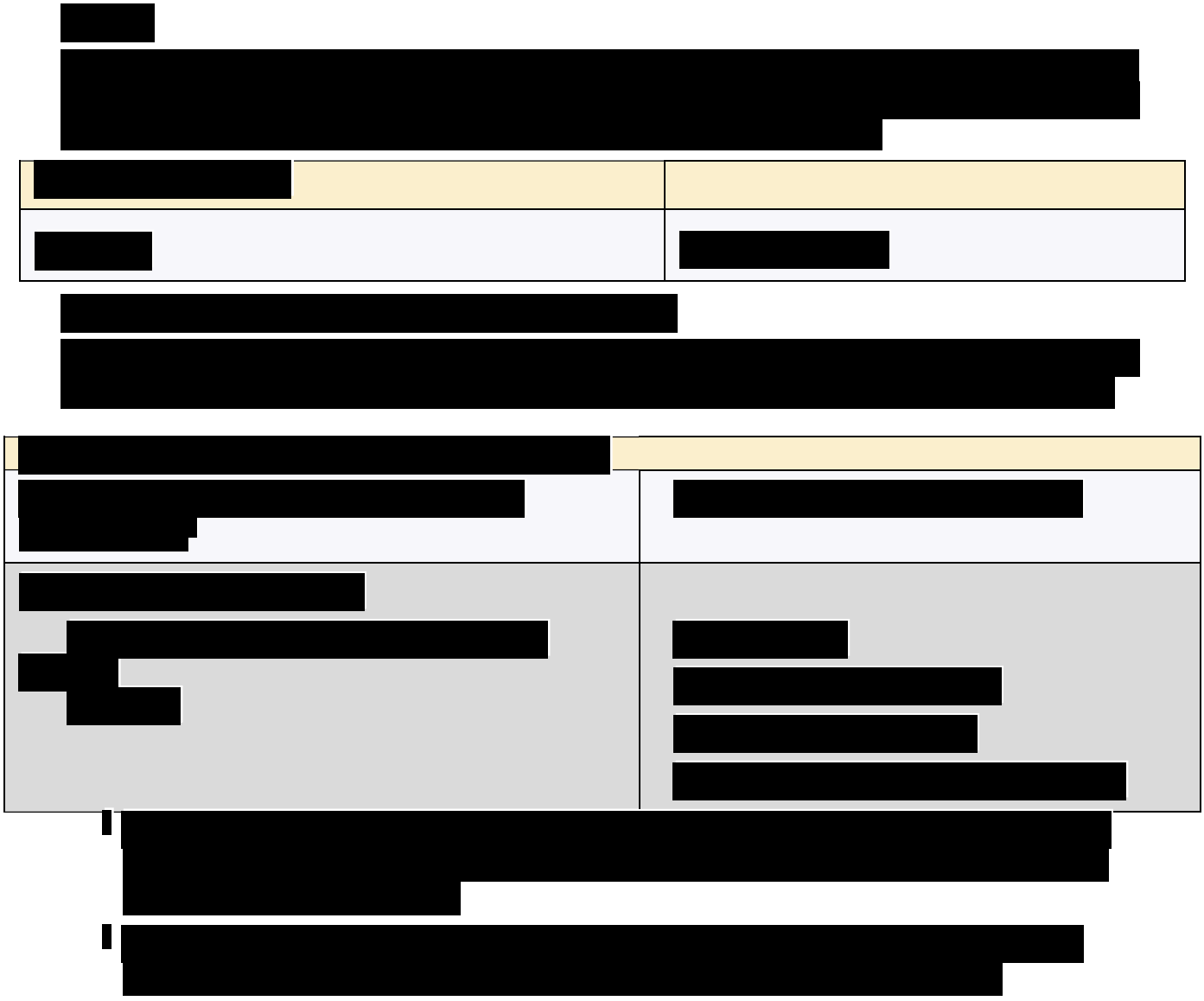
WCCCO will utilize an online PA platform that allows providers to submit authorization requests 24 hours a day, 7 days a week, 365 days a year. The platform is available at no-cost to providers and is integrated with many electronic medical record (EMR) systems. The platform also allows providers to answer drug-specific questions and submit chart notes and supporting documentation, which expedites WCCCO's review of submissions and reduces the need to reach out to providers for additional information. Our online PA platform also integrates with pharmacies, which allows a pharmacy to initiate a PA to the prescriber as soon as they see the need for PA at point-of-sale. WCCCO's customer support center can be reached via phone or email for members and providers who have questions or need assistance with PA requests between 7:30am and 5:30pm PST Monday through Friday. Outside of regular business hours, phones are re-routed to our PBM's call center automatically, which is available 24 hours a day, including weekends and holidays.

(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.**

WCCCO has adopted OPDP to administer its pharmacy benefit. OPDP has been administered by Moda Health since 2007.

OPDP fulfills a critical component of OHA's CCO 2.0 RFA by providing a fully transparent CCO PBM agreement. In addition to providing market leading transparency, OPDP is a "no-spread" contract that delivers 100 percent pass-through of all pharmacy charges and manufacturer rebates. PBM fees are fixed and paid on a per paid claim basis; all fees and costs are fully documented and in OPDP's contract with WCCCO, so there are no hidden or unforeseen charges.



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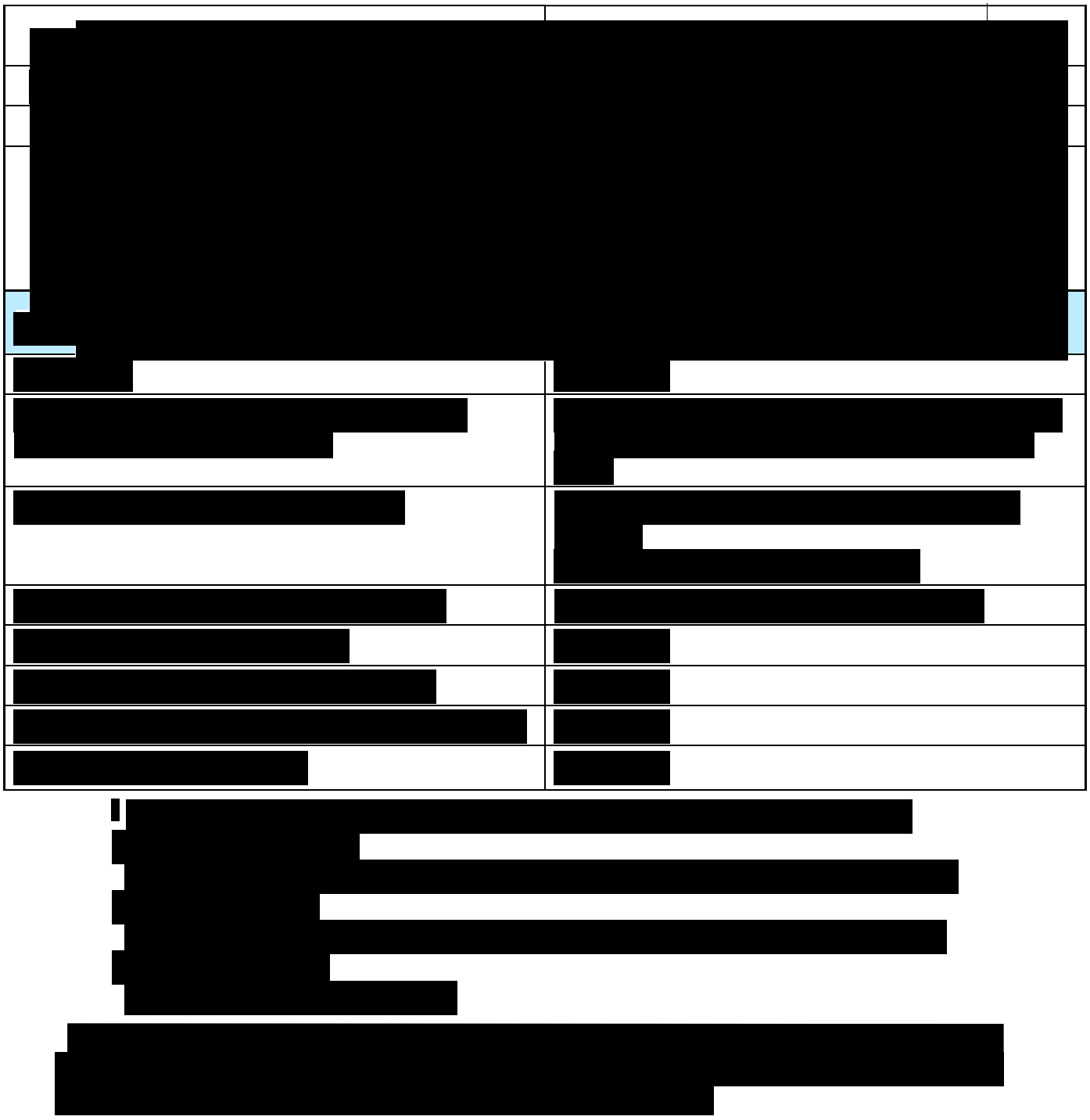

(7) Describe Applicant's ability to engage and utilize 340B enrolled Providers and pharmacies as a part of the CCO including:

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

WCCCO is not initiating shared savings programs with Public Health Service (PHS) covered entities that carve-out Medicaid patients into their 340B programs. No 340B spread will be retained by WCCCO.

WCCCO represents a wide service area with several covered entities that participate in the 340B Public Health Service (PHS) program. Many of these 340B entities carve-out Medicaid patients into their 340B programs. Regardless of the 340B carve-out status for Medicaid claims, WCCCO does not intend to initiate shared savings programs with 340B covered entities and no 340B spread is intended to be retained by WCCCO.

An important consideration for PHS covered entities in WCCCO's service area is that the drug savings generated from the 340B program are available to further the health care dollars and grant funding available to the safety net on a dollar for dollar basis. In recognition of the risk to OHA for potential duplicate discounts that can arise with a 340B program, WCCCO will work with its 340B community to apply the method established by OHA for PHS covered entities so that 340B eligible drugs will not create a duplicate MDRP discount. WCCCO will also coordinate with the PHS covered entities in its service area to develop programs that use 340B savings to benefit underserved populations. As examples, these programs can include: hiring more skilled workers; care and case management for high risk populations; pharmacy fulfillment for underserved populations; enabling community based healthcare outreach; or other community-based programs. Given that the 340B program establishes broad authority for safety-net facilities to administer their own programs, not all safety-net facilities may provide the same sets of services.

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

WCCCO recognizes the value and importance of MTM for members utilizing multiple medications and medications for complex diseases. The "Continuity" core attribute of the PCPCH program places emphasis on medication reconciliation and management, including having a clinical pharmacist as part of the care team. While not a must-pass standard for recognition, Tier 4 and Tier 5 PCPCHs often meet this standard. WCCCO will work with primary care providers to achieve PCPCH recognition and achieve these tier designations. This work will be financially supported through our value-based payment models.

Our focused MTM Program is a telephonic-based program that provides medication education and tools for navigating barriers to adherence to members. Active and passive notifications of program eligibility are used for MTM services, including member welcome packets to introduce the program to the member, as well as phone outreach. Referrals from Case Managers and other

providers are also accepted. A multi-faceted approach utilizes clinical pharmacists to engage targeted members, as different members require different methods to motivate participation. New approaches have been implemented to engage members, including use of automated dialers, text messaging, follow up letters, and invitations to special events (wellness screenings, member forums, surveys, etc.).

We have an active request for proposal (RFP) out to MTM vendors soliciting enhanced capabilities and offerings for the Medicaid line of business that will extend the value of PCPCH clinical care teams. This service is expected to begin in 2020.

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

WCCCO providers can utilize the EMR software of their choice to send e-prescriptions to any network pharmacy instead of faxing or requiring the patient to carry a hard copy prescription to the pharmacy. In addition to e-prescribing, online PA submission, claims history, and real-time eligibility checks currently available, WCCCO will be able to benefit from a pilot in the second quarter of 2019 that provides additional member-specific benefit information to prescribers at the point of prescribing. Through this pilot, prescribers have access to member cost-sharing information, drug formulary status, utilization management requirements, lower cost alternatives, and drug pricing at a variety of network pharmacies. This tool is integrated with EMRs with the goal of improving transparent access to care. Success of the pilot will be measured by prescriber utilization of the tool, as well as changes in drug selection at the point of prescribing based on the information presented through the tool. Assuming success of the pilot, WCCCO will make this service available in 2020 and beyond.

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

WCCCO will publish and maintain a list of formulary medications that will be available to members and providers on our public site. Additionally, WCCCO will post a list of drugs that require PA, as well as a document that outlines recent changes to the formulary. Providers will have direct access to our coverage criteria via our online PA platform, which is referenced above in greater detail. We are currently in the process of converting our coverage criteria to a public-facing format that will be accessible to providers and members on our website. We anticipate that this process will be complete by the start of 2020.

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

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

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

Not all services are available locally for members who reside in rural counties. Services not provided locally are mainly tertiary provider, for example, most counties in the service area do not have a pediatric cardiologist. Members are referred to contracted providers who can provide the level of care required and are most conveniently located from the member's residence. When necessary and on a case-by-case basis, WCCCO and its provider partners allow the referral of an WCCCO member to a non-contracted provider for needed care.

WCCCO will monitor for equal access through the complaints and grievance reporting, second opinion requests and out of network quarterly trend reporting. Additionally, dedicated staff processes all of the WCCCO referrals and authorization and are audited and trained for consistency allowance.

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

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

WCCCO will provide education in the member handbook on how to appropriately access care from Ambulance, Emergency Rooms, and urgent care/walk-in clinics. WCCCO will also create a benefit summary that will describe what services are available and when to access the services. This benefit summary will be written with CLAS standards and translated into other languages.

WCCCO will create custom reporting that will identify inappropriate utilization. These reports will be used by case managers to assist member in managing their health outcomes. The reports will also be distributed to member's PCPs, to assist in the management of improper use.

(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).**

WCCCO will follow state, federal and accreditation organization regulations when identifying and reviewing Adverse Events and HACs. WCCCO will encourage hospitals to participate in the Oregon Patient Safety Commission's reporting program and use of the Oregon Patient Safety Commission's surgical checklist and demonstrate participation in the reporting program.

WCCCO will not pay for identified codes related to provider preventable conditions by the National Quality Forum (NQF), CMS, or as published by OHA. These codes will be programmed into our claims adjudication software and will be reviewed by a claims auditor prior to any payment determination.

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

WCCCO will outline the readmission policy in the provider manual found on the website. The policy states that a patient whose readmission for surgery or follow-up care is planned at the time of discharge must be placed on leave of absence status and both admissions must be combined into a single billing. WCCCO will make one payment for the combined service.

A patient whose discharge and readmission to the hospital is within 15 days for the same or related diagnosis must be combined into a single billing. WCCCO will make one payment for the combined service.

WCCCO's claims adjudication software will have edits in place to detect for claims that may fall within the 15 day period. Additionally, our analytics team will run a set of four reports related to inpatient hospital billing and results will be reviewed by a claims auditor. The four reports are:

- Inpatient admission claims billed for readmissions
- Separate outpatient ER and admission claims that should be a single claim
- Pre-Admission Treatment claims billed separately from admission claims
- Transfer to rehab

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

WCCCO will continue education and outreach efforts to the clinics and hospitals in each county on use of the MDT program to decrease hospitalizations. By assigning an intensive case manager for physical or behavioral health issues early it can prevent unnecessary ED use. WCCCO will also expand our network for specialists where available to provide for OP treatment of chronic and complicated disease conditions. The use of care coordination to assist members/providers in obtaining referrals when necessary to OON specialists and clinics will improve access at the OP level. WCCCO will also utilize Pre-Manage to identify members at admission for assignment to transition case management and decrease any cause for readmission by coordinating PCP and specialist follow-up, medication management and education on post hospital discharge instructions.

(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.

Bi-weekly regional MDTs will provide opportunity to coordinate care for those members who are dually eligible. All WCCCO members, including those who are dually eligible, may be referred to the MDTs for care coordination needs.

Moda Health Plan, Inc. Medicare Advantage is the Affiliated Medicare Advantage plan partner. WCCCO Case Management staff will work within the same department, in the same location, as the case managers that work on the affiliated Medicare Advantage plan. When a WCCCO member is dually enrolled in both, the case managers have an in-person consultation to assess and manage the member's overall health, including Behavioral Health issues.

Attachment 8 — Value-Based Payment Questionnaire

VBP Questions

For all questions below, describe VBP data using The Health Care Payment Learning and Action Network (LAN) categories and the OHA Value-Based Payment Roadmap Categorization Guidance for Coordinated Care Organizations

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 refer to WCCCO's completed VBP data template.

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.**

   a. **Payment differential across the PCPCH tier levels and estimated annual increases to the payments**

   WCCCO will provide per member per month (PMPM) payments to PCPCH's recognized by the State of Oregon for each member enrolled or assigned to the PCPCH. Our PMPM payments will include a payment differential by PCPCH tier as follows:

PCPCH Tier	PMPM
1	$0
2	$0
3	$8
4	$10
5	$12

WCCCO does not expect to report any payments in the 2A category for 2020, because in order to receive PCPCH PMPM payments, clinics must also participate in the pay for performance for quality metrics incentives. HCP-LAN guidelines indicate that all payments to a provider count toward the highest or dominant category, therefore most of WCCCO's PCPCH funding will fall into LAN category 2C.

WCCCO intends to make investments in PCPCH funding, to build on the statewide commitment of its equity partner Moda. Moda's commitment to transforming primary care across all of its lines of business (including EOCCO, OEBB, PEBB and other commercial business) extends to its work with WCCCO too.

The table above represents the initial starting point, but we expect that during the 5-year contract period, the annual increases will ensure compliance with the minimum requirements for primary care spending per Oregon's law on Primary Care Transformation through S B934 (2017). We anticipate that annual increases in PCPCH payments will be aligned with the annual increase in capitation premium from OHA, not to exceed 3.4% per year. Additionally, other factors such as quality performance, risk adjustments or embedded behavioral health could also be incorporated into the PMPM amounts. For example, a Tier 5 PCPCH that performs well on quality metrics and has a higher risk population may receive a higher PMPM payment than a PCPCH with lower performance and a lower risk.

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

WCCCO fundamentally believes that high functioning advanced tier Patient Centered Primary Care Homes (PCPCHs) offer the best pathway to assist CCOs in meeting incentive measure targets, to operate within the global budget and to achieve the Triple Aim.

WCCCO's affiliate, Moda, has provided enhanced funding to PCPCH's since 2013 through the EOCCO, OEBB, PEBB and other commercial employer plans. State certified PCPCH's receive a PMPM payment for each member enrolled or assigned. The PCPCH payments are tiered by the level of PCPCH certification, with tier 5 PCPCH's receiving the highest level of funding. PCPCH payments are in addition to the standard reimbursement for services provided and does not include other forms of compensation such as shared savings payments and quality bonus payments.

We are confident in our approach based on EOCCO's success in Oregon's most rural counties. As a result of EOCCO's efforts and its investments in PCPCHs, all of EOCCO's contracted providers that have achieved State PCPCH certification are at tier 3 or higher and 92% of all EOCCO members have their primary care services provided by a State certified PCPCH. As a result, EOCCO has provided $33.7 Million in PCPCH funding since 2013.

We anticipate that WCCCO, similar to EOCCO, will work continuously with its Clinical Advisory Panel and the Board to determine the level of PCPCH funding needed to account for the work it takes to achieve and maintain advanced tier PCPCH status in our service area, while ensuring that the funding levels can also be financially supported. WCCCO will seek to achieve results, similar to EOCCO's, by increasing the percentage of contracted primary care providers with PCPCH certification at Tier 3 or higher.

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:**

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

   b. **Use of risk-adjustment models that consider social and medical complexity within the VBP; and**

   c. **Monitoring number of patient that are "fired" from Providers.**

   WCCCO will use VBP budget mechanisms that take into account the risk profile of the populations served by each participating provider. We won't use national benchmarks. WCCCO can utilize two methodologies, as appropriate, to achieve this.

   1. One way, is to calculate a risk-adjusted total cost of care for the provider's member population in the previous year, and set budgets for the measurement year based on any changes to the overall risk profile of the population during the measurement year. In some cases, when a provider's member population is small and highly variable, the data is combined with overall program data (aggregated data for other members in the same risk pool) to increase credibility. Risk-adjustment algorithms used take into account medical and social factors.

   2. The second way, is a pool-based method in which all providers are held accountable for budgets based on the overall WCCCO population and the available premium. This provides an incentive for all providers to work together toward common goals, without penalizing providers who might have a larger than average share of health care risk. Like in the previous example, the budget is adjusted based on the final composition of the pooled population.

   Quality incentive bonuses will take into account the composition of each provider's member population. For example, providers with a large population of diabetics are held accountable for diabetes measures, but providers without diabetics in their population (e.g. some pediatric groups) will not be held accountable for those measures. Furthermore, denominator size is also taken into account, so as to not penalize providers for random variability due mainly to small sample size.

For VBPs which use capitation as a payment mechanism, it is important to monitor the underlying utilization to make sure that all members continue to receive the appropriate level of services. For this reason we will collect encounter data from all of our capitated providers, which will provide insight into how people are utilizing services and how providers are performing on quality measures. All of our data will be stored centrally, including claims data, enrollment data, REAL+D data and demographic data; and all data will be indexed with common keys. This will allow the WCCCO analytics team to run reports showing how different sub-populations have performed from an overall utilization and quality measures perspective.

As WCCCO adopts more VBPs to reach the 70% goal, we will produce regular reporting to review the utilization and performance of various sub-populations, to ensure that shifts to value based payments do not adversely impact health equity. Our ability to report on each sub-population below will be enhanced as identification of each sub-population is made available by OHA:

- People of different racial, ethnic, and/or cultural backgrounds
- LGBTQ people
- Immigrants and refugees
- People with limited English proficiency
- People with chronic conditions and/or complex health care needs

WCCCO will use cost and utilization dashboards to monitor for and identify non-utilizers. We will break out data on this group by age, gender, race/ethnicity, and more, to look for any groups who might be underserved. The objective will be to try to understand how to increase appropriate utilization (e.g. preventive care or routine visits). Additionally, the WCCCO analytics team will produce a report showing how members performed on quality metrics by race, ethnicity and language. The WCCCO stakeholders have the ability to request ad hoc reporting for any areas that seem to contain areas for improvement.

WCCCO will monitor for population trends at the provider level through the grievance/appeal process and through notifications of member dismissals. When WCCCO receives a member dismissal, a provider relations representative and case manager will collaborate to find the member a new PCP and evaluate the member's health needs as well as the social needs.

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.**

   WCCCO will work with its CAP, its subcommittees, its contracted provider partners and its Board to develop and implement the new and expanded care delivery area VBP's for 2020 and thereafter.

   We expect to begin by establishing VBPs in category 2C, and then working to move each provider type to higher LAN levels over time, as noted in question 5 below. The size of the performance incentive will ultimately need to be determined by the WCCCO Board, but assuming that WCCCO is eligible to earn about $12 million in annual quality bonus payments, and assuming distribution of 30% each to primary care practices and to hospitals, each of these provider group types could earn up to $3.6 million. These funds would be distributed to primary care practices and hospitals based on their performance meeting quality metrics. The WCCCO Board will determine the estimated incentive each year.

   WCCCO will implement the Health Plan Quality Metrics Committee's 2019 Aligned Measure Menu set with particular emphasis on the Children's Health Care measures in 2020. Additionally for 2020, WCCCO will implement two hospital quality metrics for the hospitals located within the service area. Both of these steps will bring these provider services to LAN 2C to begin the contract period with at least 20% in category 2C+.

   <u>Children's Health Care Metrics:</u>

   For 2020, WCCCO plans to have pay for performance VBPs in place with primary care providers related to children's health care in the form of quality bonus payments for the following HPQMC measures:

   - Adolescent Well Care Visits
   - Developmental Screening in the First Three Years of Life
   - Childhood Immunization

   <u>Hospital Metrics:</u>

   For 2020, WCCCO anticipates having pay for performance VBPs in place with hospitals in the form of quality bonus payments for the following HPQMC measures:

   - Cesarean Rate for Nulliparous Singleton Vertex
   - Standardized Healthcare-Associated Infection Ratio

Maternity Metrics:

Newly effective in 2021, WCCCO expects to incorporate the revised maternity care measure, into the quality bonus payment structure for providers:

- Maternity Care: Post-Partum Follow-Up and Care Coordination

WCCCO's inclusion of a Post-Partum Follow-up and Care Coordination measure into our quality bonus payment structure means that for the first time, PCPs that provide maternity care will be rewarded based on their performance. This will also incorporate OBGYN and other providers who deliver maternity care into our quality bonus payment structure.

Oral Health Metrics:

For 2022 or earlier, WCCCO expects to have pay for performance VBPs in place with primary care providers, as well as with contracted DCOs, related to oral health in the form of quality bonus payments for the following HPQMC measures:

- Members Receiving Preventive Dental Services
- Oral Evaluation for Adults with Diabetes
- Dental Sealants for Children
- Dental Services Utilization for Adults & Children (Note: Not an HPQMC measure but is one used for some 2019 DCO contracts, requiring minimum thresholds for percentage of adults and percentage of children who have utilized any type of dental service during the measurement year.)

Behavioral Health Metrics:

For 2023 or earlier, WCCCO anticipates incorporating pay for performance VBPs in place with behavioral health providers in the form of quality bonus payments for quality measures which we will define together with provider practices. If it becomes feasible by then as a result of EHR adoption and HIE capabilities, we would also plan to pursue adding SBIRT (Alcohol and Drug Misuse: Screening, Brief Intervention and Referral for Treatment) and Depression Screening and Follow-Up for Adolescents and Adults to the quality bonus payments. These measures are contingent on the ability to garner the relevant clinical data from EHR systems.

5. **Provide a detailed plan for how the Applicant will achieve 70% VBP by the end of 2024, taking into consideration the Applicant's current VBP agreements. The plan must include at a minimum information about:**

   a. **The service types where the CCO will focus their VBPs (e.g. primary care, specialty care, Hospital care, etc.)**

   b. **The LAN categories the CCO will focus on for their payment arrangements (e.g. mostly pay for performance, shared savings and shared risk payments, etc.)**

      Moda, a WCCCO equity partner, has demonstrated experience implementing Value Based Payment models in both Medicaid through EOCCO and in its commercial lines of business through OEBB and PEBB. As we begin operating in the WCCCO service area we will initially take a gradual approach to implementing VBPs and work with

our partners to design and implement the VBP models that work best for the community.

Below is a brief history of Moda's VBP evolution.

2010	Moda joined the OHLC's PCPCH Demonstration Project for Medical Homes
2011	Established a Coordinated Care Network for OEBB
2012	EOCCO was established with the following concepts: > EOCCO implemented a shared savings model limited to primary care and hospital participation only > EOCCO's equity partner, GOBHI assumed full risk for behavioral health services > EOCCO made quality bonus payments to PCP's based solely on membership attribution.
2015/2016	EOCCO invited Specialists to participate in the shared savings model and PCP's had the option of a full risk capitation option.
2017/2018	Moda became a payer participating in CPC+ with EOCCO and OEBB, PEBB Moda and EOCCO significantly increased its financial investment in primary care and PCPCH's through higher capitation payments and higher PCPCH payments up to the levels in place today. PCP quality bonus payments were based 100% on performance.
2018/2019	EOCCO transitioned more eligible PCP practices from a Fee-For-Service contract to a full risk capitation model for primary care services. EOCCO required participation in EOCCO's shared savings model in order for PCP's to be eligible for PCP quality bonus payments.

Work plan for achieving 70% VBP by the end of 2024:

Building upon the VBP experience of the stakeholders participating in WCCCO, we are confident that the goal to achieve 70% VBP by the end of 2024 can be met.

The below table outlines our work plan for achieving a 70% VBP target by 2024 compared with our current/anticipated state for calendar year 2020. For each year below we have estimated the percent WCCCO expects to achieve based on LAN categories 2C+ and 3B+ along with the service type(s) we plan to implement for that calendar year and the LAN category we will focus on for the service type. WCCCO will continuously monitor the Health Plan Quality Metrics (HPQM) Committee Aligned Measure set and will use these metrics to implement new VBP service type focus areas including appropriate modifications to existing VBP service type focus areas.

Year	Estimated Percent of Payments in LAN category 2C+	Estimated Percent of Payments in LAN category 3B+	Service type focus area	LAN category focus areas
2020	23.0%	0%	Children's Health Care, Hospital Care	2C
2021	27.0%	0%	Maternity Care	2C
2022	39.8%	20.0%	Oral Health Care	3A, 3B
2023	63.8%	28.0%	Behavioral Health Care	3A, 3B, 4A
2024	71.8%	33.0%	Recruitment of additional providers into VBPs, enhancements to existing VBP arrangements as needed to achieve at least 70% VBP	3A, 3B, 4A

On an annual basis, WCCCO will evaluate its current state with respect to VBP targets in LAN categories 2C+ and 3B+ to ensure planned targets are met. WCCCO, its Clinical Advisory Panel and its provider partners will work throughout the term of the CCO 2.0 contract to develop and implement new VBP's in the focus areas identified above.

General Instructions

Complete all yellow highlighted cells, if applicable, on the "Data_template" tab, the "Data_narrative" tab, the
Include payments associated with VBPs on an incurred basis (as opposed to a paid basis). If any payment arrangements have a specified quality incentive payment, estimate the size of the payment for calendar year 2020
Include all payments to providers or contracted entities for which the payment aligns with one or more of the HCP-LAN categories for VBP. See the "HCP-LAN Framework" tab for definitions of the categories.
In order for a payment arrangement to qualify as a value-based payment, there must be a quality component. Arrangements without any quality component should be listed under fee-for-service, category 3N, or category 4N
For payments that span multiple HCP-LAN categories, use the most advanced category. If for example you have a contract that includes a shared savings arrangement with a pay-for-performance component - such as a quality incentive pool - then you should put the total value of the annual contract in Category 3A for shared savings
multiple "data_template" tabs have been provided so that you can provide details about how your
CCO will meet the 20% minimum VBP threshold for 2020.
On the "data_template" tabs, submit two variations of the information: a detailed estimate—based on historical data—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-

You are required to complete at least two "data_template" tabs. Completing a third is optional.
For additional guidance, see the RFA and other resource documents such as the VBP categorization document.

CCO RFA DATA COLLECTION - VALUE-BASED PAYMENTS

CONTRACTOR/CCO NAME: **WCCCO**
REPORTING PERIOD: **1/1/2020 - 12/31/2020**

Definitions: Column c "Total dollars paid for provider contracts and/or arrangements, exclud
exclusively FFS": Enter the sum of all contracts by VBP category. These totals r
contract, even if a portion of the contract is based on fee-for-service. For multi-n
multiple VBP categories, attribute all payments for that contract to the most adv
Column f "Total dollars paid for provider contracts and/or arrangements": Enter
that are not VBPs because they are wholly fee-for-service arrangements or have

Optional - describe any relevant details about your predicted VBPs - using terminology from LAN categories - for 2020. (50 words or less)	This is the minimum membership estimate. Based on 35,200 members. For 202 of payments to be in LAN category 2C+ and 0% of payments to be in LAN categ focus on expanded VBP service type of Children's Health Care and Hospital Ca

a	b	c
Value-Based Payment Category	**Examples (lists not exhaustive)**	**Total dollars paid for provider contracts and/or arangements, excluding contracts that are exclusively FFS**
2A Foundational Payments for Infrastructure & Operations	care coordination fees and payments for HIT investments	
2B Pay for Reporting	bonuses for reporting data or penalties for not reporting data	
2C Pay-for-Performance	bonuses for quality	$ 43,522,331
3A Shared Savings	savings shared with contracted entity	
3B Shared Savings and Downside Risk	episode-based payments for procedures and comprehensive payments with upside and downside risk	
4A Condition-Specific Population-Based Payment	capitation payments for specialty services	

4B Comprehensive Population-Based Payment	global budgets	
4C Integrated Finance & Delivery System	payments to a highly-integrated finance and delivery system.	

All VBP Sub-total	**$**	**43,522,331**
VBP 2C or higher sub-total	**$**	**43,522,331**

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Non-Value-Based Payment Category	**Examples (lists not exhaustive)**	**Total dollars paid for provider contracts and/or arrangements**
Fee for service payments	All contracts and/or payment arrangements that are exclusively fee for service	$ 145,705,196
3N: Risk-based payments not linked to quality	payments with upside and downside risk but no connection to quality	
4N: Capitated payments not linked to quality	capitation payments with no connection to quality	$ -

Total payments	**$**	**189,227,527**
Percent of payments that are VBP 2C or higher		**23%**

CCO RFA DATA COLLECTION - VALUE-BASED PAYMENTS

CONTRACTOR/CCO NAME: **WCCCO**
REPORTING PERIOD: **1/1/2020 - 12/31/2020**

Definitions: Column c "Total dollars paid for provider contracts and/or arrangements, exclud
exclusively FFS": Enter the sum of all contracts by VBP category. These totals r
contract, even if a portion of the contract is based on fee-for-service. For multi-n
multiple VBP categories, attribute all value-based payments to the highest, mos
Column f "Total dollars paid for provider contracts and/or arrangements": Enter
are not VBPs because they are wholly fee-for-service arrangements or have no

Optional - describe any relevant details about your predicted VBPs - using terminology from LAN categories - for 2020. (50 words or less)	This is the maximum membership estimate. Based on 92,400 members. For 20 23.0% of payments to be in LAN category 2C+ and 0% of payments to be in LA we will focus on expanded VBP service type of Children's Health Care and Hosp

a	b	c
Value-Based Payment Category	**Examples (lists not exhaustive)**	**Total dollars paid for provider contracts and/or arangements, excluding contracts that are exclusively FFS**
2A Foundational Payments for Infrastructure & Operations	care coordination fees and payments for HIT investments	
2B Pay for Reporting	bonuses for reporting data or penalties for not reporting data	
2C Pay-for-Performance	bonuses for quality	$ 114,246,120
3A Shared Savings	savings shared with contracted entity	
3B Shared Savings and Downside Risk	episode-based payments for procedures and comprehensive payments with upside and downside risk	
4A Condition-Specific Population-Based Payment	capitation payments for specialty services	

4B Comprehensive Population-Based Payment	global budgets	
4C Integrated Finance & Delivery System	payments to a highly-integrated finance and delivery system.	

VBP Sub-total	**$ 114,246,120**

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Non-Value-Based Payment Category	**Examples (lists not exhaustive)**	**Total dollars paid for provider contracts and/or arrangements**
Fee for service payments	All contracts and/or payment arrangements that are exclusively fee for service	$ 382,476,140
3N: Risk-based payments not linked to quality	payments with upside and downside risk but no connection to quality	
4N: Capitated payments not linked to quality	capitation payments with no connection to quality	

Total payments	**$**	**496,722,260**
Percent of payments that are VBP		**23%**

CCO RFA DATA COLLECTION - VALUE-BASED PAYMENTS

CONTRACTOR/CCO NAME:

REPORTING PERIOD: **1/1/2020 - 12/31/2020**

Definitions: Column c "Total dollars paid for provider contracts and/or arrangements, exclud
exclusively FFS": Enter the sum of all contracts by VBP category. These totals r
contract, even if a portion of the contract is based on fee-for-service. For multi-n
multiple VBP categories, attribute all value-based payments to the highest, mos
Column f "Total dollars paid for provider contracts and/or arrangements": Enter
are not VBPs because they are wholly fee-for-service arrangements or have no

Optional - describe any relevant details about your predicted VBPs - using terminology from LAN categories - for 2020. (50 words or less)	

a	b	c
Value-Based Payment Category	**Examples (lists not exhaustive)**	**Total dollars paid for provider contracts and/or arangements, excluding contracts that are exclusively FFS**
2A Foundational Payments for Infrastructure & Operations	care coordination fees and payments for HIT investments	
2B Pay for Reporting	bonuses for reporting data or penalties for not reporting data	
2C Pay-for-Performance	bonuses for quality	
3A Shared Savings	savings shared with contracted entity	
3B Shared Savings and Downside Risk	episode-based payments for procedures and comprehensive payments with upside and downside risk	
4A Condition-Specific Population-Based Payment	capitation payments for specialty services	

4B Comprehensive Population-Based Payment	global budgets	
4C Integrated Finance & Delivery System	payments to a highly-integrated finance and delivery system.	

VBP Sub-total	**$ -**

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t advanced category.
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link to quality.

d	e	f
Non-Value-Based Payment Category	**Examples (lists not exhaustive)**	**Total dollars paid for provider contracts and/or arrangements**
Fee for service payments	All contracts and/or payment arrangements that are exclusively fee for service	
3N: Risk-based payments not linked to quality	payments with upside and downside risk but no connection to quality	
4N: Capitated payments not linked to quality	capitation payments with no connection to quality	

Total payments	**$ -**
Percent of payments that are VBP	**#DIV/0!**

Describe the kinds of services/providers/populations your CCO focuses on for VBPs (e.g. primary care, maternity care, hospital-based care, oncology, etc.). Briefly list as many as are applicable. Limit your

WCCCO's value-based-payment models encompass most service categories, and impact all members of the WCCCO population.

Primary Care:

- PCPCH
- Capitation

Quality Incentive Measures (including children's health care)

- Shared Savings Model

Hospital & Specialty Care:

- Shared Risk/Shared Savings Models
- Quality Incentive Measures

Oral Health:

- Capitation
- Quality Incentive Measures

Behavioral Health:

Enter the per-member-per-month dollar amount you intend to pay clinics participating in the Patient Cente
If the PMPMs vary for a given tier, you may enter a range. Otherwise, enter a single dollar amount.

PCPC Tier	PMPM (or range) dollar amount
Tier 1 clinics	$ -
Tier 2 clinics	$ -
Tier 3 clinics	$ 8.00
Tier 4 clinics	$ 10.00
Tier 5 clinics	$ 12.00

ered Primary Care Home (PCPCH) program

Instructions: Fill in the cells that are shaded yellow in this worksheet. For questions on terms

A	B	C
		Types c
Question	**LAN APM Category**	**APM Types - Subcategories** **Select all that apply by putting an X applicable row**
Which types of APM payment models were in effect during any portion of the payment period?	**2A**	X
	2B	
	2C	X
	2C	
	2C	
	3	
	3	
	3 or 4*	
	3 or 4*	

	3*	
	4*	
	4	

* = whether these APMs are in Category 3 vs. Category 4 depe
made prospectively based on subcapitated payments/budgets

see the Definitions tab.

D	E
of VBP (Subcategories)	
X in Column C in each	**Brief description of:** A) Type of providers/services involved; AND if a contracts with multiple APMs, where plan determined 'dominant AP APM payments based on performance in this period not reflected he shared savings/risk arrangements. Please describe if and how these account racial and ethnic disparities. Please also describe how mode individuals with complex health care needs.
Foundational spending to improve care	A) Primary Care. B) Future capitation payments may vary based on b level and the member risk, to ensure that members with complex ne resources allocated.
FFS plus Pay for Reporting (no penalties, upside only)	
FFS plus Pay for Performance (no penalties, upside only)	A) Primary Care, including Childrens Health Care and Hospital Care in contracts generally all include PCPCH payments which would have fa will report 2C as the dominant mechanism. C) Future capitation payr based on both the PCPCH tier level and the member risk, to ensure t complex needs have more resources allocated.
FFS plus Pay for Performance (potential for penalties)	
FFS plus Pay for Performance (potential for incentives and penalties)	
FFS-based Shared Savings	
FFS-based Shared Risk	
Procedure-based Bundle/Episode Targets or Payments	
Condition-Specific Bundle/Episode Targets or Payments	

Population-based Targets (not condition-specific)	
Population-based Payments (condition-specific)	
Full or % of Premium Population-based Payment (prospective payment)	

nds in part on whether the provider payments are made using a FFS architecture with retrospective r
. See "Definitions" worksheet for more details.

pplicable B)
M' and C) future
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models take into
ls have considered

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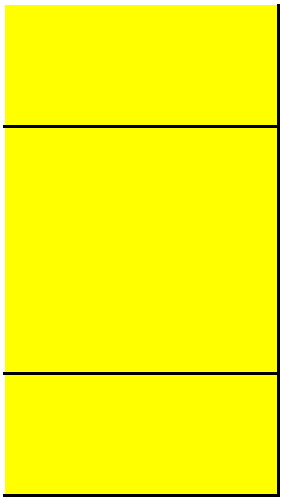
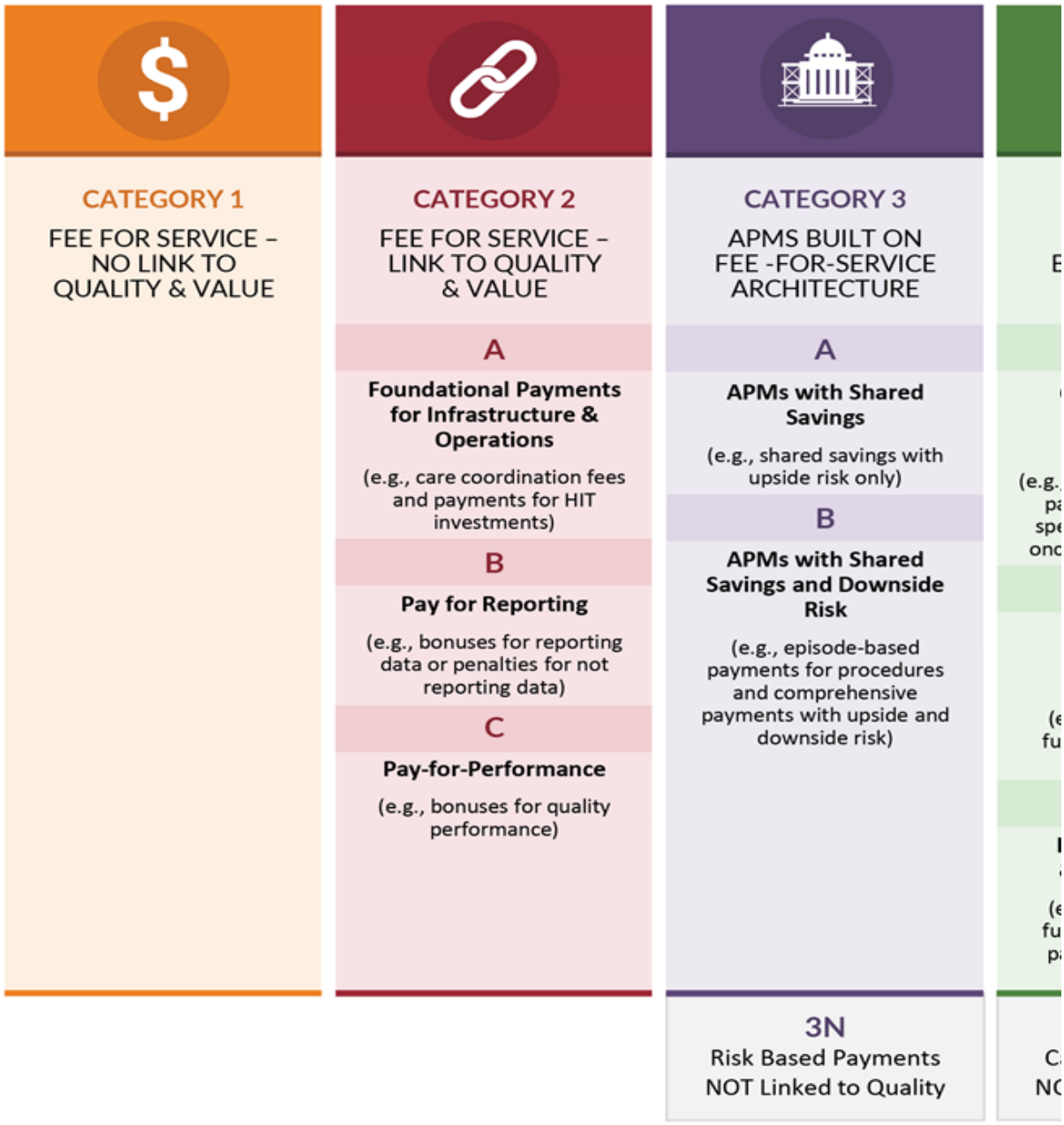
llen into 2A, but we
ments will vary
hat members with



econciliations (3) or

https://hcp-lan.org/groups/apm-refresh-white-paper/



CATEGORY 4

POPULATION – BASED PAYMENT

A

Condition-Specific Population-Based Payment

, per member per month
ayments payments for
ecialty services, such as
cology or mental health)

B

Comprehensive Population-Based Payment

e.g., global budgets or
ll/percent of premium
payments)

C

Integrated Finance & Delivery System

e.g., global budgets or
ll/percent of premium
ayments in integrated
systems)

4N

apitated Payments
OT Linked to Quality

Definitions

Category 2A (Foundational Payments for Infrastructure & Operations)	Foundational spending to improve care , e.g., care coordination payments, PCPCH payments, and infrastructure payments.
Category 2B (Pay for Reporting)	Payments for reporting on performance measures.
Category 2C (Rewards for Performance)	Pay-for-performance (P4P) rewards to improve care, such as provider performance to population-based targets for quality such as a target HEDIS rate.
Category 2C (Penalties for Performance)	Pay-for-performance (P4P) penalties where providers miss target rates on select performance measures.
Category 3A (Shared Savings)	Providers have the opportunity to share in a portion of the savings they generate against a cost target or by meeting utilization targets if quality targets are met. Cost target may be for a comprehensive set of services (total cost of care) or for a limited episode/bundle.
Category 3B (Shared Risk)	Providers have the opportunity to share in a greater portion of the savings that they generate against a cost target or by meeting utilization targets if more quality targets are met. Additionally, payers recoup from providers a portion of the losses that result when cost or utilization targets are not met.
Category 4A (Partial Capitation or Episode-Based Payment)	Providers receive prospective-based payments, structured in a manner that encourages providers to deliver well-coordinated, high-quality, person-centered care within a defined scope of practice (e.g., partial capitation or episode).
Category 4B (Comprehensive Population-Based Payment)	Providers receive prospective population-based payments, structured in a manner that encourages providers to deliver well-coordinated, high-quality, person-centered care for a comprehensive set of services that covers all of an individual's health care.
Category 4C (Integrated Finance and Delivery System)	Payments to a highly-integrated finance and delivery system.

Attachment 9 — Health Information Technology

A. HIT Partnership

1. **Informational Question (recommended page limit 1 page)**

   a. **What challenges or obstacles does Applicant expect to encounter in signing the 2020 HIT Commons MOU and fulfilling its terms?**

   WCCCO sees no challenges or obstacles in signing the 2020 HIT Commons MOU and fulfilling its terms. Through our work with EOCCO, we have a current MOU with the HIT commons and pays our portion of dues. Additionally, EOCCO currently serves on the HIT Commons Governance Board. We expect to use this experience with WCCCO.

B. Support for EHR Adoption

1. **Evaluation Questions (recommended page limit 5 pages)**

   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.

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

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

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

   As a new CCO organization, WCCCO will first prepare an inventory of the EHR systems used by all the providers in the area – physical, behavioral and oral health. Once that inventory is established, we will implement some of the same processes and supports that we have used in our Eastern Oregon region to work with providers to adopt or upgrade their systems.

   Similar to what we have done with EOCCO, WCCCO may establish a program for annual community benefit initiative reinvestments (CBIR) to physical health providers, based on an application and review process. These CBIRs are often directly related to EHR capabilities, for example it could be a request to provide funding to support population health management efforts for chronic conditions through the use of EHR based data. Another example could be participation in a CBIR to support the implementation of an HIE, such as Arcadia Analytics, which requires an EHR to connect with this web-based platform. The HIE then allows for clinic EHR data to be

combined with Moda Health claims data in a format that is easily viewable and accessible for population health management.

WCCCO intends to replicate the collaborative processes we have implemented in Eastern Oregon with physical health providers surrounding the annual quality metric reporting process and quality metric tracking through the year. This includes provider outreach through Quality Improvement Specialists who regularly meet with clinics to review the status of their quality metrics. In this process, the alignment of how effectively their EHR reports the data is addressed, including investigations which assess the usability and reliability of the data. Primary care providers, whose EHRs are the primary data source for quality metric calculations, are incentivized to provide accurate and complete quality data. These incentives are significant, encouraging these providers to not only implement but continue to upgrade their EHRs.

In addition to incentives for quality data, WCCCO will provide per member per month (PMPM) payments to primary care clinics based on their PCPCH tier. One mechanism for gaining a higher tier level, and hence a higher PMPM, is to effectively implement an EHR. Virtually all of the sections of the tiering program incorporate EHR adoption – Access to Care, Accountability, Comprehensive Whole Person Care, and Continuity Coordination and Integration.

As it relates to Behavioral Health Providers, the WCCCO CMHP is currently utilizing an EHR -- NextGen. The inventory process referenced above would identify non-CMHP behavioral health providers that are not using an EHR.

With respect to oral health Providers, we will work directly with our contracted dental plans to expand oral health case management processes to include internal EHR training and instruction for interpreting data received from EHR systems. We will facilitate the preparation of a process for care coordination among oral health, physical health and behavioral health providers. Newly defined case management procedures will be shared with oral health providers.

In the WCCCO area, ODS operates an Arrow Clinic in West Eugene which provides Medicaid dental services for Lane county, together with Advantage, Capitol and Willamette Dental. With ODS (a “sister” company of Moda) and the other DCOs, WCCCO will work to provide opportunities for coordination and EHR development.

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?

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?

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?

All health providers face a variety of barriers when working towards adopting and improving their EHRs, including: determining the appropriate EHR vendor type, staff usability, reporting capability, data sharing compatibility, and cost. During the process

of preparing the EHR inventory of the providers in this region, we will gain a better understanding of the specific barriers they are experiencing, which will define the approach needed to address these barriers through education, funding resources, sharing best practices with other providers serving OHP populations or other methods.

Similar to Eastern Oregon, WCCCO may also partner with the Oregon Rural Practice Based Research Network (ORPRN) who works alongside clinics to assist with EHR use and workflows to address staff usability, and reporting capabilities.

In general, a larger portion of Behavioral Health Providers and oral health Providers tend to be independent and smaller clinics, so the barriers for EHR adoption are typically more significant. While they may have some digital capabilities such as scheduling and billing, there are fewer who have adopted a digital patient record. With these independent and smaller clinics, there is often a lack of understanding about the importance of data sharing and interoperability, and the systems they are using to run their clinics may not readily connect to an HIE. In addition, it is difficult for these independent and smaller clinics to justify the financial investment required to purchase, support, and staff these systems, including the loss of productivity during implementation. These providers perceive changes like these bring unnecessary administrative burden to their workflow, taking staff away from chairside patient care. They see very little value in return for the significant disruption implementing a system creates. The majority of smaller offices have very limited technical resources and no in-house IT staff to manage the system and maintain security.

After completing the assessment of EHR adoption for the providers by the contract date, WCCCO will create a specific tracking document based on the results. This will include mechanisms for educating providers on the benefits of EHR/HIE adoption, providing specific solutions to the barriers identified, and collaboratively defining a timeline to success in improving EHR adoption and enhancing HIE connectivity. The high level oral health clinic specific information will be documented in WCCCO's HIT Roadmap.

2. Informational Questions (recommended page limit 2 pages)

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

While WCCCO expects to be able to gather EHR status for contracted primary care practices and health systems, we may require assistance with specialty care partners and public health partners. If we determine that assistance is indeed necessary, we ask that OHA help us in retrieving EHR adoption and improvement data from our specialty care and public health partners. We also expect to require assistance from OHA in determining reasonable targets and timelines for EHR adoption by our contracted physical, behavioral and oral health providers.

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.

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.

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.

WCCCO will utilize online surveys, direct phone calls, provider and facility application processes, site reviews and contract negotiations to collect data on EHR and HIE adoptiong. Our outreach will be prioritized first with primary care providers which are the most critical for clinical quality metrics measurement, and then to other provider types.

WCCCO plans to survey providers on an annual basis to determine EHR adoption and improvement efforts. For some of the providers, WCCCO will incorporate EHR status updates during site visits. These surveys and site visits will allow for continual tracking and support for improvement efforts. These updates will all be recorded in a tracking database and used to regularly update our WCCCO HIT Roadmap.

Once we have a baseline understanding of the EHR adoption rate within the survey area, we plan to set a reasonable improvement target our physical health, behavioral health, and oral health partners. All of this information will be recorded in our WCCCO HIT Roadmap.

C. Support for Health Information Exchange (HIE)

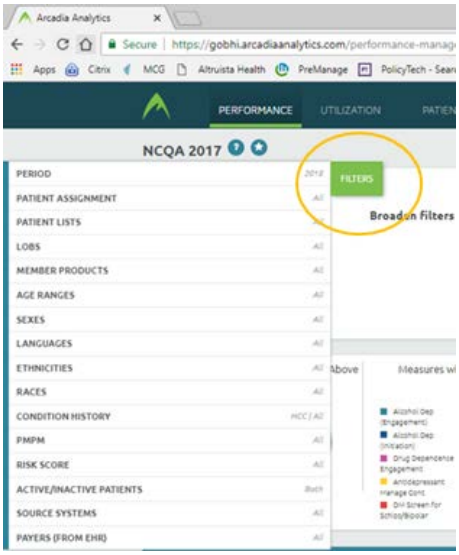
1. Evaluation Questions (recommended page limit 8 pages)

For each evaluation question, include information on Applicant's current operations, what Applicant intends to arrange by the Contract Effective Date, and Applicant's future plans. When answering the evaluation questions, please include a narrative as well as a roadmap that includes activities, milestones and timelines.

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.

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.

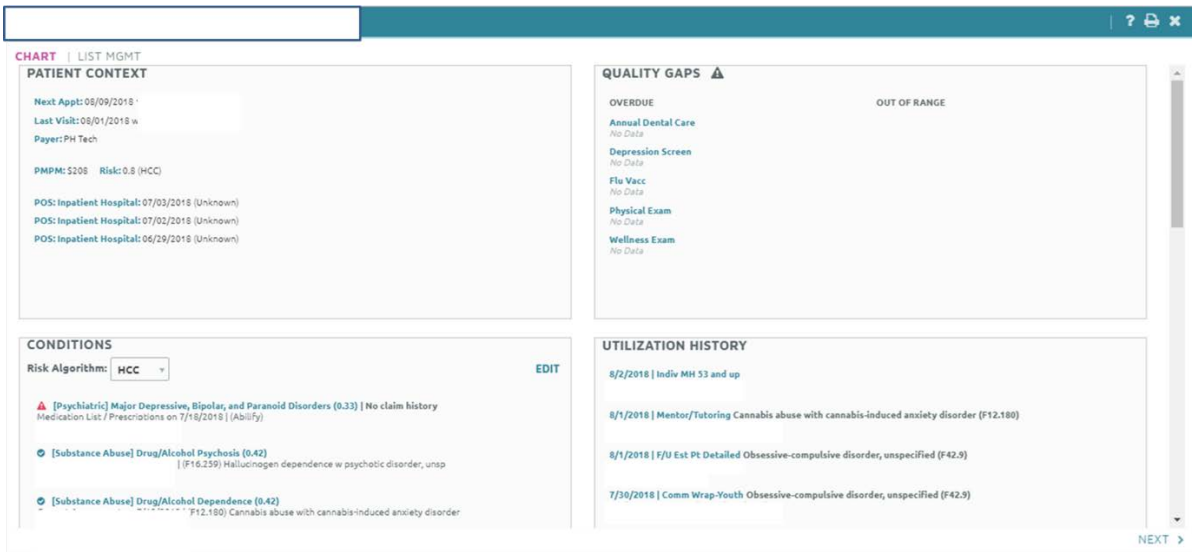
c. How will Applicant support increased access to HIE for Care Coordination among contracted oral health Providers? Please describe your strategy, including any focus on use cases or types of Providers, any HIE tool(s) or HIE methods included, and the actions you plan to take.



As a new CCO, WCCCO has not yet committed to a specific HIE path or solution. In Eastern Oregon, we have partnered with Arcadia Analytics to support quality metric reporting and data sharing among our connected provider EHRs. This platform allows providers to view high level visit information of their patients who have received services from other providers who are also integrated in the platform. Additionally, if a clinic chooses to change their EHR vendor and are already integrated with Arcadia Analytics, they will not lose access to pertinent patient level data from their previous EHR as the data will still be accessible within the platform.

An HIE platform, such as Arcadia Analytics or other similar platforms, aggregates data from all of the different EHRs, claims software, utilization management systems. The HIE provides information on individual, organizational and CCO (population health) levels. Data is turned into actionable information through dashboards, alerts, gap in service notifications, report writing capabilities, and trend charts. Information can be filtered based on a variety of criteria, allowing for specific operational questions to be analyzed, including information regarding SDOH&HE population-specific indicators.

Arcadia Analytics, or other similar platforms, can provide resources for enhanced care coordination by showing a “whole” picture of each member. Care providers can see which other providers the member is seeing, any upcoming appointments with other providers, what screenings have been completed, as well as a complete medication list. (Note that information related to substance abuse is only shown to appropriate entities as outlined in CFR 42, Part B.) In this screenshot, it can be noted that the patient may not have had a recent dental exam, so the care coordinator could work with them to get this scheduled, arrange transportation, or remove any other barriers so the member can receive needed care.



One option could be for WCCCO to partner with this same vendor, Arcadia Analytics, but there are other HIE vendors which could also be considered. The final determination for how best to handle the HIE needs of this CCO population will be made by the key provider stakeholders in WCCCO.

In the meantime, however, we would anticipate that for purposes of facilitating Care Coordination, EDIE/PreManage would provide some functionality. EOCCO has utilized this tool to coordinate and focus care based on members presenting to the hospital through the ED or direct inpatient admission. Moda currently holds a contract with Collective Medical, the vendor for PreManage, which allows us to offer this tool to provider groups at no additional charge to the clinic. Similar to our approach in Eastern Oregon, Moda will employ a Quality Improvement Clinical Integration Specialist whose role is to outreach to participating clinics to promote and assist in onboarding PreManage technologies and implementing shared workflows across organizations. WCCCO will promote and support community adoption of EDIE/PreManage technology.

In Eastern Oregon, the EOCCO created opportunities for Community Based Initiative Reinvestment (CBIR) programs. A similar program could be created by WCCCO to assist practices requiring financial support with the implementation of EDIE/PreManage, to identify and follow a cohort of patients. This reinvestment program encourages collaboration between hospitals, behavioral health and/or primary care to reduce barriers and increase access, coordinate care, and integrate new services or workflows. The program also promotes interventions that target patients with mental/behavioral health needs and/or multiple chronic conditions, the use of CHWs for care coordination and patient education, utilization of telehealth services for low acuity complaints presenting to the ED in partner hospitals, and primary care and behavioral health organizations. The final determination regarding the details for implementing such a reinvestment program will be made by the key WCCCO provider stakeholders.

The EDIE/PreManage tool is already accessible to all hospitals, the CMHP and a number of primary care clinics in the WCCCO region. And, as noted above, WCCCO will focus on expanding the accessibility and use of this tool. Care coordination processes using EDIE/PreManage are already being used with behavioral health providers in the region,

and WCCCO will expand these processes to other providers, similar to what currently exists in Eastern Oregon.

Here is an example of processes facilitated by EDIE/PreManage with behavioral health providers in Eastern Oregon:

- Discharge Planning: The CCO collaborates with Community Mental Health Programs (CMHP) in discharge planning involving all members moving between levels of care and Episodes of Care. The CCO/CMHPs monitor PreManage daily to track admissions. An Enhanced Need Care Coordinator (ENCC) immediately begins the discharge planning process and communicates the plan with the CCO Care Manager (CM) within one to two days. The patient or patient's representative are included in the discharge process. Throughout the discharge planning process, open communication and close collaboration occurs between the CMHP and the CCO to ensure a timely and successful discharge.

- Substance Abuse Disorder Medication Assisted Therapy (MAT) services: MAT care coordinators work with members engaged in these services on a regular basis. They develop individualized care plans that are entered into PreManage as appropriate based on HIPAA regulations.

- Members with Severe and Persistent Mental Illness (SPMI): To coordinate care, CMHP staff enter PreManage care plans on all members with an SPMI that are receiving services. The goal of the care plans is to provide the ED physician key information when the member visits the ED.

The EDIE/PreManage tool provides opportunities to align and coordinate across all participants in the care continuum, including medical, behavioral and oral health providers as well as long-term care facilities and community partners. In Eastern Oregon, the use of this tool continues to expand as the providers adopt PreManage and roles, responsibilities, work-flows and communication protocols are identified.

The current processes in place facilitated by EDIE/PreManage in Eastern Oregon which would be replicated by WCCCO include:

- Member/patient outreach following an ED or inpatient event:
    - Use of mutual patient cohorts and agreed upon workflows to avoid duplicate calls
    - Primary care office can contact patient post-discharge for follow-up care and appointment scheduling
    - Use of mutual scripting, best on shared best practices, to document the reason for the visit, discharge plans, medication plans, and follow-up steps
    - If primary care and specialist/BH are both involved, coordinated care recommendations can be generated
    - For members not actively managed by primary care, Moda will provide support services to connect the member to appropriate care through a hand-off to primary care, and if needed, provide short-term intensive care management for patients at high risk of readmission.

- Care team proactively outreaches to ED high utilizers who have not seen a PCP for over one year; outreach is stratified by risk score, history of behavioral health issues, or avoidable/ inappropriate ED utilization.

- Cross Organizational Care Coordination Huddles/"Rounds"
    - For patients with sustained high utilization all appropriate members of the care team, including care managers (PCP & ED), other primary care staff, specialty provider, behavioral health and health plan representative, would convene a care conference to discuss patient-specific goals and plans. Primary Care is responsible for coordinating the care conference and for creating/updating the care recommendation in PreManage.
    - Shared cohorts can be established in the tool to increase transparency among care team members. Follow-up documentation, reporting sessions and huddle summaries can all be entered into EDIE/PreManage (Care Provider/Care Team section).

Our contracted dental plan partners have access to statewide information from EDIE/Pre-Manage. PreManage provides real time notifications when one of their members has been seen in the emergency department for non-traumatic dental related issues such as pain and swelling. The contracted dental plans have dedicated case management teams who follow up with members seen in the emergency department. If the member has been seen in the emergency department multiple times or if the member has other possible health concerns, the dental case management team will outreach to the member's physical health provider who can then ensure the member receives the appropriate follow up care, incorporating a care team if needed.

Action Plans: After completing an inventory of the providers in the WCCCO area using EDIE/PreManage, a detailed roadmap will be created to expand the utilization of the EDIE/PreManage tool across the network of providers. The best mechanisms to incorporate oral health providers will also be evaluated based on the EHR inventory information obtained. Initial activities will be focused on those discussed above, and subsequent areas of focus will be determined as we evaluate effectiveness of best practices learned.

WCCCO has developed an initial HIT Implementation Roadmap and Tracking document to manage the implementation of the various platforms within the clinics across the care continuum. This initial version is at a high level but will be further refined as we complete EHR inventories and define a specific HIT strategy for WCCCO.

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.

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.

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.

WCCCO will utilize the EDIE/PreManage tool to ensure access to timely Hospital event notifications for contracted medical, behavioral and oral health providers. This tool, and WCCCO's implementation of it, are discussed at length in the previous response.

By promoting and extending the use of EDIE/PreManage through the WCCCO area, the entire community will benefit since access to the participating clinics covers their entire patient population, not just WCCCO members.

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.

WCCCO care management staff and data analytics teams will utilize the EDIE/PreManage tool to access and use timely Hospital event notifications. WCCCO staff will receive real-time notifications delivered to internal email distribution lists representing their membership. These notifications will be triaged according to workflows which have been established through our experience in Eastern Oregon. WCCCO staff will also receive scheduled reports that track and inventory the cumulative notifications over time for aggregate reporting.

WCCCO will established internal PreManage cohorts that monitor WCCCO members who meet notification criteria for conditions "most likely to readmit", including sepsis, pneumonia, COPD, and heart failure. Once identified, these members will be followed by Nurse Case Managers.

As a new CCO, we are not currently aware of how the providers are using EDIE/PreManage for the OHP population. Here is an example of how EOCCO is working with CMHP's using this tool, and depending on the processes that may already be in place in Lane County, this could be replicated or combined with existing processes at WCCCO:

- CCO receives immediate notifications of members who have arrived at the ED through the use of PreManage. Scheduled reports are produced daily showing admits and discharges for behavioral health reasons.

- CCO's utilization management team has a process in place for the daily monitoring of the EDIE/PreManage system specifically looking at behavioral health hospital admissions. The care management specialist receives the report and enters the patients in a utilization management tracking system for seven-day follow-ups.

- CCO utilizes EDIE/PreManage to assign Members admitted for a 2nd inpatient stay related to behavioral health within 3 months to a CCO physician to work with the care team on discharge planning.

- CCO care management specialist will contact the behavioral health contractor's exceptional needs care coordinator (ENCC) to engage with the patient and begin discharge planning including follow-up services with the community mental health program.

- CCO care management team coordinates and engages the hospital and community services needed to ensure the best outcome for the patient. This can include technical support for the hospital and the contracted behavioral health services.

- ENCC provides inpatient documentation and encounter notes within seven days of the patient discharge. Utilization management software records this data and makes it available to the contracted behavioral health provider for continued treatment through the use of an online portal.

Action Plans: WCCCO will work with its stakeholders to define an HIE strategy solution, capitalizing on experience gained by Moda and by the provider stakeholders in the area. While it is anticipated that EDIE/PreManage will be used for its functionality, WCCCO will consider options available for other functions. With the processes currently in place with the existing providers in the area, though, we do not anticipate any significant disruption or inconvenience for the OHP membership. The providers in the area are supportive of WCCCO's approach and are appreciative of this new CCO's efforts for enhanced data sharing and collaboration.

2. Informational Questions (recommended page limit 2 pages)

a. What assistance you would like from OHA in collecting and reporting on HIE use and setting targets for increased use?

WCCCO recommends a review of Collective Medical Technology's roadmap for extending the use of EDIE/PreManage across the state. OHA's assistance in preparing an inventory of PreManage utilization of clinics across the State, and tracking onboarding and engagement, would be helpful. Review of the roadmap would assist in the development of future outreach and support to clinics to better use the tool and/or implement the tool. OHA assistance would also be helpful with respect to ensuring that Medicaid eligibility and enrollment data is aligned with EDIE/PreManage for the benefit of all CCO's across the State.

OHA's assistance would also be appreciated in surveying HIE utilization statewide. Reporting on utilization by clinic would be helpful in identifying and prioritizing outreach and provider onboarding initiatives. Survey components could include information on current clinic workflow, current technology utilized, barriers to implementation including IT staffing, financial barriers other clinic priorities. As with EHR utilization, WCCCO will seek to create a comprehensive inventory of HIE utilization in the area. Based on our existing relationships with the providers and

stakeholders, this should not be difficult. However, the process would potentially be more efficient and consistent if OHA could provide this support during 2019, prior to the contract start.

Another area that WCCCO would request OHA assistance relates to the Clinical Quality Metrics Registry (CQMR) which is supporting CCO incentive measures and the Oregon Medicaid EHR Incentive Program. It would be very helpful to understand the timelines and expectations for deliverables from this project, as they relate to CCO planning. As WCCCO develops its HIE strategy, knowing which pieces will be supported by CQMR, and when, would be valuable.

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.

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.

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.

Consistent with WCCCO plans to create an inventory of EHR utilization by providers in the area, this inventory process will also include collecting data on type of HIE and use.

WCCCO will utilize online surveys, direct phone calls, provider and facility application processes, site reviews and contract negotiations to collect this data. Our outreach will be prioritized first with primary care providers which are the most critical for clinical quality metrics measurement, and then to other provider types.

WCCCO plans to survey providers on an annual basis to determine HIE use. These updates will be recorded in a tracking database and used to regularly amend our HIE Implementation Roadmap and Tracking document. As this Roadmap evolves, it will be used to track utilization metrics including number of clinics adopting inter-organizational workflows through PreManage or other HIE solutions.

WCCCO also has a unique opportunity to develop HIE mechanisms for the oral health provider community. Moda's "sister company", Dentists Management Corporation offers DAISY dental software, a full-featured dental practice management system used by several hundred dental practices in Oregon. As this product is evolving, additional HIE data features are being incorporated which will facilitate additional data sharing capabilities and enhanced interoperability features.

The inventory of EHR and HIE usage for all providers in the area, incorporating support from OHA as needed, will support a longer-term HIE strategy for WCCCO. Based on the statewide hospital implementation of EDIE, we anticipate that PreManage will continue to play a critical role in the HIE structure with respect to hospital notifications. The functionality for integrating clinical and claims data, calculating and tracking quality metrics, care management coordination and integration, and population health management across physical, behavioral and oral health providers will be assessed in the

process of defining the costs, benefits and needs of the stakeholders. Currently, we have experience using Arcadia Analytics as an HIE with our EOCCO population. This is also a tool that is currently available and being utilized with the CMHP providers in Columbia, Clatsop, and Tillamook counties. NWCCO plans to engage with key stakeholders in these counties to determine the most appropriate HIE to implement. Because these decisions and this strategy significantly impact provider operations and workflows, it is critical for these decisions to support the providers across all of their patient populations, not just OHP populations. WCCCO stakeholders will seek to find solutions to align the HIE data-sharing mechanisms to better serve all Oregonians.

D. Health IT For VBP and Population Health Management

1. **Informational Questions: (recommended page limit 3 pages)**

   a. **If Applicant will need technical assistance or guidance from OHA on HIT for VBP, please describe what is needed and when.**

   WCCCO does not require assistance in these areas, but would welcome any strategic guidance or assistance that the OHA would be providing.

   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?**

   WCCCO will collect SDOH&HE data from a variety of sources, such as member surveys, EHR data, and publicly available data. The standard process is to match this data with the member's claims and enrollment data, using combinations of member first name, last name, date of birth, gender, and/or address as appropriate. Our existing data warehouse already holds demographic data. Once matched, the data can then be used for general analytics and reporting purposes, in combination with any other existing WCCCO data.

   EOCCO plans to determine an appropriate a SDOH-HE survey that can be administered to all existing EOCCO members after the contract effective date. This survey tool includes validated questions regarding SDOH-HE needs including housing status and quality, food insecurity, transportation needs for both medical and SDOH-HE purposes, utility needs, safety, employment, and education. After the contract effective date, EOCCO will administer this survey on an annual basis to continue to determine the SDOH-HE needs within our service area and use this information as a baseline to implement strategies and identify areas for SDOH-HE investments.

   c. **What are some key insights for population management that you can currently produce from your data and analysis?**

   The WCCCO analytics team currently produces high-level dashboards for OHP populations that highlight trends and opportunities in care delivery. For example, one recent report highlighted characteristics of members who have not been using primary

care services, to help develop plans for impacting that population. Other areas of focus have included ED utilization, quality measures (OHA Incentive Measures) analysis, pharmacy cost and utilization, high risk members, and more.

On a tactical level, our ongoing OHP reporting identifies specific outreach and treatment opportunities to improve patient care and quality measure performance. For example, we can highlight members who have significant health issues but have not accessed primary care. Members who are nearing the limits of age guidelines for preventive treatments (such as infants needing immunizations) are highlighted on a timely basis to ensure sufficient ability to intervene. Members taking expensive brand name medications for which there is a less expensive and therapeutically equivalent alternative are also highlighted.

As a product of Oregon's vision and commitment to improve the health of children and youth, the Children Health Complexity project has produced a data-driven initiative to strengthen the capacity of its CCOs to provide the best quality care for this sub-population and in tandem reduce costs burdens to health care systems and society at-large. The initiative has produced a population health management stratification of children (ages 0-17 years) in the Medicaid population. This children health complexity stratification system notably integrates medical complexity (e.g., due to severity of chronic health conditions) with social complexity levels that tap into indicators of social determinants of health, childhood trauma, and child and/or parent behavioral health risks and contact with the justice system.

WCCCO's analytics infrastructure can be used to leverage Children Health Complexity data by integrating risk scoring and experience data to facilitate effective screening, as well as assessment and referral functions that channel children and their families to the types and levels of care that best fit their needs.

2. Evaluation Questions (recommended page limit 15 pages)

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.

WCCCO has capabilities for handling a variety of VBP arrangements. These capabilities have been developed by Moda both through its work with the OHP population in Eastern Oregon and its work with the OEBB and PEBB populations and other commercial populations during the past six years. The HIT infrastructure required to administer VBP arrangements has evolved as these risk-sharing structures have developed and continue to support higher levels of reimbursement methodologies supporting the HCP-LAN categories. Elements of this infrastructure include:

- In-house Provider Reporting Portal for providers to access cost, quality, and utilization metrics, with data on overall results plus drill down capability to individual members with care gaps. Included in this portal are reports including member rosters, Rx utilization, risk scores and diagnoses, and a multitude of comprehensive patient data, which can be sorted and formatted based on clinic preference. In addition, financial reports are available tracking interim progress and results for risk-sharing components of the VBP arrangements.

- Ad hoc provider reporting can be produced from time to time as needs arise.

- In-house Provider Data Exchange (PDE) platform enabling automated two-way data sharing of EHR and claims data, including integration of EHR data into our existing data warehouse for seamless combination with claims, capitation, and enrollment data as needed.

- Advanced member attribution methodologies, which are deployed as needed in place or alongside direct member selection of PCPs (the preferred method of PCP assignment), taking into account members' historical utilization patterns, PCPCH tier status, PCP network status (in or out of network), geographic area, provider specialty, and/or other factors.

- Established processes for designing, producing, maintaining, and distributing VPB progress reports to providers.

- Established processes for making payments to providers under VBPs, including fee-for-service claims payments, capitation payments, quality bonus payments, and shared savings payments.

- Established processes for collecting penalties from providers for cases in which providers do not perform to cost or quality expectations under VPBs.

- Two years' experience with managing VBPs under the CPC+ program, with infrastructure in place to administer the capitation and quality payments inherent in that program.

- Strong analytics team with deep knowledge and experience in health care data generally and VBPs specifically, supported by state-of-the-art analytics tools and technology such as SAS, Tableau, Tableau Server, Business Objects, Crystal Reports, etc.

- Robust data warehouse built on SQL Server technology, updated weekly, which includes all medical, pharmacy, vision, dental, behavioral health, enrollment, and demographic data needed to support VBP administration.

The WCCCO stakeholders, including Moda and participating provider groups, will work collaboratively to develop a community-based HIE for the OHP population in Lane

County. All of these stakeholders have gained experience working with the OHP population within the CCO structure. The experience they have gained, coupled with the current status of EHR and HIE participation, will guide the strategic HIE path for this new CCO. The goals for creating such an HIE strategy for WCCCO during the next five years will include:

- Bidirectional exchange of health and wellness information collected from a variety of data sources and disciplines; connectivity and participation not reliant on standardized data file exchange thereby allowing for the exchange of more diverse datasets, mitigating the administrative burden of participation, as well as making it easier to connect to a wider variety of unaffiliated EHRs.

- Robust analytics platform focused on tracking performance metrics, cost drivers, utilization trends, and operational functions. HEDIS, NQF, CCO incentive, and internally produced measures drive VBP activities, and cost and utilization data drives solutions for facilitating care interventions and transformation.

- Population risk driven by diagnosis, social determinants, utilization and other data, incorporating behavioral health and oral health.

- Creation of meaningful, integrated clinical documentation across the exchange while ensuring a high level of data quality as each data source is continually tested, combined, and run against existing information in the data warehouse.

- HIE staff resources to provide technical, legal, and training support throughout the development and post-production phases to ensure that both the project success of participants as well as the integrity of the exchange.

- Ability to maintain timely and accurate patient attribution to ensure the eligible population is accurately defined and appropriately managed and served.

- Comprehensive patient health record with near real-time data accessible to all servicing providers, including medications, problem lists, appointment historical and future schedule, care gaps, labs, etc. facilitating referrals and avoiding duplication to improve care.

- Ability to connect with community partners such as jails/prisons, Oregon State Hospital, programs such as WIC and SNAP which could provide supplemental data to enhance the comprehensive “holistic” patient health record.

- Ability to analyze provider-level data, and summarized clinic or system level data, to identify best practices and opportunities for improvement.

The majority of these goals have already been achieved by the OHP program in Eastern Oregon, and WCCCO is confident that solutions for these goals can be achieved collaboratively among the stakeholders in this CCO.

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:

(1) Timely (e.g., at least quarterly) information on measures used in the VBP arrangement(s) applicable to the Providers;

At a minimum the information on VBP measures is currently available at least quarterly, and usually monthly. The goal for the HIE strategic development is to make this data available for providers "near real time" to use daily as they interact with patients and work toward VBP goals.

(2) Accurate and consistent information on patient attribution; and

The current analytics platform used in Eastern Oregon will be replicated for WCCCO and reliably provides accurate and consistent information on patient attribution.

(3) Identification of specific patients who need intervention through the year, so the Providers can take action before the year end.

Successful communication and collaboration with providers is a cornerstone of the success of any VBP. To that end, WCCCO equity partner Moda and employer group partners (including OEBB and PEBB) have developed comprehensive strategies, tools, and tactics for the dissemination and discussion of cost, quality, attribution, and performance data to and with providers. Below is a timeline showing historical and future planned activities and milestones. As evidenced by the information below, WCCCO already has infrastructure in place to provide timely and accurate information to providers on measures used in the VBPs, patient attribution, risk stratification, care gaps, and intervention opportunities.

Date	Topic	Activity / Milestone
2012	Data exchange	First EHR data sharing agreements implemented and data transmissions begin
2013	PCPCH capitation begins	First program to increase primary care capabilities by funding PCPCH infrastructure, via capitation payments for members with serious and/or multiple chronic conditions
2013	Attribution	Development and implementation of attribution models to support VBPs, including risk-adjusted total cost of care calculations by provider entity
2014	PCPCH capitation	PCPCH infrastructure payments expanded statewide for all members in VBP plans
2014	Provider reporting	Development and population of a new provider contact database, to allow secure electronic transmission of VBP reporting to

		provider personnel involved with VBP management (beyond the traditional contracting personnel)
2014	Provider Reporting	First incentive measures progress reports distributed to CCO providers, showing current and active list of all VBP members with care gaps, plus YTD performance statistics on overall measure set
2014-2015	Provider reporting	Rollout of standard monthly provider reporting package, to provide timely and actionable information for providers to manage their patients under VBPs, such as: > Complete list of members assigned / attributed > Risk stratification of all assigned members > Summary of diagnoses and chronic conditions > Complete claims and prescription history for high-risk members > Care gap information such as missing PCP visits, screenings, or diagnostic tests, with targeted care gap details for members with chronic disease (e.g. HBA1c) > Interim performance reports showing bonuses (or penalties) incurred under VBPs
2015	Provider Reporting	Provider reports portal goes live. Providers have online access to monthly and quarterly reports on cost, quality, utilization, and member attribution in a secure environment; secure e-mail connections, prompts, and reminders continue via secure e-mail
2015	Provider Reporting	Near-daily IP / ED notification reporting goes live, to immediately warn PCPs of ED admissions or inpatient authorizations for their assigned populations
2016	Provider reporting	First risk-adjusted total cost of care reports generated and sent to providers, with provider results calculated and compared to a variety of risk-adjusted benchmarks, with cost, utilization, and quality performance broken down by type of service
2016	Payment Models	First large scale distributions of provider bonus payments under CCO shared risk models – all of which performed favorably and resulted in shared savings distributions
2016	Data exchange	EOCCO work begins with Arcadia Analytics to create direct connections to provider EHRs, with data to flow to a common platform with a web portal for providers to access and manage quality data
2017	EDIE / PreManage	PreManage feed to enhance population management efforts in care coordination and ED utilization

2017	Payment Models	Rollout of first comprehensive primary care capitation model (Category 4A) to selected EOCCO providers, eliminating fee-for-service payments for most primary care services
2018	Payment Models	VBP quality measures tied to capitation payments for risk bearing behavioral health providers
2018	Payment Models	Comprehensive population-based payments (Category 4A) adopted for a majority of CCO primary care practices
2018	Payment Models	OHP members covered by the first agreement in HCP-LAN Category 4B
2019	Data exchange	Complete EHR quality metric and care gap data, plus claims data, available for 55% of EOCCO patients in the Arcadia Analytics web-based reporting platform
2019	Provider reporting	Development and production of referral pattern reporting, to provide PCPs with insights into the cost and quality of specialists and facilities in their referral network
2019	Provider reporting	Development and production of enhanced pharmacy opportunity reports, which compare PCPs and specialists to benchmarks on their utilization of brand name and specialty medications, and highlight any adherence issues
2019	Provider reporting	Next generation of Provider Reports Portal goes live (Spring 2019), with vastly improved navigation and organization features, with added ability for providers to access any and all custom and ad hoc analysis produced by the VBP team, all in one place
2020	Payment Models	Adjustment of EOCCO hospital payment model to move from Category 3N to 3B, adding new quality measures from the state-approved list

WCCCO Analytics and Information Technology team will work with the providers to assure information is being captured accurately and transmitted correctly. This includes validating information, working as a liaison when there are issues and providing technical assistance. Also, as previously discussed, provider teams are individually supported by WCCCO to assist with understanding VBP reporting. Some reports are delivered in PDF form, where readability and presentation of information is critical to provider understanding and acceptance. However, reports containing tabular data – for example member rosters with risk stratifications and care gaps – are sent in Excel form, with pre-set filter buttons to make it easy for non-technical staff to sort and filter the lists for action and/or analysis. In addition, every report contains a mini-glossary of terms, and is supported by complete documentation of every term, abbreviation, column name, etc. made available alongside the reports on the Provider Reporting portal.

c. Describe other ways the Applicant plans to provide actionable data to your Provider Network. Include information on what you currently do, what you plan to do by the start of the Contract (Jan. 1, 2020), and what you intend to do in the future. Please include a narrative as well as a roadmap that includes activities, milestones and timelines.

As previously described, we have a wealth of information and data capabilities to inform our provider partners. To the extent we may be able to obtain some level of historical data from the predecessor CCO, and through onboarding for members as of January 1, 2020, WCCCO will seek to provide risk assessments to quickly identify members requiring specific services and attention for care coordination.

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.

We believe that providing timely and accurate information to providers is critical to success in VBPs, but that information has to be accompanied by a dedicated and proactive outreach strategy. It is through person-to-person discussion and collaboration that the maximum value of information sharing will be achieved. For this reason, WCCCO will dedicate significant time and personnel to provider outreach.

As an example, there are three full-time staff devoted to working directly with EOCCO providers on data issues such as the interpretation and use of reports, resolution of data quality issues, identification of opportunities for intervention, measurement of performance on VBPs, and more. WCCCO via Moda, expects to assign a proportional number of staff to work directly with WCCCO providers.

The following table describes some of the activities currently in place in Eastern Oregon that could be replicated in WCCCO (if appropriate after understanding processes already in place with the participating provider groups) and adjusted as the HIE strategy is defined.

Date	Topic	Activity / Milestone
Q1 Annually	New Incentive Measures	Staff updates provider clinics regarding the current year incentive measures via email and WCCCO website.
Q2 Annually	Clinic Visits	Staff travels to clinics to review provider progress reports, new measures, metric related workflows, review of previous year preliminary results, clinic incentive measure trends, and discuss available resources.
Q4 Annually	Clinic Visits	Staff travels to clinics to review current year incentive measure progress, and determine any additional initiatives to implement to meet the current year metrics.
Weekly	HIE Vendor Touchpoint	Staff meets weekly with HIE vendor (Arcadia Analytics for EOCCO) to review current status of the onboarding

		process and allow for continual communication to ensure any barriers are addressed
Quarterly	HIE Vendor Focus Group	Staff facilitates meeting with HIE vendor (Arcadia Analytics for EOCCO) and on-boarded clinics to address common questions/concerns and identify resolutions.
Bi-weekly	EDIE/PreManage Touchpoint	Staff meets with PreManage vendor (CMT) staff on a bi-weekly basis to review current status of the onboarding process and allow for continual communication to ensure barriers are addressed as they arise.
Continually	QI clinic support	Clinic staff will have continual access to QIS's through a shared email WCCCOMetrics@modahealth.com as well as phone contact. This allows clinics a streamlined way to reach out and request assistance as needed regarding the provider progress reports and any other related data questions.
Annually	Staff and Clinician Summit	WCCCO's Clinical Advisory Panel will coordinate an annual conference for providers and staff. Relevant updates to HIE strategy and technology plans will be presented.

Throughout the year, WCCCO will provide training and education to physical, behavioral and oral health providers in HIE platforms, analytics tools and ad hoc reporting capabilities, and technical assistance, including liaison services to any HIE vendors. In addition, WCCCO will provide additional training opportunities through an annual provider conference, and through user conferences available through HIE vendors.

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:

(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.

As described above, WCCCO, through Moda's participation, has extensive experience using VBPs in our Medicaid and commercial networks, and supporting those VBPs with HIT for information sharing, risk stratification, care gap mitigation, care coordination, and more.

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)?

As described above, WCCCO already has the ability to provide data on risk stratification and member characteristics to providers through its Provider Reporting portal and also through ad hoc reporting for any specific initiatives or interventions. Standard reports not only highlight risk stratification on a total cost of care basis, but also highlight members with significant opportunities for intervention on utilization or quality opportunities, which may or may not be short-term drivers of cost. These reports are based on each provider's attributed/assigned members.

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.).

WCCCO will use a combination of claims, authorizations, EHR data, encounter data, EDIE/PreManage, member assessments / surveys, and more to perform risk stratification, measure health outcomes, calculate quality metrics, and provide reporting to providers.

h. Describe Applicant's HIT capabilities for the purposes of supporting VBP and population management. Again, please provide plans for start of Year 1 as well as plans over the 5- year contract, including activities, milestones, and timelines. Include information about the following items:

(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?

Medical, behavioral health and dental claims data is generated continuously and fed into the Analytics Data Warehouse (ADW) on a weekly basis. Pharmacy claims data is received for OPDP from its Pharmacy Benefits Manager (PBM), MedImpact, on a bi-weekly basis and integrated into the ADW. All claims data is rigorously audited and quality-controlled by WCCCO's actuarial and data science teams employed by Moda. Extensive business logic is applied to transform and summarize data in a way that streamlines analysis and reporting. Claims data is the main input to a majority of the quality and efficiency measures used in provider reporting.

Authorization data is used to provide the earliest possible alert for inpatient admissions, to make sure that providers have the maximum opportunity to coordinate care. This data is generated continuously, and extracted from core Moda systems several times per week so that it can be summarized and reported out to PCPs immediately.

EHR data can be collected in several ways. Providers can submit data to Moda to be incorporated into the ADW. Or, once the HIE plan for WCCCO is created, there will be options to have EHR data pulled from the provider systems into a central repository. The setup process for each provider data feed involves a significant amount of testing and

validation, as different providers may store data differently even if they are using the same EHR. EHR data combined with claims data will then be used to support the annual submission process for clinical quality measures.

Encounter data flows to the data warehouse from all capitated medical, behavioral health, and oral health services. Upon receipt, this data is transformed via an automated process to match the file format, naming conventions, and business logic used in the ADW.

As noted previously, WCCCO will utilize PreManage for timely notification of hospital events. WCCCO staff will receive real-time notifications delivered to internal email distribution lists which are triaged according to established workflows. WCCCO staff will also receive scheduled reports that track and inventory the cumulative notifications over time for aggregate reporting. WCCCO will established internal PreManage cohorts that monitor WCCCO members who meet notification criteria for conditions "most likely to readmit" post discharge. These conditions include sepsis, pneumonia, COPD, and heart failure. These members will be followed by Nurse Case Managers. WCCCO data analytics staff is developing an internal reporting process that involves data feeds that filter and triage event notifications for appropriate next steps, and assignments to care managers.

Similar to processes currently used in Eastern Oregon, WCCCO will utilize the Patient Activation Measure (PAM) at the individual level to tailor interventions appropriate for members and to serve as an outcome measure to assess change in member activation. This data is specifically used for our Tobacco Cessation Health Coaching program. The four levels of the PAM help the health coaches to gauge members' knowledge and confidence to manage their health. Each member's PAM scores will be reviewed and entered into Moda's CaseTracker Dynamo system for continued tracking and improvement efforts. The CaseTracker data is combined with other data from the ADW, as needed, for further reporting and analysis.

(2) Data storage: Where do you store data (e.g., enterprise data warehouse)?

Claims, enrollment, member, and provider data is stored in the Analytics Data Warehouse (ADW), an enterprise data warehouse, is managed by Moda and is accessible to more than 150 analysts and data users. The ADW has complete redundancy, and complete change history is captured and stored for validation, audit, and backup purposes.

(3) Tools:

(a) What HIT tool(s) do you use to manage the data and assess performance?

The ADW ETL (extract, transform, load) process runs on Microsoft SQL Server. From there, the data is loaded onto a SAS server for analysis. The core package of automated VBP reports, which includes shared risk settlement reports, is generated in Crystal Reports from a combination of data sources including ADW, EHR feeds, and various other sources such as pharmacy rebate data. A number of other reports are produced on a regular basis and exported to final Excel layout in an automated process using SAS. A large number of ad hoc reports are also created using combinations of SAS, Tableau, and Excel, as needed. All of these tools are maintained and managed by Moda.

(b) What analytics tool(s) do you use? What types of reports do you generate routinely (e.g., daily, weekly, monthly, quarterly)?

Analytics tools used include Crystal Reports, SAS, Tableau, Tableau Server, and even Excel, depending on the specific report and circumstances. Following is a description of past, current, and planned provider reports that support VBPs, including CCO, OEBB, PEBB and other commercial populations.

Report Name	Purpose / Description	Frequency	Status
ER / Inpatient Notification	Timely notification to PCPs for ED admissions and inpatient authorizations	2-3X / week	Current
Member Roster	List of assigned members for each provider. Basic risk and utilization info.	Monthly	Current
High Risk Member Report	Detail on high risk members, such as diagnosis and treatment history	Monthly	Merged with Member Roster
Chronic Condition Report	Detail on all members with a chronic condition (e.g. Diabetes, COPD, etc.)	Monthly	Merged with Member Roster
Inpatient & ER Report	List of all Inpatient and Emergency Room visits	Monthly	Merged with Member Roster
High Risk Member Claims Detail	List of all claims for high-risk members	Monthly	Current
Pharmacy	List of all claims for prescriptions filled, including medication possession ratios	Monthly	Current
Member Detail Report	Contains basic member demographic and contact information, including name, address, and phone number.	Monthly	Merged with Member Roster
Settlement Report	Calculates the amount of the risk sharing bonus earned by each provider	Quarterly	Current
Utilization Summary Report	Displays utilization statistics such as PMPM cost and claims/000 by	Quarterly	Current

	service category, PCP utilization, drug costs, etc., with benchmarks		
Quality Summary Report	Shows YTD progress compared to targets for quality measures	Monthly	Current
Quality Progress Report	Highlights specific members with gaps in care and/or opportunities to influence quality metric performance, plus overall summary of performance	Monthly	Current
Pharmacy opportunity report	Identifies members with pharmacy management opportunities; highlights excessive use of drugs with less expensive and equally effective alternatives	Quarterly	In development
Facility referral analysis	Stratifies facilities and ancillary providers by quality and cost of care, to inform referral decisions	TBD	In development

(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?

All reports and analysis are produced, maintained, and distributed by an in-house Analytics team for WCCCO that is staffed by Moda. Reports produced by vendor systems will be audited and validated via joint efforts of vendor and in-house staff. The Analytics team produces all analysis and reporting for VBPs, but also produces customer reporting, internal management reporting, regulatory reporting, and other tasks. With access to Moda's large analytics capabilities, WCCCO is supported by a team which has the scale to conduct training and development activities, invest in new tools, techniques, and processes, and generally maintain a high level of analytics excellence. Members of the Analytics team have significant experience in the analytics generally and health care data specifically, and many have advanced credentials including Ph.D, MPH, and MBA.

(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?

Initially, the primary method of report distribution will be via the Provider Reporting. Providers can log in and see the complete history of their clinical and financial reports that pertain to VBPs (the reports listed above). WCCCO will maintain a contact database of

provider personnel involved in quality and medical management activities, including e-mail addresses, and this information is used for outreach and transmission purposes where needed. Often, announcements of new or updated reports are sent via e-mail, to prompt visits to the provider portal. Some reports are also sent via secure (encrypted) e-mail, though we are transitioning away from this method of delivery.

In 2019, a new version of the provider portal will go live. This new tool will provide with vastly improved navigation and organization features, with added ability for providers to access any and all custom and ad hoc analysis produced by the WCCCO value based payment team, all in one place.

We plan to convert some provider reporting over to Tableau Server, to allow providers to access their performance, membership, and/or care gap data in a customized, intuitive, and interactive format. This project is expected to begin in late 2019, with the first reports available sometime in 2020.

Within WCCCO, internal management reports will be reviewed on a regular basis. These reports are generally distributed via intranet links or direct e-mail attachments. In addition, similar to EOCCO, a Management Reports intranet site will be created and updated monthly with performance metrics and statistics on cost and utilization. In the coming months, we expect to convert a significant amount of our internal management reporting to Tableau Server, where it will be available to all employees in an interactive format. Tableau Server provides intuitive graphics-rich summary 'dashboards' for high-level trend and opportunity insights, as well as self-service drill-downs for ad hoc analysis. As this becomes available, WCCCO stakeholders will receive specialized training on using this powerful tool.

Consistent with the way EOCCO functions, WCCCO will orchestrate regular meetings with the Community Advisory Councils (CACs) to review information on issues affecting local communities. Several times each year, detailed data on cost, utilization, and quality is presented; and trends, issues, and opportunities for improvement are discussed. These forums are valuable for dissemination and discussion of information, and can lead to new ideas about resource allocations, process changes, or opportunities for further study.

(6) Effectiveness: How will you monitor progress on your roadmap and the effectiveness of the HIT supports implemented or to be implemented?

WCCCO will be tracking progress on multiple fronts – progress on HIE and EHR roadmaps, progress on meeting quality metrics and goals, and progress on other metrics for success in meeting the Triple Aim. Progress for all of these will be monitored through tracking documentation and periodically reviewed and shared by the WCCCO Board, provider groups, CACs, and all other relevant stakeholders.

WCCCO will be supported by excellent Analytics and Actuarial team members who can effectively articulate the progress made, including defining targets and success. WCCCO will be data-driven and relationship-driven, similar to the way the governance model for EOCCO has been functioning. VBP performance, quality performance, management performance, results of targeted interventions and other initiatives will all be tracked

through data, and adjustments for HIT support will be made through data-driven decisions. Solutions for how the adjustments should be handled, or how larger strategy changes should be made, will be relationship-driven and developed in collaborative forums.

For example, in addition to providers receiving periodic VBP reports, internal management reports will also be reviewing progress on a monthly or quarterly basis, as appropriate, to inform VBP management efforts. In reviewing the status of overall quality metric performance across the CCO organization, issues and/or opportunities can sometimes be discovered which lead to resource allocation for targeted activities – additional provider outreach, member mailings, etc. The WCCCO Incentive Measures team will meet on a regular basis for this purpose.

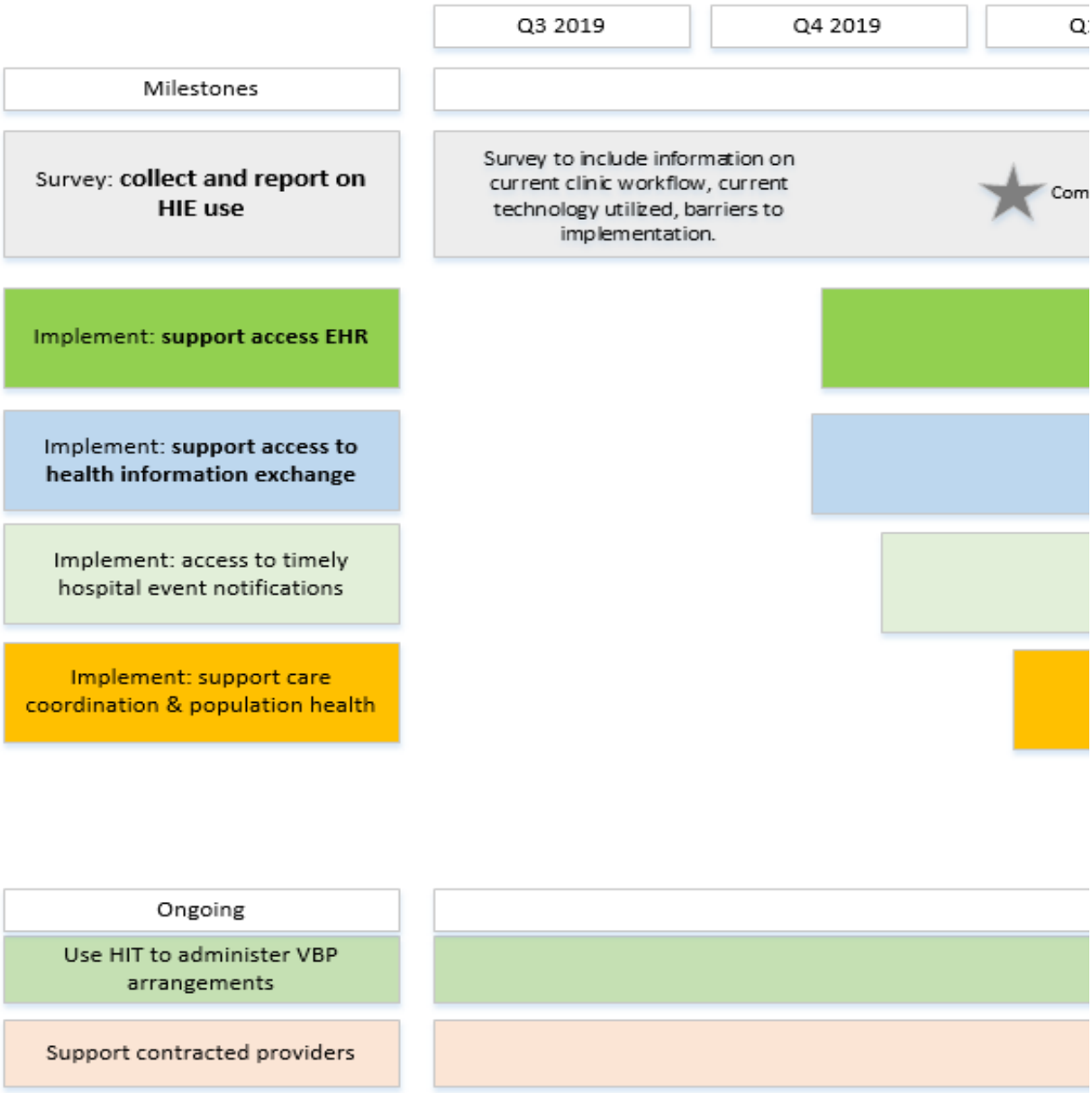
Given the importance and prominence of VBPs in the WCCCO, board of directors meetings frequently have cost, quality, and utilization updates on the agenda. Analytics staff prepare and present summaries of trends, challenges, and opportunities to inform the leadership for decision-making and resource allocation.

On a tactical level, usage tracking has been enabled on the Provider Reporting portal, so that the team can gain insights into which providers are viewing and downloading which reports. Although the next-generation update to the portal will to some extent create some obsolescence in this tracking data, continued monitoring of provider usage will enable refinement of the HIT tools through late 2019 and beyond.

(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?

WCCCO already possesses the technology, infrastructure, people, and processes to fully support a wide range of VBPs. Provider-side challenges are resolved on an ongoing basis through the WCCCO governance structure and through targeted provider engagement activities discussed previously. There is always room for improvement, and planned upgrades are in the works for our technology and reporting platforms, as well as our level of staffing (e.g. adding positions). These planned changes will have a positive impact on our future capabilities, with no interruption of current capabilities.

WCCCO HIT Roadmap Data Collection



RFA OHA-4690-19 – CCO 2.0 Coordinated Care Organization – Amended and Restated

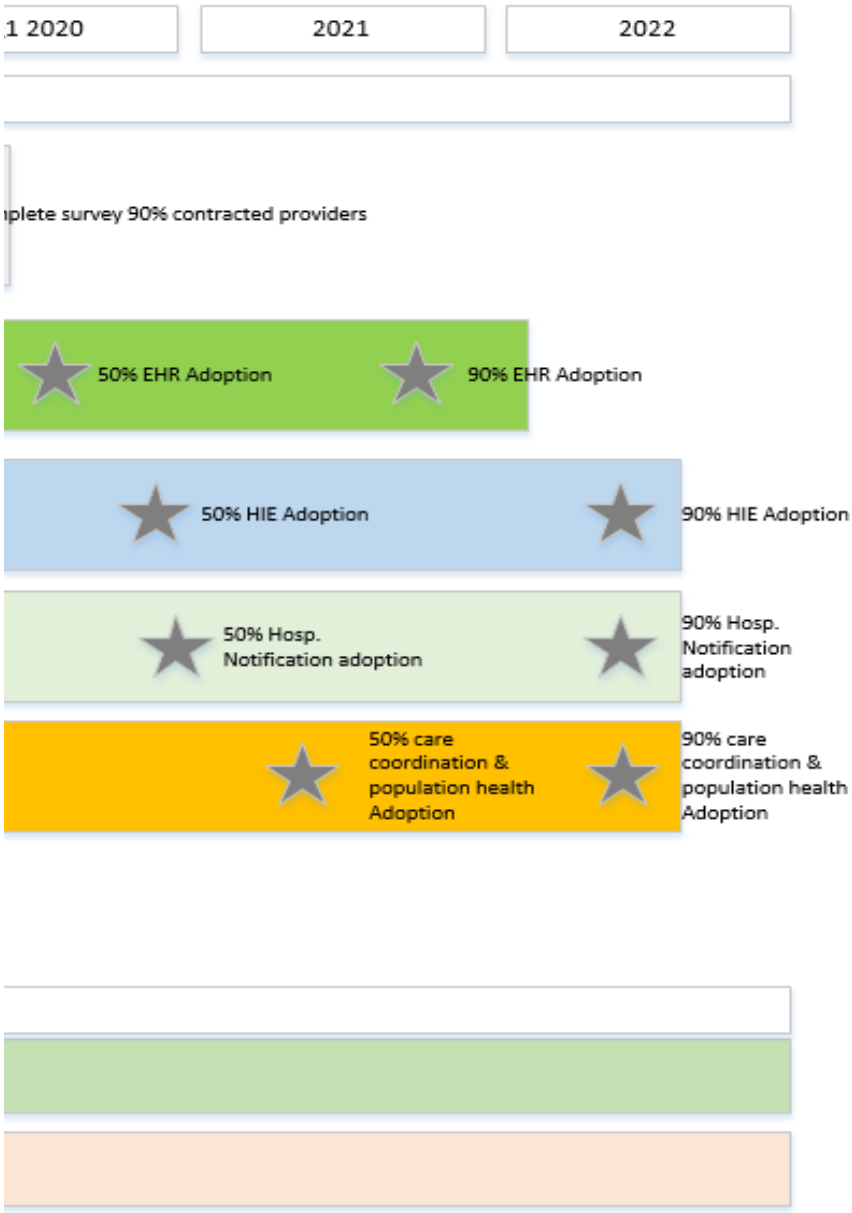


Exhibit L
Appendix B – Sample Contract

WCCCO HIT Roadmap Data Collection

EHR Adoption	
Physical Health	
Behavioral Health	
Oral Health	
All	

Access to Hospital Event Notifications	
Physical Health	
Behavioral Health	
Oral Health	
All	

EHR Adoption	
Physical Health	
Behavioral Health	
Oral Health	
All	

Access to Hospital Event Notifications	
Physical Health	
Behavioral Health	
Oral Health	
All	

EHR Adoption	
Physical Health	
Behavioral Health	
Oral Health	
All	

Access to Hospital Event Notifications	
Physical Health	
Behavioral Health	
Oral Health	
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EHR Adoption	
Physical Health	
Behavioral Health	
Oral Health	
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Access to Hospital Event Notifications	
Physical Health	
Behavioral Health	
Oral Health	
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EHR Adoption	
Physical Health	
Behavioral Health	
Oral Health	
All	

Access to Hospital Event Notifications	
Physical Health	
Behavioral Health	
Oral Health	
All	

EHR Adoption	
Physical Health	
Behavioral Health	
Oral Health	
All	

Access to Hospital Event Notifications	
Physical Health	
Behavioral Health	
Oral Health	
All	

Q3 2019

Utilzing Hospital Event Notifications	
Physical Health	
Behavioral Health	
Oral Health	
All	

Access to HIE	
Physical Health	
Behavioral Health	
Oral Health	
All	

Q3 2020

Utilzing Hospital Event Notifications	
Physical Health	
Behavioral Health	
Oral Health	
All	

Access to HIE	
Physical Health	
Behavioral Health	
Oral Health	
All	

Q3 2021

Utilzing Hospital Event Notifications	
Physical Health	
Behavioral Health	
Oral Health	
All	

Access to HIE	
Physical Health	
Behavioral Health	
Oral Health	
All	

Q3 2022

Utilzing Hospital Event Notifications	
Physical Health	
Behavioral Health	
Oral Health	
All	

Access to HIE	
Physical Health	
Behavioral Health	
Oral Health	
All	

Q3 2023

Utilzing Hospital Event Notifications	
Physical Health	
Behavioral Health	
Oral Health	
All	

Access to HIE	
Physical Health	
Behavioral Health	
Oral Health	
All	

Q3 2024

Utilzing Hospital Event Notifications	
Physical Health	
Behavioral Health	
Oral Health	
All	

Access to HIE	
Physical Health	
Behavioral Health	
Oral Health	
All	

Utilizing HIE	
Physical Health	
Behavioral Health	
Oral Health	
All	

Utilizing HIE for Care Coordination	
Physical Health	
Behavioral Health	
Oral Health	
All	

Utilizing HIE	
Physical Health	
Behavioral Health	
Oral Health	
All	

Utilizing HIE for Care Coordination	
Physical Health	
Behavioral Health	
Oral Health	
All	

Utilizing HIE	
Physical Health	
Behavioral Health	
Oral Health	
All	

Utilizing HIE for Care Coordination	
Physical Health	
Behavioral Health	
Oral Health	
All	

Utilizing HIE	
Physical Health	
Behavioral Health	
Oral Health	
All	

Utilizing HIE for Care Coordination	
Physical Health	
Behavioral Health	
Oral Health	
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Utilizing HIE	
Physical Health	
Behavioral Health	
Oral Health	
All	

Utilizing HIE for Care Coordination	
Physical Health	
Behavioral Health	
Oral Health	
All	

Utilizing HIE	
Physical Health	
Behavioral Health	
Oral Health	
All	

Utilizing HIE for Care Coordination	
Physical Health	
Behavioral Health	
Oral Health	
All	

WCCCO HIT Status: Physical Health

		Organization Name
1	Physical Health	Lane Independent Primary Providers
2		Benson Health Clinic
3		Bethel Health Clinic
4		Blaker Enterprises Inc/Two Rivers Health Center
5		Camas Swale Medical Clinic
6		Cascade Health Solutions
7		Community Health Centers of Lane County
		Lane Independent Primary Providers
8		Lane Independent Primary Providers
9		Kernan Family Practice LLC
10		Lane Independent Primary Providers
11		McKenzie Willamette Medical Center
12		Northwest Naturopathic Medical Clinic PC
13		Oregon Medical Group
14		Pacific Womens Center
15		PeaceHealth
16		PeaceHealth
17		PeaceHealth
18		PeaceHealth
19		PeaceHealth
20		PeaceHealth
21		PeaceHealth
22		Planned Parenthood of Southwestern Oregon
23		Praxis Medical Group
24		Quillin Family Medicine LLC
25		Lane Independent Primary Providers
26		Lane Independent Primary Providers
27		Lane Independent Primary Providers
28		Springfield Family Physicians
29		Lane Independent Primary Providers
30		Lane Independent Primary Providers
31		Womens Care Associates
32	Public Health	Lane County Public Health, Alcohol and Drug
33	ecialty Care	Absolute Wellness Center
34		Bay Eye Clinic, PC
35		Complete Vision Center
36		Custom Eyes Pam Ebert

	Spe
37	Eugene Eye Clinic LLC
38	Eugene Eyewear PC
39	Eye Center LLP
40	Eye Focus Northwest
41	Eyeglass Wholesale
42	Eyeland Family Optical LLC
43	Eyes of the World Optical
44	Fairfield Eye Clinic
45	Family Vision Center
46	Florence Reedsport Eye Clinic
47	Grassroots Gynecology LLC
48	Mark Gotcher OD
49	Mckenzie Pediatrics LLC
50	Oregon Eye Docs LLC
51	Oregon Eye Surgery Center
52	Ron V Cuevas OD PC
53	Semler Optical Services
54	Specialty Eye Care LLC
55	The Eye Team PC
56	Timothy Arbow OD
57	Willamette Family Inc
58	William Losie OD

Practice Name	PhoneNumber	EHR Product Name	EHR Version Number
Applegate Medical Associates	5418681876		
Benson Health Clinic	5413451722		
Bethel Health Clinic	5416071430		
Blaker Enterprises Inc/Two Rivers Health Center	5415790936		
Camas Swale Medical Clinic	5416585301		
Cascade Health Solutions	5416861427		
Community Health Centers of Lane County	5416823550		
Eugene Pediatric Associates	5414845437		
Inkwell Medical Group LLC	5418441495		
Kernan Family Practice LLC	4582102940		
McKenzie Family Practice PC	5413448225		
McKenzie Willamette Medical Center	5417264402		
Northwest Naturopathic Medical Clinic PC	5416839357		
Oregon Medical Group	5416867007		
Pacific Womens Center	5413428616		
Cottage Grove Community Hospital	5419420511		
Peace Harbor Hospital/Health Assoc. of Peace Harbor	5419973418		
PeaceHealth Medical Group	5416876061		
PeaceHealth South Lane Medical Group	5419420511		
Sacred Heart Medical Center - RiverBend	5412227300		
Sacred Heart Medical Center - University District	5416867191		
Sacred Heart Physicians	5412222700		
Planned Parenthood of Southwestern Oregon	5417670566		
Praxis Medical Group dba Pacific Medical Group	5414853636		
Quillin Family Medicine LLC	5413424660		
River Road Medical Group	5416887011		
Santa Clara Medical Clinic	5416883000		
South Hilyard Clinic	5416878581		
Springfield Family Physicians	5417474300		
Timber Valley Medical Clinic	5417411226		
Wild Rose Medical Clinic PC	5416864153		
Womens Care Associates	5418689700		

Lane County Public Health, Alcohol and Drug	5416823550

Absolute Wellness Center	5414845777
Bay Eye Clinic, PC	5419973331
Complete Vision Center	5417470616
Custom Eyes Pam Ebert	5417410144

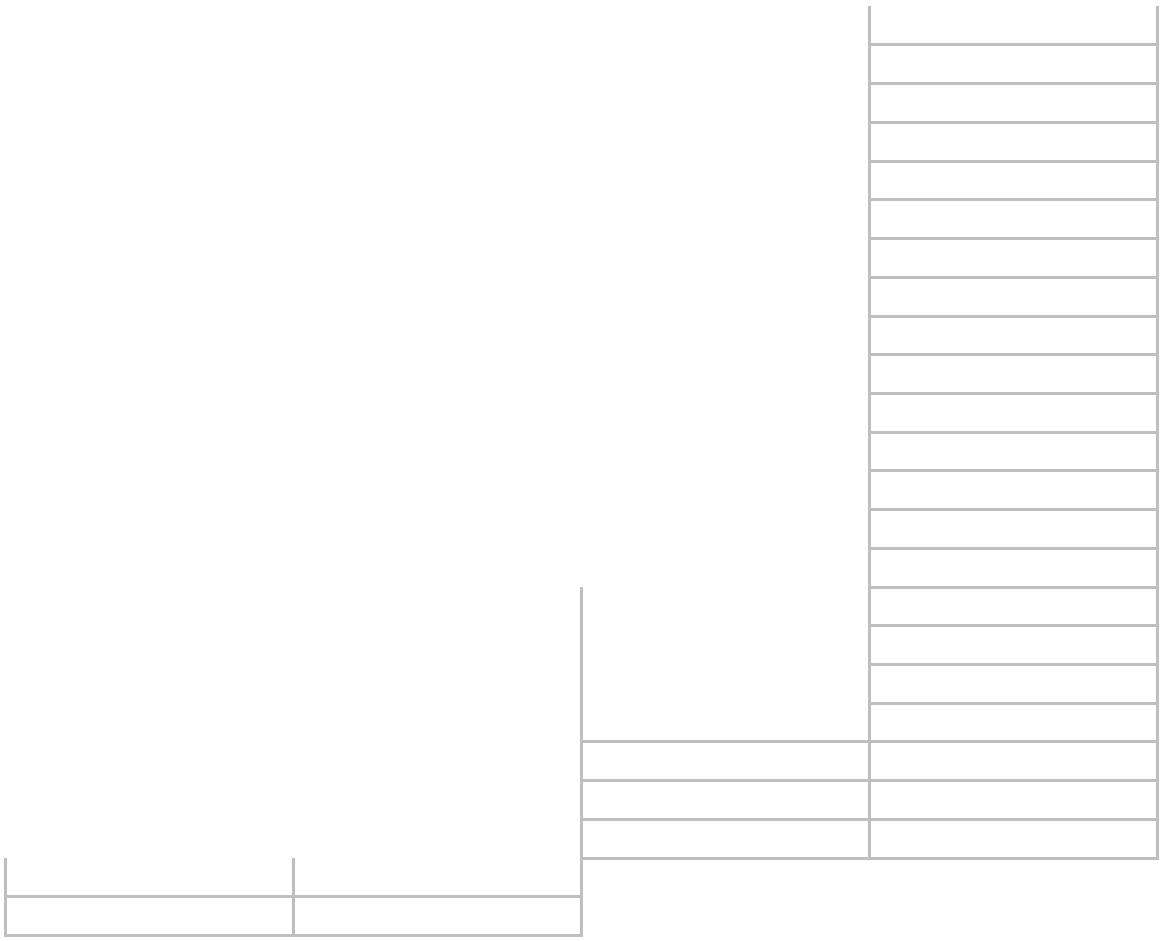
Eugene Eye Clinic LLC	5416833744
Eugene Eyewear PC	5413384844
Eye Center LLP	5416832020
Eyecare Focus and Specialties LLC	5417265055
Eyeglass Wholesale	5417266822
Eyeland Family Optical LLC	5418953937
Eyes of the World Optical	5416892881
Fairfield Eye Clinic	5416832224
Family Vision Center	5416861237
Florence Reedsport Eye Clinic	5419973331
Grassroots Gynecology LLC	5415057510
Mark Gotcher OD	5419420176
Mckenzie Pediatrics LLC	5417264100
Oregon Eye Docs LLC	5413422201
Oregon Eye Surgery Center	5416838771
Ron V Cuevas OD PC	5416878666
Semler Optical Services	5413458734
Oregon Retina LLC dba Specialty Eye Care	5419425000
The Eye Team PC	5414346727
Timothy Arbow OD	5414852020
Willamette Family Inc	5417624300
William Losie OD	5416861117

Q3 2019				
2015 Certified EHR	Access to Hospital Event Notifications	Status of Hospital Event Notifications	Access to HIE	Status of HIE

Using HIE for Care Coordination	EHR Product Name	EHR Version Number	2015 Certified EHR

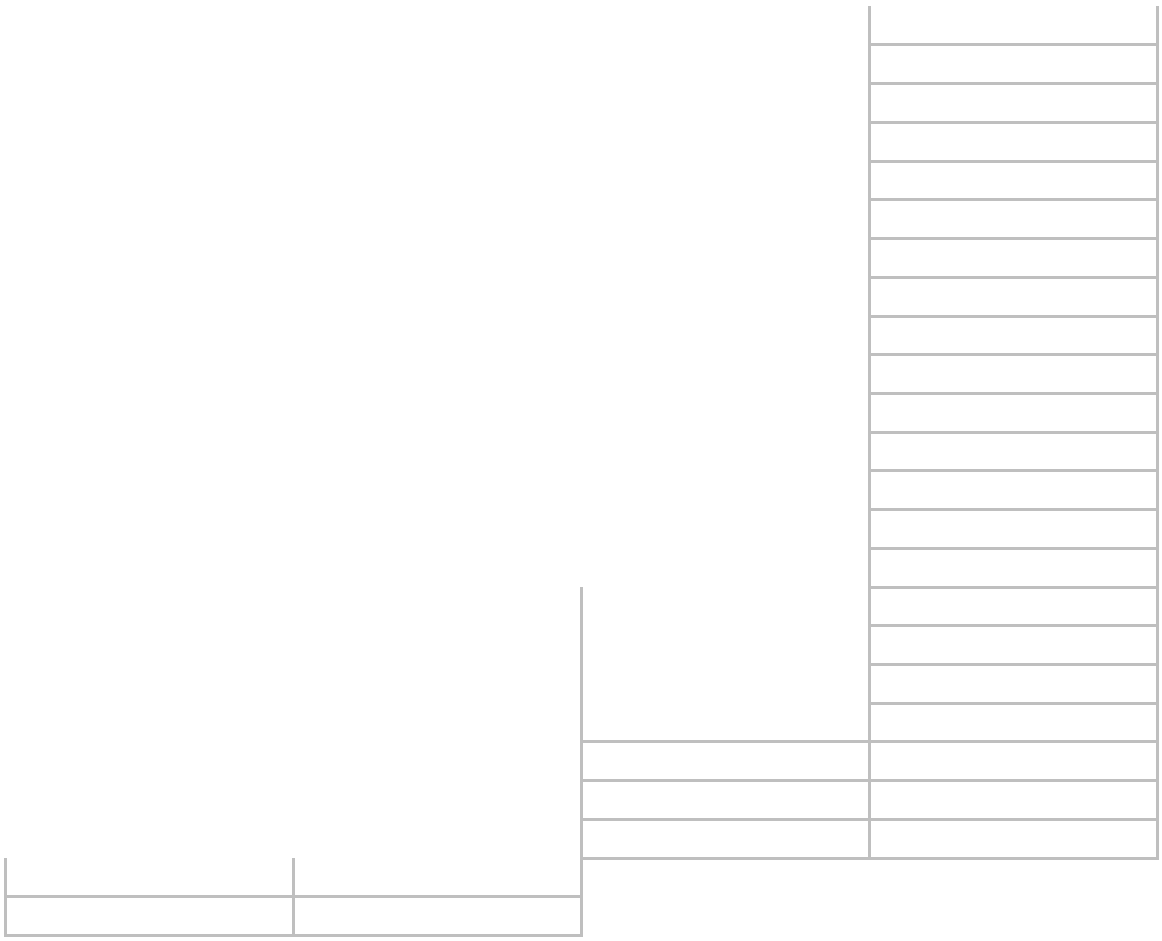
Q3 2020			
Access to Hospital Event Notifications	**Status of Hospital Event Notifications**	**Access to HIE**	**Status of HIE**

Using HIE for Care Coordination	EHR Product Name	EHR Version Number	2015 Certified EHR



Q3 2021			
Access to Hospital Event Notifications	Status of Hospital Event Notifications	Access to HIE	Status of HIE

Using HIE for Care Coordination	EHR Product Name	EHR Version Number	2015 Certified EHR



Q3 2022				
Access to Hospital Event Notifications	Status of Hospital Event Notifications	Access to HIE	Status of HIE	Using HIE for Care Coordination

Q3 2023				
EHR Product Name	EHR Version Number	2015 Certified EHR	Access to Hospital Event Notifications	Status of Hospital Event Notifications

Access to HIE	Status of HIE	Using HIE for Care Coordination	EHR Product Name

Q3 2024			
EHR Version Number	2015 Certified EHR	Access to Hospital Event Notifications	Status of Hospital Event Notifications

Access to HIE	Status of HIE	Using HIE for Care Coordination

WCCCO HIT Status: Behavioral Health

	Organization Name	Practice Name
1	Alan Siebel	Alan Siebel
2	Amy McCormick LCSW	Amy McCormick LCSW
3	Angelia Marie Thomas	Angelia Marie Thomas
4	Annelise P Heitman	Annelise P Heitman
5	Applegate Medical Associates	Applegate Medical Associates
6	Avamere Skilled Advisors LLC	Avamere Home Health Care LLC
7	Avodah Therapy Services Corporation	Avodah Therapy Services Corporation
8	Barbara Weinstein LCSW	Barbara Weinstein LCSW
9	Benson Health Clinic	Benson Health Clinic
10	Bethel Health Clinic	Bethel Health Clinic
11	Bridges Community Health Inc	Bridges Community Health Inc
12	Broomberg, Lola M.	Broomberg, Lola M.
13	Caren Liebman LCSW	Caren Liebman LCSW
14	Carolyn Rexius LCSW	Carolyn Rexius LCSW
15	Cascade Health Solutions	Cascade Health Solutions
16	Center For Family Development	Center For Family Development
17	Chaunce Windle	Chaunce Windle
18	Christians As Family Advocates	Christians As Family Advocates
19	Community Rehabilitation Services Of Oregon	Community Rehabilitation Services Of Oregon
20	Creative Spirit Counseling	Creative Spirit Counseling
21	Csilla Andor LCSW	Csilla Andor LCSW
22	Daniel Duncan LPC	Daniel Duncan LPC
23	Dave Boyer LMFT	Dave Boyer LMFT
24	David Northway	David Northway
25	David Thompson LMFT	David Thompson LMFT
26	Dennis Viene PhD	Dennis Viene PhD
27	Diane Andrews LCSW	Diane Andrews LCSW
28	Direction Service Counseling	Direction Service Counseling
29	Dorota H Parys	Dorota H Parys
30	Dr M Sophia Aguirre PhD LLC	Dr M Sophia Aguirre PhD LLC
31	Drake, Maggie T.	Drake, Maggie T.
32	Element Psychiatric Group	Element Psychiatric Group
33	Emergence	Emergence
34	Erica Freeman LCSW	Erica Freeman LCSW
35	Erik Sorensen PHD	Erik Sorensen PHD
36	Erin J Kitumba	Erin J Kitumba
37	Eugene Therapy	Eugene Therapy
38	Eve Peirce	Eve Peirce
39	Evelyn Evano LPC LMFT	Evelyn Evano LPC LMFT

40	Franc Stgar MD, PC	Franc Stgar MD, PC
41	Gail Keller LCSW	Gail Keller LCSW
42	Gail Richards LCSW	Gail Richards LCSW
43	Galyn Forster LPC	Galyn Forster LPC
44	Gina M Siqueiros	Gina M Siqueiros
45	Gretchen E Scheidel	Gretchen E Scheidel
46	Healey, Cynthia V.	Healey, Cynthia V.
47	Henrietta W Knox LPC	Henrietta W Knox LPC
48	Henry Elder MD	Henry Elder MD
49	iFinish Strong LLC	iFinish Strong LLC
50	Ivan Sumner LCSW	Ivan Sumner LCSW
51	Jennifer Gordon PHD	Jennifer Gordon PHD
52	Jennifer Rossi PHD	Jennifer Rossi PHD
53	Jill Wolf PSYA	Jill Wolf PSYA
54	Joe Steiner	Joe Steiner
55	John Bundy PHD	John Bundy PHD
56	Jordan J Shin LPC	Jordan J Shin LPC
57	Josephine C W Pruch	Josephine C W Pruch
58	Kara Myers LCSW LLC	Kara Myers LCSW LLC
59	Kara S Litwiller	Kara S Litwiller
60	Karlene L Howie	Karlene L Howie
61	Lane County Public Health, Alcohol and Drug	Lane County Public Health, Alcohol and Drug
62	Larita Brown LPC	Larita Brown LPC
63	Laura Stockford LCSW	Laura Stockford LCSW
64	Laurel Anderson LCSW	Laurel Anderson LCSW
65	Lincoln T Witt	Lincoln T Witt
66	Lisa J Griffin	Lisa J Griffin
67	Lisa Shanahan LCSW PC	Lisa Shanahan LCSW PC
68	Looking Glass Youth and Family Services, Inc.	Looking Glass Youth and Family Services, Inc.
69	Lori B Allen PHD	Lori B Allen PHD
70	Lori K Cunnington-Elam	Lori K Cunnington-Elam
71	Madrone Mental Health Services LLC	Madrone Mental Health Services LLC
72	Marcia Kennedy LCSW	Marcia Kennedy LCSW
73	Margaret Hadley	Margaret Hadley
74	Markham Giblin PHD	Markham Giblin PHD
75	Mary Jo Sanders LCSW	Mary Jo Sanders LCSW
76	Matthew Fleischman PHD	Matthew Fleischman PHD
77	Melissa Gomsrud	Melissa Gomsrud
78	Michele A Monroe LCSW	Michele A Monroe LCSW
79	Mina Dickson LPC	Mina Dickson LPC
80	Nancy Kemp PHD	Nancy Kemp PHD
81	Natalie Berkman	Natalie Berkman
82	Oasis Mental Health PC	Oasis Mental Health PC
83	OHSU Hospitals and Clinics	University Professional Services
84	Orchid Oakridge Clinic PC	Orchid Oakridge Clinic PC
85	Oregon Psychiatric PA	Oregon Psychiatric PA
86	Patricia K Bear LPC	Patricia K Bear LPC

87	Paula Levinrad LCSW	Paula Levinrad LCSW
88	Penny Mcavoy LCSW	Penny Mcavoy LCSW
89	Peter Powers PHD	Peter Powers PHD
90	Praxis Medical Group	Praxis Medical Group dba Pacific Medical Group
91	Psychiatry Associates Of Eugene PC	Psychiatry Associates Of Eugene PC
92	Rehabilitation Medicine Associates of Eugene-Spring	Rehabilitation Medicine Associates of Eugene-Springfi
93	Reliant Behavioral Health	Reliant Behavioral Health
94	Ronald Unger LCSW	Ronald Unger LCSW
95	Sally Grosscup PHD	Sally Grosscup PHD
96	Serenity Lane	Serenity Lane
97	Shannon K Young PhD LLC	Shannon K Young PhD LLC
98	Smith, Ryan A.	Smith, Ryan A.
99	South Lane Mental Health	South Lane Mental Health
100	Southern Oregon Adolescent Study and Treatment	Southern Oregon Adolescent Study and Treatment
101	Springfield Family Physicians	Springfield Family Physicians
102	Sprouffske, Michelle L.	Sprouffske, Michelle L.
103	Stephen Pethick PhD	Stephen Pethick PhD
104	Steven Mussack PHD	Steven Mussack PHD
105	Strong Integrated Behavioral Health	Strong Integrated Behavioral Health
106	Stuart Silberman PsyD	Stuart Silberman PsyD
107	Susan Curtin PHD	Susan Curtin PHD
108	Suzanne Ponsioen	Suzanne Ponsioen
109	Tang, Sharon S.	Tang, Sharon S.
110	Teresa Faillace LCSW	Teresa Faillace LCSW
111	The Child Center	Mental Health for Children dba The Child Center
112	Victoria M Corbett	Victoria M Corbett
113	Victoria McMillan LCSW	Victoria McMillan LCSW
114	Viola E Washburn	Viola E Washburn
115	Vista Counseling and Consultation	Vista Counseling and Consultation
116	Willamette Family Inc	Willamette Family Inc
117	Zak Schwartz PHD	Zak Schwartz PHD

				Q3 2
PhoneNumber	EHR Product Name	EHR Version Number	2015 Certified EHR	Access to Hospital Event Notifications
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2019				
Status of Hospital Event Notifications	Access to HIE	Status of HIE	Using HIE for Care Coordination	EHR Product Name

Q3 2020				
EHR Version Number	2015 Certified EHR	Access to Hospital Event Notifications	Status of Hospital Event Notifications	Access to HIE

Status of HIE	Using HIE for Care Coordination	EHR Product Name	EHR Version Number	2015 Certified EHR

Q3 2021				
Access to Hospital Event Notifications	Status of Hospital Event Notifications	Access to HIE	Status of HIE	Using HIE for Care Coordination

			Q3 2022	
EHR Product Name	EHR Version Number	2015 Certified EHR	Access to Hospital Event Notifications	Status of Hospital Event Notifications

Access to HIE	Status of HIE	Using HIE for Care Coordination	EHR Product Name	EHR Version Number

Q3 2023				
2015 Certified EHR	Access to Hospital Event Notifications	Status of Hospital Event Notifications	Access to HIE	Status of HIE

	Q3 2			
Using HIE for Care Coordination	EHR Product Name	EHR Version Number	2015 Certified EHR	Access to Hospital Event Notifications

2024

Status of Hospital Event Notifications	Access to HIE	Status of HIE	Using HIE for Care Coordination

WCCCO HIT Status: Oral Health

	Organization Name	Practice Name
1	Absolute Dental Hygiene LLC	Absolute Dental Hygiene LLC
2	Acorn Dentistry For Kids -Corvallis LLC	Acorn Dentistry For Kids -Corvallis LLC
3	Affordable Dentures & Implants -Springfield PC	Affordable Dentures & Implants -Springfield PC
4	Arrow Dental LLC	Arrow Dental LLC
5	Artistic Denture Center	Artistic Denture Center
6	Butler Family Dental PC	Butler Family Dental PC
7	Calapooia Family Dental PC	Calapooia Family Dental PC
8	Capitol Dental	Capitol Dental
9	Community Health Centers of Lane County	Community Health Centers of Lane County
10	Cottage Grove Dental	Cottage Grove Dental
11	Daniel J Olson DDS Phd PC	Daniel J Olson DDS Phd PC
12	David A Lester DDS PC	David A Lester DDS PC
13	Dentistry For Children NW LLC	Dentistry For Children NW LLC
14	Douglas M Johnson DMD	Douglas M Johnson DMD
15	Eugene Endodontics LLC	Eugene Endodontics LLC
16	Eugene Kids' Dentist	Eugene Kids' Dentist
17	Firas Salhi DDS Prosthodontist	Firas Salhi DDS Prosthodontist
18	George A McCully DMD PC	George A McCully DMD PC
19	Howerton Hopkin Kennedy LLC	Howerton Hopkin Kennedy LLC
20	Jeffrey A Kobernik DMD PC	Jeffrey A Kobernik DMD PC
21	Jenson Family Dental	Jenson Family Dental
22	Jonathan G Foshay DMD	Jonathan G Foshay DMD
23	Lohring S Miller DMD PC	Lohring S Miller DMD PC
24	Matt W Anderson DDS PC	Matt W Anderson DDS PC
25	Mercedes R Del Valle DDS	Mercedes R Del Valle DDS
26	Mid-Valley Dental of Philomath LLC	Mid-Valley Dental of Philomath LLC
27	Mill City Dental Center	Mill City Dental Center
28	Natural Dentures-Dental	Natural Dentures-Dental
29	Natural Smiles	Natural Smiles
30	Norman D Magnuson DDS	Norman D Magnuson DDS
31	Northwest Eugene Family Dental	Northwest Eugene Family Dental
32	Oral and Maxillofacial Surgeons PC	Oral and Maxillofacial Surgeons PC
33	Oregon Oral & Implant Surgeons PC	Oregon Oral & Implant Surgeons PC
34	Pediatric Dental Associates	Pediatric Dental Associates
35	Personal Dental Hygiene Care	Personal Dental Hygiene Care
36	Peter T Raven DDS LLC	Peter T Raven DDS LLC
37	Quest Dental	Quest Dental
38	Riverbend Dental	Riverbend Dental
39	Seth Holland DMD LLC	Seth Holland DMD LLC

40	Smiles Dental	Smiles Dental
41	Smith & Jackson Family Dental	Smith & Jackson Family Dental
42	Soft Touch Dental	Soft Touch Dental
43	Springfield Kids Dentist LLC	Springfield Kids Dentist LLC
44	T Matthew Jacks DDS LLC	T Matthew Jacks DDS LLC
45	Thomas R Huhn DDS PC	Thomas R Huhn DDS PC
46	Tom Laster DDS LLC	Tom Laster DDS LLC
47	Veneta Family Dental	Veneta Family Dental
48	White Bird Dental Clinic	White Bird Dental Clinic
49	Woods Family Dentistry	Woods Family Dentistry

				Q3 2
Phone Number	EHR Product Name	EHR Version Number	2015 Certified EHR	Access to Hospital Event Notifications
5415057258				
5038744560				
5417479830				
5416538610				
5416732724				
5414856645				
5419263689				
5412156788				
5416823550				
5419427934				
5416733355				
5416869372				
5413454076				
5033943345				
5414849018				
5418441667				
5414849106				
5414851444				
5417571566				
5416736525				
5413423398				
5419982328				
5413574938				
5413454076				
5413411404				
5419295227				
5038972353				
5417540914				
5416869897				
5413432735				
5416864567				
5416869750				
5416730888				
5416862446				
5419136145				
5419885555				
5416887278				
5033919016				
5417470101				

5416733552
5413422477
5417465555
5416544996
5417264690
5417466517
5417581505
5419352113
5413448302
5419268611

2019

Status of Hospital Event Notifications	Access to HIE	Status of HIE	Using HIE for Care Coordination

Q3 2

EHR Product Name	EHR Version Number	2015 Certified EHR	Access to Hospital Event Notifications

2020			
Status of Hospital Event Notifications	Access to HIE	Status of HIE	Using HIE for Care Coordination

Q3 2

EHR Product Name	EHR Version Number	2015 Certified EHR	Access to Hospital Event Notifications

2021			
Status of Hospital Event Notifications	Access to HIE	Status of HIE	Using HIE for Care Coordination

Q3 2			
EHR Product Name	EHR Version Number	2015 Certified EHR	Access to Hospital Event Notifications

2022

Status of Hospital Event Notifications	Access to HIE	Status of HIE	Using HIE for Care Coordination

Q3 2			
EHR Product Name	EHR Version Number	2015 Certified EHR	Access to Hospital Event Notifications

2023			
Status of Hospital Event Notifications	Access to HIE	Status of HIE	Using HIE for Care Coordination

Q3 2			
EHR Product Name	EHR Version Number	2015 Certified EHR	Access to Hospital Event Notifications

2024

Status of Hospital Event Notifications	Access to HIE	Status of HIE	Using HIE for Care Coordination

WCCCO's HIT Narrative

Questions
How is WCCCO using HIT To achieve desired outcomes?
Where is WCCCO implementing its own HIT system?
Where is WCCCO leveraging collaborative HIT efforts?

To be completed/updated at each annual review with OHA.

Responses

To be completed/updated at each annual review with OHA.

To be completed/updated at each annual review with OHA.

To be completed/updated at each annual review with OHA.

Attachment 10 — Social Determinants of Health and Health Equity

A. Community Engagement

1. Evaluation Questions

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

As a newly forming CCO, WCCCO is deeply committed to building profound partnerships with robust community engagement, and we understand that this is the key to a truly integrated model. As we will discuss throughout the application, and within Attachment 10, our primary equity partner Moda, has a track record of utilizing an active Community Advisory Council (CAC) structure in the administration of its program in Eastern Oregon with excellent results.

WCCCO is actively meeting with local providers and community groups to better understand the lay-of-the-land, identify local community expertise and understand the opportunities for collaboration and growth. WCCCO appreciates that the existing Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) for Lane County involved numerous stakeholders with key involvement from Lane County HHS. We look forward to supporting "Live Healthy Lane (Lane County's Healthy Future), and understand that we will be the new partner in the process and look forward to the opportunity for collaboration and partnership with these important stakeholders. We look forward to learning from the community and adjusting our plans accordingly.

b. Applicant will submit a plan via the RFA Community Engagement Plan for engaging key stakeholders, including OHP consumers, Community-based organizations that address disparities and the social determinants of health, providers, local public health authorities, Tribes, and others, in its work. The Plan will include strategies for engaging its Community Advisory Council and developing shared Community Health Assessments and Community Health Improvement Plan priorities and strategies.

WCCCO will support the existing CAC in Lane County, and as a new CCO be prepared develop a new CAC as we establish our collaborative partnership with community stakeholders. As a starting point, we have developed and attached a Community Engagement Plan along with required tables.

2. Requested Documents

Completed RFA Community Engagement Plan, including all required elements as described in RFA Community Engagement Plan Requirement Components and attaching required Tables in RFA Community Engagement Plan Required Tables (page limit: 4 pages, excluding tables)

See Community Engagement Plan included with our submission.

B. Social Determinants of Health and Health Equity (SDOH-HE) Spending, Priorities, and Partnership

1. Informational Questions

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.

WCCCO doesn't currently have any MOUs with entities that meet the definition of SDOH-HE partners, though we expect that to change in the near future. We look forward to working with community partners to identify local areas of need and develop additional partnerships to increase housing resources, support individuals who face housing insecurity, and to provide whole-person wellness support at home that is accessible to people with transportation or mobility issues.

We have reviewed the current CHA and CHP in the service region and identified our focus areas: health equity, access to health care, obesity prevention, tobacco cessation, and substance abuse avoidance. Other potential partnerships include support for early learning, Children's System of Care Wraparound, Youth and Family Grant funding, use of Peers for SUD engagement and other programs identified through the community advisory council.

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.

WCCCO will set performance metrics related to SDOH-HE in collaboration with the CAC as we establish partnerships. We expect processes to reflect our learnings through EOCCO but confirmed in collaboration with our new WCCCO partnership:

1) Partner projects and programs use performance metrics created at the local level and must submit three progress reports each year, including a final report;
2) WCCCO SDOH-HE regional activities are measured by CAC performance metrics, and reviewed mid-way to ensure enough time has passed to collect adequate data.

We expect performance metrics for partner programs to be created at the project level, and we will work collaboratively with partners to establish performance expectations and then review the results together quarterly. Successful projects will be considered for scope and scale expansion and those that do not meet measurement objectives will be reengineered or discontinued. For example, our Frontier Veggie Rx project in the EOCCO region was initially funded for one county. We worked with the county to create metrics for taking a count of the number of patients who were screened for food insecurity; the number receiving Veggie Rx "prescriptions"; and the number who redeemed those vouchers. In 2018, a total of 1,707 bags of fresh vegetables were redeemed. After the data was reviewed and the project deemed successful, we expanded it to two additional counties the following year, and have plans to add more counties in the future.

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.

WCCCO will adopt EOCCO's policy on CAC responsibilities for tracking, reviewing and determining SDOH-HE spending. This includes the requirement that 60-70% of allotted CAC funds be spent on SDOH-HE needs (see LCAC CBIR Application included with our submission). With this policy in mind, EOCCO is in the fifth year of its Community Benefit Initiative Reinvestment (CBIR) program. CBIR is a policy approved by the EOCCO Board to allocate 6% of each year's quality pool funding to the CACs. The CACs are then responsible for determining how to use these funds for SDOH-HE and transformation projects that connect to their CHPs, and how much of their funding allotment to spend on each project. The CACs are then required to write up a summary plan which is submitted for feedback and approval. We are attaching the EOCCO documents that CACs use to apply for the CBIR funds including: 1) LCAC CBIR Application; 2) the CBIR Review Template; and 3) the CBIR Final Report Template. We expect WCCCO to replicate this process.

WCCCO plans that the amount allocated to the CAC will be calculated by adding a base funding amount plus an amount per member residing in the county. We have a robust policy and practice in our other service area for working with our CACs in each county first to identify SDOH-HE needs; and then the Regional CAC reviews and approves spending.

EOCCO has contracted for the past five years with the Oregon Rural Practice Based Research Network (ORPRN) to manage the CBIR program. They provide feedback as well as technical assistance to the CAC. Technical assistance often includes how to select appropriate interventions, evaluation metrics, and methods to measure impact. ORPRN then tracks these metrics as the CAC report on their projects on a quarterly basis. This enables us and ORPRN to provide additional support to struggling projects and to continuously build the capacity of grantees to do transformation work. Each year ORPRN works with our leadership to develop and review RFPs for CAC and transformation grants (see LCAC CBIR Application attached). Transformation grants are available for all community organizations to apply for. They include opt-in projects such as adolescent well care events, colorectal cancer screening mailed FIT projects, population health management projects and emergency department utilization projects. Transformation grant opportunities also include funding for innovative new ideas that an organization may want to pilot. We continuously work to improve the process and increase the CBIR program's impact. For example, in the 2019 grant cycle we incorporated performance-based awards for certain transformation grant projects for EOCCO, thus moving the program more towards paying for value. Due to our success in EOCCO, we plan to contract with an outside agency similar to ORPRN for WCCCO.

d. Please describe how Applicant intends to award funding for SDOH-HE projects, including:

1) How Applicant will guard against potential conflicts of interest;

WCCCO plans to use an outside agency such as ORPRN that employs set guidelines for the application and funding process of the SDOH-HE projects. Through an established review process, qualified personnel will read and score each proposal using an established rubric. The current rubric used by ORPRN for EOCCO guides reviewers to assess proposals using the domains of: Significance, Approach, Community and Staff, Impact and Sustainability, Strengths, Weaknesses, and Suggestions for Improvements and Technical Assistance (see CBIR Review Template included with our submission). Reviewers must not have conflicts of interest with the CCO, Lane County, or the applicants, and are not eligible to apply for funding. Reviewers are paired and practice scoring sample grants and discussing scores across the reviewer teams to improve inter-rater reliability. The two scores assigned by reviewer pairs are averaged prior to the final scores that are submitted to the CBIR Subcommittee. At the beginning of each CBIR scoring Subcommittee meeting, all members disclose any conflicts of interest. Those with conflicts abstain from discussion and voting on those proposals. Once the CBIR Subcommittee completes its assessment, it makes recommendations to the Board of Directors who votes on approval or denial of funding.

2) How Applicant will ensure a transparent and equitable process;

WCCCO will ensure a transparent process for funding SDOH-HE projects through the CBIR RFP and review process (see B.1.c. and B.1.d.(1).). This process ensures that potential applicants are aware of the availability of funds, know how and when to apply, are assured that conflicts of interest are avoided, and are aware of how and when decisions are made. We will provide reviewer feedback to applicants, regardless of the outcome of their proposals. Reviewers of diverse backgrounds will be available to discuss and help applicants either improve upon their funded grant projects or hone their ideas for an application the following year. Finally, amounts of all awarded CBIRs will be published on our website along with highlights about each funded project so that all applicants and community members know where funds have been committed.

To ensure an equitable process across all community organizations, we will use a straightforward application form with brief questions written in plain language. This enables community-based organizations to develop and submit grants that can compete equally with health systems and clinics. Reviewers will be instructed to ignore things like poor grammar and spelling in proposals and work to understand the crux of each proposal, knowing that many issues can be addressed in technical assistance after an award. Additionally, WCCCO will provide the CAC with a $10,000 award for a CAC coordinator position. Part of the role of the CAC coordinator is

to ensure that underrepresented or marginalized groups have representation on the CAC. This diverse membership helps to ensure a more equitable process of decision making regarding which projects to propose each year for funding through CAC dollars.

3) **How Applicant will demonstrate the outcome of funded projects to Members, SDOH-HE partners, and other key stakeholders in the Community.**

CBIR applicants will be required to propose appropriate process and/or outcome metrics and report on metrics through quarterly interim reports aimed at identifying and helping to address issues. Once grantees are awarded funds, ORPRN will work with them to provide feedback on their metrics, sometimes suggesting metrics that are more directly attributable to grantee projects or more impactful for assessing project results. Grantees are also required to submit a final report at the end of the grant cycle to demonstrate outcomes. In addition to the selected project-specific metrics, grantees will be required to report on overall project activities, how activities aligned with goals, number of WCCCO and non-WCCCO members served, significant changes to the project as planned, challenges and barriers and how they were addressed, expenditures, the most important outcomes of the project, and stories that capture the impact of the project (CBIR Final Report Template attached). Outcome metrics and project reports are then taken into consideration to refund future projects.

Outcomes of funded projects described above will be shared in a variety of ways with members, SDOH-HE partners and other key stakeholders. The WCCCO CAC will share the results of their projects with members, SDOH-HE organizations, and other key stakeholders at monthly meetings, and minutes of these meetings will be published online. Many projects will also be highlighted in the media which reaches a greater audience than the CAC. The WCCCO Board of Directors, including a WCCCO member, CAC and community partner representatives, will receive presentations on the outcomes of funded projects delivered by staff and grantees at their meetings. Other presentations of project outcomes will be provided at WCCCO sponsored meetings in participating communities. We have piloted a brief annual report in our EOCCO service area on the outcomes of funded projects with the Board of Directors and plan to refine this document so that it can be shared more broadly.

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

WCCCO will use the following measures for making targeted investments in housing and assessing the impact:

- Pre- and post-housing Emergency Room Visits – Measuring from baseline to the end of the first year in supportive/supported housing.

- Housing Stability - Based on self-reporting for pre-placement as compared to length of time in placement.
- Hospital bed days – Measuring from baseline to the end of the first year in supportive/supported housing.
- Residential and inpatient utilization – Similar as above, with desired outcome of reduced utilization.
- Initiation of either SUD treatment or co-occurring treatment services.
- Population specific outcome metrics would also be advantageous to collect as related to housing. This includes, but is not limited to, child welfare and legal involvement.
- Increased primary care utilization upon accessing affordable housing.

2. Evaluation Questions

a. Please describe the criteria Applicant will apply when selecting SDOH-HE partners.

WCCCO will select SDOH-HE partners by identifying community-based entities who effectively deliver services and impact systems change related to SDOH-HE. The CAC will serve as subject matter experts in identifying organizations within their county who support members and may be interested in partnerships. This will include community based social and human service organizations such as local housing authorities and food banks. Culturally-specific organizations and government associated entities including neighboring tribes will also be identified as potential SDOH-HE partners. WCCCO will partner with local public health entities and Early Learning Hubs who are influential in addressing SDOH-HE needs.

When determining which new or existing SDOH-HE partners to invest resources in, WCCCO will follow a similar approach to that of its CBIR program by engaging members, the CAC, contracted providers and community organizations in identifying areas of need, releasing RFPs for organizations to respond to, and following a non-conflicted process to vet and select organizations to support. Also similar to the CBIR program, WCCCO will work with partners to select performance metrics and review progress toward project goals on a regular basis. Additional criteria may include: historical performance with other contracts with WCCCO equity partners; organizational capacity; and interest and willingness to work with WCCCO staff in a collaborative manner.

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.

WCCCO will communicate SDOH-HE spending priorities, funding availability, application procedure, and project selection process similarly to how we currently communicate our CBIR funding. Spending priorities will be established by the Grant Subcommittee of the Board of Directors with input from CAC members and community partners. We recognize the roll that public health plays in the community to support SDOH-HE needs. Similar to EOCCO, WCCCO plans to offer additional funding for public health projects related to SDOH-HE. WCCCO will publish these

priorities in RFPs released on the WCCCO website and through our email list. Our email list will include contacts from SDOH-HE organizations identified through the 211info inventory of community-based organizations plus any others identified by the CAC. RFPs will specify funds available in total and by priority, how interested organizations can apply for consideration, and how the selection process will occur. Selection criteria will be included in the RFPs and applicants will be asked to select process and outcome metrics appropriate to the projects.

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.

WCCCO will use a combination of claims, authorizations, EHR data, encounter data, EDIE/PreManage, member assessments/surveys, and more to perform risk stratification, measure health outcomes, calculate quality metrics, and provide reporting to providers. WCCCO will also explore using PreManage as a tool for community communication regarding SDOH-HE.

WCCCO will collect SDOH-HE data from a variety of sources, such as member surveys, EHR data, and publicly available data. The standard process is to match this data with the member's claims and enrollment data, using combinations of member first name, last name, date of birth, gender, and/or address as appropriate. WCCCO's equity partner, Moda has an existing data warehouse that already includes demographic data. Once matched, the data can then be used for general analytics and reporting purposes, in combination with any other existing WCCCO data. Specifically, WCCCO plans to administer an annual survey to all members. The survey tool will include validated questions regarding SDOH-HE needs. Once we receive outcomes data we will incorporate it into our Analytics Data Warehouse (ADW). The ADW generates monthly provider progress reports which will be disseminated to all WCCCO clinics. This will encompass survey outcomes data including: housing status and quality, food insecurity, transportation needs for both medical and SDOH purposes, utility needs, safety, employment, and education. This data will provide clinics with additional opportunities to coordinate care beyond the medical setting. We will also share the WCCCO wide data with our SDOH-HE partners to stratify risk and complexities across patient panels and populations. These data will also be used to determine areas of SDOH-HE investments.

WCCCO will track SDOH-HE spending using quarterly cost and utilization reports. These reports will be shared bi-annually with the WCCCO Board of Directors as well as the Clinical Advisory Panel. Additionally, we will track spending using the HRS funds that are allotted to SDOH-HE projects. Lastly, CBIR funding related to SDOH-HE will be tracked and reported by our outside CBIR agency.

d. Applicant will submit a plan for selecting Community SDOH-HE spending priorities in line with existing CHP priorities and the statewide priority on Housing-Related Services and Supports via the RFA Community Engagement Plan, as referenced in section A.

As referenced under A.1.b., the CAC will review its community engagement plan annually for relevancy and progress. A component of this work is to identify where

there are opportunities to align the CBIR dollars allotted to the CAC with meeting Incentive Measures and/or implementing portions of the CHP. Also, please see WCCCO's community engagement plan.

C. Health-Related Services (HRS)

1. Informational Questions

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.

In addition to the CBIRs (see section B.1.c.), WCCCO will use HRS funding for needs that are unique to each community. WCCCO plans to implement a simple request process for HRS funding that is available to members, clinics, and community organizations. The application will be posted on the WCCCO website so that everyone is aware of this service and can easily submit a request. We will also share this opportunity with the CAC and at our annual provider trainings. WCCCO will set a baseline amount of funding so that if a request falls under that amount then it is quickly reviewed and administered by Moda's Medicaid Services Team if approved. If the request is above the baseline amount then it goes to a review committee that includes CCO leadership and the CCO Medical Director for a rapid approval process.

Some examples of HRS funding requests that WCCCO's equity partner Moda receives from community organizations/clinic partners include adolescent well care incentives such as backpacks for children as well as gift cards for adolescents who complete a wellness visit. Moda also receives specific requests from members that include paying for temporary shelter for individuals recovering from surgery, a one year gym membership for a member who needed access to a pool for physical therapy, and other requests related to SDOH-HE needs. Lastly, from the health plan side, Moda utilizes HRS funding for a Cribs for Kids program for which WCCCO members will be eligible for. We will share information about the Cribs for Kids program at CAC meetings so that community members and local healthcare organizations are aware of the program.

D. Community Advisory Council membership and role

1. Informational Questions

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.

We will utilize demographic information from the 834 enrollment files. We will also use the Portland State University (PSU), Center for Population Research as our base for defining the population. Additionally, we will collect member information on age, gender, zip code (geography) and preferred language.

In addition to using these data sources, we will also seek cultural understanding from people of all ethnic and cultural groups in the WCCCO service area through targeted outreach and engagement. There are two federally recognized tribes in the WCCCO region, and Native American people (approximately 1% of the region's population) who are both affiliated and unaffiliated with federally recognized tribes. The Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians are made up of three tribes (four Bands): two bands of Coos Tribes: Hanis Coos (Coos Proper), Miluk Coos; Lower Umpqua Tribe; and Siuslaw Tribe. The five-county service area is made up of Coos, Curry, Lincoln, Douglas and Lane counties. The second tribe is the Coquille Tribe whose service area includes Lane County, in addition to Coos, Curry, Douglas, and Jackson counties.

2. Evaluation Questions

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). Applicant may refer to guidance document CAC Member Assessment Recruitment Matrix.

Please see the WCCCO Community Engagement Plan included in our submission for information on the planned membership and role of the CAC.

E. Health Equity Assessment and Health Equity Plan

1. Informational Questions

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.

WCCCO has the opportunity to build on the success of our primary equity partner Moda's experience with EOCCO and its attention to health equity. WCCCO will use the structures Moda already has in place to successfully execute health equity strategies and meet future health equity metrics. Moda on behalf of all of its government programs, including EOCCO and WCCCO, offers regular instructor-led diversity trainings through the year and three diversity classes (cultural competence, Implicit Bias and Working in an inclusive environment) through its online platform Moda University. Moda is working to develop workplace strategies to identify racial and ethnic disparities through our Equity Compass 360° program. This includes collecting and analyzing race, ethnicity and language data from a portion of our members to better recognize and understand our member populations; and adopting a company-wide set of Cultural Sensitivity and Health Literacy (CSHL) standards to better communicate with Moda's members.

Our partner dental care organizations through ODS Community Dental provide annual cultural competency training to their staff as well. We evaluate which employees have been trained in workplace diversity and cultural competency. We

expect that 100% of WCCCO team members who are WCCCO member interfacing receive the training on an annual basis.

As we already do in EOCCO, we will conduct annual provider trainings across the WCCCO service area with all contracted clinic staff. This training includes topics such as health related services, community health workers, language assistance, and compliance. We are also currently in the development phase of optimizing the online training platform that our equity partner Moda uses in order to create training modules for all contracted providers. These online modules will comprise of a variety of health related topics including cultural competence, healthy equity, and implicit bias. We would like to offer these courses to the Board of Directors as well as all CAC members.

Additionally, we will hold an annual clinician summit with contracted providers and partner organizations in Lane County. In 2019, we expect to offer an in person health literacy training for clinic staff and providers at the clinician summit in our EOCCO service area. If it is successful then we will offer it at the WCCCO clinician summit in 2020 as well.

b. Please describe Applicant's capacity to collect and analyze REAL+D data.

WCCCO's primary equity partner, Moda collects the REAL+D data provided in the 834 enrollment file. Currently, we are importing this data into our system to identify the population. We utilize this data to assist in claims adjudication and for targeted member outreach and care coordination. Similar to EOCCO, we will start reporting REAL+D data on our monthly provider rosters in April 2019, to ensure that WCCCO primary care providers also have access to the data.

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

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.

We are committed to eliminating health disparities and providing the highest quality of care to all WCCCO members, regardless of race, ethnicity or primary language. To provide culturally and linguistically appropriate services to WCCCO members, we will stratify data from multiple sources including the member eligibility files from the state, internal data, and CAHPS survey data. The monthly provider progress reports that we will send out to all WCCCO contracted providers will contain information on incentive measure rates as well as member demographic information including both race and ethnicity data. This will allow clinics to minimize gaps in care while also outreaching and delivering services in a culturally competent manner. WCCCO will analyze this data to reveal health disparities among certain cultural and ethnic groups. WCCCO will analyze claims data and compare OHA race and ethnicity data to identify trends in underutilized services. Assets within the WCCCO communities will be identified as well in order to enhance

current capabilities. All of this data will drive quality improvement initiatives as well as the provision of services.

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.

WCCCO will seek to allow equal employment opportunities for all qualified persons without regard to race, religion, color, age, sex, sexual orientation, national origin, marital status, disability, veteran status or any other status protected by law.

Similar to EOCCO, WCCCO will evaluate race, ethnicity, and language data of our membership to identify demographic characteristics of the service area. We will then align our strategies to recruit personnel and leadership to match this demographic composition. To help us with this, we will utilize Portland State University, Center for Population Research as our base strategy for defining the population of our service area, and our effort for effective and diverse recruitment and operation of our CAC.

The CAC is intended to be reflective of the local community and community partners that they serve. It will represent the diversity of the community, including race/ethnicity, age, gender identity, sexual orientation, socio-economic and geographic location. The WCCCO CAC charter will state that, to the greatest extent possible, membership should reflect individuals or agencies representing the; healthcare provider community (for example a physician, nurse, dentist, etc.); social service agencies including Department of Human Services (DHS); hospice; local school districts; public health services; publicly funded mental health and substance use treatment; a county government representative and general community members.

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.

WCCCO recognizes that providing linguistically appropriate healthcare in both verbal and written forms plays a crucial role in effectively delivering healthcare services. Quarterly, WCCCO and its delegated entities will verify the languages of the substantial population from the declared languages reported on the 834 eligibility files. As needed, WCCCO will adjust translated member materials for significant new languages in the WCCCO membership. Our WCCCO member informational materials will be assessed using the Flesch-Kincaid Readability Statistics to ensure that member materials are written between a sixth and seventh grade reading level. Member materials and notices will be sent to the member through the mail. Member handbooks will include a tag line on the first page that offers the handbook in alternate languages and formats. The handbooks will also be made available on the WCCCO website in both English and Spanish.

WCCCO will provide multilingual customer service at no charge to the member through Moda's vendor, Voiance. WCCCO is prepared to meet the special health care needs of members who are hearing and visually impaired. When clinics don't have bilingual services, WCCCO will arrange for interpreter services at members' medical provider appointments through Moda's interpretation vendor, Passport to Languages. WCCCO member handbooks and participating provider manuals will include instructions on how to request these services. This information will also be made available on the WCCCO website. WCCCO intends to evaluate the number of utilized interpreter services at medical office visits and implement strategies to increase utilization among members who identified a primary language other than English.

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.

WCCCO will notify members in the member handbook of the availability of auxiliary aids. For example, we will provide the member handbook and other letters in other languages, large print, a computer disk, audio tape, spoken presentation or Braille. WCCCO will also ensure all communication providing the toll free customer service number also notes TTY users can dial 711. WCCCO will monitor the availability of these services through the grievance and appeal process for both internal and provider concerns. Additionally, monitoring will be done through the care coordinators and case managers to ensure availability to our providers.

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.

WCCCO expects to adopt policies that are similar to those of EOCCO. We have included the EOCCO policy for Interpreter Services as our example.

F. Traditional Health Workers (THW) Utilization and Integration

1. Informational Questions

a. Does Applicant currently utilize THWs in any capacity? If yes, please describe how they are utilized, how performance is measured and evaluated, and identify the number of THWs (by THW type) in the Applicant's workforce.

WCCCO expects to capitalize on the investments of EOCCO, via our equity partners, in the promotion and use of Community Health Workers (CHWs). Beginning with a pilot project through transformation grants, EOCCO saw early success and began dedicating funding for THW initiatives, including reimbursement at a fee-for-service basis and funding for the development of a regional OHA certified CHW training program. As a result, EOCCO developed a CHW billing and payment policy to help ensure a sustainable revenue source for the EOCCO provider

partners that employ CHWs. We expect to replicate this sustainable funding source in WCCCO.

WCCCO believes that THWs play an important role in helping patients navigate and use the healthcare system more efficiently by developing relationships with patients, arranging appointments, improving provider/patient communication, reducing healthcare disparities and helping locate community resources.

We will utilize THW's within the Wraparound Process and for youth who receive Intensive Care Coordination (ICC). Performance will be measured and evaluated utilizing encounter data, CANS scores and Peer Support Competencies Assessment Tool. Additionally, these positions are subject to the same chart audits as all other staff, clinical and non-clinical. We will utilize and/or assist practices in the recruitment of Family Peer Support Specialists – specialty code (606) and Youth Support Specialists – specialty code (607). In addition, WCCCO will support the utilization of Family and Youth Support Specialists when youth are in the Emergency Department.

WCCCO will build additional THW workforce capacity in the coming years. We will do this through investment in the development of OHA-approved CHW continuing education training programs in partnership with Oregon State University and by continually improving the billing and payment policy for certified CHWs. CHWs can be reimbursed for time spent with WCCCO members. Examples of reimbursable services include face-to-face time spent with members to address SDOH-HE, assistance navigating community resources, and obtaining assistance with food or housing. See RFA Community Engagement Plan Tables: Table 2; and the THW Integration and Utilization Plan included with our submission for more information.

b. If Applicant currently utilizes THWs, please describe the payment methodology used to reimburse for THW services, including any alternative payment structures.

WCCCO will utilize EOCCO's established sustainable payment model. This is a billing policy that allows THWs to reimburse for their services, and includes but is not limited to: personal heath navigators, CHWs, peer support specialists, and doulas. This reimbursement is on a fee-for-service basis. By the end of 2020, we plan to implement a reimbursement model that focuses on a PMPM reimbursement.

2. Evaluation Questions

a. Please submit a THW Integration and Utilization Plan which describes:

- **Applicant's proposed plan for integrating THWs into the delivery of services;**
- **How Applicant proposes to communicate to Members about the benefits and availability of THW services;**
- **How Applicant intends to increase THW utilization;**
- **How Applicant intends to implement THW Commission best practices;**
- **How Applicant proposes to measure baseline utilization and performance over time;**

- **How Applicant proposes to utilize the THW Liaison position to improve access to Members and increase recruitment and retention of THWs in its operations.**

  Please see the THW Integration and Utilization Plan as required for this response.

3. **Requested Documents**
   Completed THW Integration and Utilization Plan (page limit: 5 pages)

   Please see the Community Engagement Plan as required for this response.

G. Community Health Assessment and Community Health Improvement Plan

1. **Evaluation Questions**

   a. **Applicant will submit a proposal via the RFA Community Engagement Plan, referenced in Section A, describing how it intends to engage key stakeholders, including OHP consumers, Providers, local public health authorities, including local health departments, Tribes, Community-based organizations that address disparities and the social determinants of health, and others, in its work. The Plan should detail the Applicant's strategies for engaging its Community Advisory Council, its process for developing and conducting a Community Health Assessment, and development of the resultant Community Health Improvement Plan priorities and strategies. The Plan should specify how the Applicant's strategy for health-related services links to the CHP. Applicants should include information on approaches to coordinate care across the spectrum of services, as well as to encourage prevention and health promotion to create healthier communities.**

   Please see the Community Engagement Plan as required for this response.

Traditional Health Worker (THW) Integration and Utilization Plan

Background – Building regional capacity

WCCCO is dedicated to the support, reimbursement and continuous training of THWs to help improve member outcomes and provide sustainable support to the communities they serve. WCCCO will not employ THWs or Community Health Workers (CHWs) but instead support their local employment as needed. This provides for local support and expertise, while creating jobs within the region.

WCCCO will build on EOCCO's early success with THWs through dedicated funding for THW initiatives, including reimbursement at a fee-for-service (FFS) basis and funding for the development of a regional OHA certified CHW training program. As a result, EOCCO developed a CHW billing and payment policy to help ensure a sustainable revenue source for the EOCCO provider partners that employ CHWs. We expect to follow this model for support.

Because WCCCO expects that THWs will be employed locally by community partners, clinics and hospitals, member communication and engagement must be focused at the community level. WCCCO's care coordination team and case management team will work with clinics, through multiple channels, including the county multi-disciplinary teams, to work on referring members to resources within their communities, including the availability of THWs.

CCO 2.0 and the future of THWs

THW Integration into the delivery system

WCCCO will build successful integration of THWs into the service area through the following activities:

- Locally employing THWs as needed
- Identifying a THW Liaison
  - THW Liaison will convene THWs across the WCCCO service area to provide support and resources
- Offering CHW training courses, continuing education and leadership certification in partnership with OSU
- Utilizing best practices learned through the THW Commission

Member communication of benefits and availability of services

- WCCCO will continue to focus member communication of benefits and availability of services at the local community level and collaborate with THWs in the service area.
- WCCCO will publish THWs in the provider directory.
- WCCCO will support the use of THWs through care coordination and case management services available to members.

- The WCCCO THW Liaison will promote the network of THWs in the service area at the Community Advisory Council, as well as health fairs and other community events.

Increase THW Utilization

WCCCO will work one on one with providers that employ CHW's and provide technical assistance to implement CHW billing.

Additionally, WCCCO will work on implementing a model to pay Public Health and provider clinics a per member per month (PMPM) to perform THW services. The contract will include the requirement to that the entity provides data using the THW Minimum Reporting Requirements Template, in lieu of traditional encounter claims billing.

WCCCO will survey partners to identify the number of THWs, utilization trends and to identify clinics with additional support/needs.

Implementation of THW Commission best practices

WCCCO will utilize the THW Liaison to participate in the THW Commission and learn and share best practices along with fellow THW Liaisons.

WCCCO THW Liaison will also share learnings from the THW Commission at the Community Advisory Council as well as health fairs and other community events.

WCCCO will focus our approach for implementation by limiting new areas to 1-2 best practices each year for the region. This will allow the THW Liaison to evaluate the efficacy of the best practice and have the THWs focus on key areas of implementation. However, the THW Liaison will deploy best practices at the individual level, as needed by a specific THW employer.

Baseline utilization and performance measurement

WCCCO expect to track utilization and claim encounters as part of our Transformation and Quality Strategy (TQS). In 2020-2024, WCCCO plans to collect the following measurements:

- Track encounter claims and data reported by providers on the THW Minimum Reporting Requirements Template
- Conduct annual THW survey, after obtaining baseline data in 2020. The survey will also incorporate the fields of the THW Minimum Reporting Requirements Template
- Incorporate the THW Minimum Reporting Requirements Template into the contract for Public Health, to ensure proper reporting
- Continue to utilize the evaluations from the CHW training
- Monitor grievance and appeals for any reports of inappropriate use and accessibility of THWs
- Annual reporting to the WCCCO Board related to the THW survey

Utilization of THW Liaison to increase recruitment and retention

WCCCO will identify a THW Liaison to participate in the THW Commission, and certify as a CHW. The THW Liaison will be charged with holding at least annual listening tours in the WCCCO service area to best understand the challenges and success; and to provide support to the THW workforce.

The THW Liaison will also collaborate and be a point of contact for all THWs in the service area. In an effort to retain and build local support, the position will provide billing support, recruitment best practices, implement THW Commission best practices, and help support providers.

Final Report Template

Instructions

Deadline: Please refer to your contract

Contacts:

For questions contact Sankirtana Danner, danners@ohsu
E-mail completed report to Sankirtana Danner danners@ohsu.edu

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Report Information

Grantee name:

Project Title:

Award Type:

Report submitted by:

Phone number for questions:

Email address:

Report Questions

A. Overall project goals (1-2 paragraphs)

B. Results:

1. **Please provide a one to two-page narrative summary of the results of your project (include: objectives, activities, description of how your activities aligned with your metric goals, and a description of your overall results).**

2. **Provide data on your targeted incentive measure(s) and/or other goals using the table below:**

Targeted Metric	Activity Planned	Current Results	
		#of EOCCO Members	*#of Non-EOCCO Members*

EXAMPLE: *AWC visits*	*AWC fair*	*250/450*	*200*

3. **Were there any significant changes to your project team, goals, or activities, including any changes to targeted incentive measures and clinical services outlined in your original proposal? (please explain)**

4. **What challenges or barriers did you experience and how did you address them?**

5. **What were the most important outcomes of your project?**

6. **What have been the most successful and the least successful aspects of your project?**

7. **What one or two stories do you have that capture the impact of this project?** (Such as people/communities the project has helped; lives that have changed; work that led to policy change, such as legislation or regulation; and quality improvement or research breakthroughs)

8. **How has your project affected your organization and your community?**

9. **Was there any media coverage or publications related to this project? If yes, what type (e.g. print, TV, radio, newsletter, website, other)?**

10. **What is the plan for sustaining this project?**

11. **Were there any significant changes to your project budget that have not already been reported? (please explain)**

12. Please complete the budget table below showing how funds for your project were expended compared to your original grant budget.

Personnel								
Name	**Role**	**FTE**	**Salary Originally Requested**	**Benefits Originally Requested**	**Total Originally Requested**	**Actual Spent**	**In-Kind Cash Contribution**	**In-Kind non-cash Contribution**
Equipment and Supplies								
Name of Item	**Description**							
Travel								
Location	**Description**							
Other expenses								
Name of Item	**Description**							
GRAND TOTAL								

2019 LCAC Community Benefit Initiative Reinvestments
Grant Application Review Sheet

Cover Sheet Information

Name of LCAC:

Project Title:

Other Application Details

Agreement to Participate Letters (list organizations):

Write a paragraph describing the proposed project, including goals of the project and incentive measures addressed:

Grant Scoring Table

		Response Scale				
		Strongly Disagree 1	Disagree 2	Neutral 3	Agree 4	Strongly Agree 5
I.	**SIGNIFICANCE**					
I.1	The focus of this project is on an important health problem faced by this community					
I.2	This project focuses on least one EOCCO incentive measure that the county is struggling to meet					
TOTAL SCORE SECTION I						
II.	**APPROACH**					
II.1	The project plan has clearly stated **goals**					
II.2	The proposed **incentive measure(s)** (and CHP goals if present) are appropriately matched to the project's overall goals and proposed activities					
II.3	The proposed **activities** are clear, reasonable, and match the proposed goals.					
II.4	**The proposal describes a feasible and detailed timeline**					
II.5	The proposed **data collection plan** includes a clear baseline, reasonable targets, a clear plan for how data will be collected **(including tracking EOCCO members)**, and matches the proposed activities and CHP goals if present					
II.6	The **budget** is clear, reasonable and appropriate to the work proposed.					
II.7	The **budget** allots at least 30% of funds towards activities to address incentive measures					
II.8	There is an appropriate plan in place to address potential **risks** with the project					
TOTAL SCORE SECTION II						
III.	**COMMUNITY AND STAFF**					

		Strongly Disagree 1	Disagree 2	Neutral 3	Agree 4	Strongly Agree 5
III.1	The proposal describes appropriate and adequate **staffing and support**, with the required skills and experience, to achieve the work and the proposed timeline.					
III.2	The **LCAC and community** have demonstrated a commitment to the topic/population/issue addressed by this project.					
III.3	The project includes the **documented stakeholders** (e.g. organizations and community partners) likely to contribute to its success, **including Letters of Committment**					
TOTAL SCORE SECTION III						
IV.	IMPACT AND SUSTAINABILITY					
IV.1	The project is likely to have a high impact on the health, health care, and costs of care for CCO members and their communities, based on the resources being expended. **(potential ROI)**					
IV.2	The project is likely to be **sustained** and/or replicated in other environments.					
TOTAL SCORE SECTION IV						
TOTAL APPLICATION SCORE						

Overall Grant Feedback

Overall Strengths of the Proposal:
Overall Weaknesses of the Proposal:
Suggestions for Improvements/Technical Assistance Areas:

Reviewer Notes

RFA COMMUNITY ENGAGEMENT PLAN TABLES

Applicants must provide a detailed plan for community engagement according to the required components in the RFA Community Engagement Plan Reference Document, including identified gaps and plans to address gaps. **Applicant's Community Engagement Plan must be no more than 4 pages (according to the RFA spacing and font restrictions), excluding tables. Tables should be completed in the format provided below and submitted with Applicant's Community Engagement Plan (narrative).**

Table 1: Stakeholders to be included in the engagement process			
All applicants must complete this full table. Applicants may add rows as needed.			
Part 1a. List stakeholder types to be included in the engagement process. Applicants must include, at a minimum, plans to engage the following stakeholder types: OHP consumers, community-based organizations that address disparities and the social determinants of health ("SDOH-HE"), providers, including culturally specific providers as available (includes physical, oral, behavioral, providers of long term services and supports, traditional health workers and health care interpreters), Regional Health Equity Coalitions (if present in the service area), early learning hubs, local public health authorities, local mental health authorities, other local government, and tribes. Add additional rows as needed.	**Part 1b.** List specific agencies, organizations and individuals, based on the stakeholder types identified in Part 1.a, with which the applicant will engage. Add additional rows under the stakeholder type as needed.	**Part 1b.** Describe why each listed agency, organization and individual was included.	**Part 1b.** Describe how Applicant plans to develop, maintain or strengthen relationships with each stakeholder and maintain a presence within the community.
OHP consumers (list in first column below)			
Lane County CAC members	None identified	Provides diverse input	Develop engagement and communication with OHP consumers through in person orientation, orientation manuals, a set agenda item for community member input, and an enhanced CCO website with CAC information materials. Include OHP member input on enhancing the CCO website.
OHP member on WCCCO Board of Directors	None identified	Provides diverse input and represents the membership of WCCCO	Identify WCCCO member to sit on the Board of Directors and attend all meetings.

Community-based organizations that address disparities and SDOH-HE (list in first column below)			
Homes for Good	None identified	Develop, plan, and coordinate housing development	Engage organization to develop partnership and host continual meetings
Community Action Agency	None identified	Addresses nutrition, rental assistance, homelessness prevention, low income, energy assistance, and weatherization	Engage organization to develop partnership and host continual meetings
Food for Lane County Food Bank	None identified	Addresses food insecurity	Engage organization to develop partnership and host continual meetings
Ophelia's Place	None identified	After school program that provides education and empowerment to girls ages 10-18 on how to make healthy life choices	Engage organization to develop partnership and host continual meetings
United Way of Lane County	None identified	Supports kindergarten readiness and healthy stable families	Engage organization to develop partnership and host continual meetings
Shelter Care	None identified	Provides housing support services, transitional housing, and life enrichment services for seniors and adults with disabilities	Engage organization to develop partnership and host continual meetings
Cornerstone Community Housing	None identified	Focus on health and wellness, food and nutrition, youth development, adult education, and community building.	Engage organization to develop partnership and host continual meetings
Providers, physical health, including culturally specific providers as available (list in first column below)			
PeaceHealth	Kim Hodgkinson CFO, Cliff Hendargo, System Director Payer Contracts	Partner in healthcare environment	Strengthen relationship and develop continual meetings
McKenzie Willamette Medical Center	Meredith Nelson, CFO	Partner in healthcare environment	Strengthen relationship and develop continual meetings
Lane Independent Primary Providers	Rob Senger, Executive Director	Partner in healthcare environment	Strengthen relationship and develop continual meetings
Bethel Health Clinic	Identify specific provider contact	Partner in healthcare environment	Strengthen relationship and develop continual meetings

Eugene Pediatric Associates	Identify specific provider contact	Partner in healthcare environment	Strengthen relationship and develop continual meetings
Inkwell Medical Group LLC	Identify specific provider contact	Partner in healthcare environment	Strengthen relationship and develop continual meetings
Kernan Family Practice LLC	Identify specific provider contact	Partner in healthcare environment	Strengthen relationship and develop continual meetings
Northwest Naturopathic Medical Clinic PC	Identify specific provider contact	Partner in healthcare environment	Strengthen relationship and develop continual meetings
Oregon Medical Group	Karen Weiner, CEO, Don Costa, CFO	Partner in healthcare environment	Strengthen relationship and develop continual meetings
Pacific Women's Center	Identify specific provider contact	Partner in healthcare environment	Strengthen relationship and develop continual meetings
Praxis Medical Group	Identify specific provider contact	Partner in healthcare environment	Strengthen relationship and develop continual meetings
Quillin Family Medicine LLC	Identify specific provider contact	Partner in healthcare environment	Strengthen relationship and develop continual meetings
River Road Medical Group	Identify specific provider contact	Partner in healthcare environment	Strengthen relationship and develop continual meetings
South Hilyard Clinic	Identify specific provider contact	Partner in healthcare environment	Strengthen relationship and develop continual meetings
Springfield Family Physicians	Identify specific provider contact	Partner in healthcare environment	Strengthen relationship and develop continual meetings
Timber Valley Medical Clinic	Identify specific provider contact	Partner in healthcare environment	Strengthen relationship and develop continual meetings
Wild Rose Medical Clinic PC	Identify specific provider contact	Partner in healthcare environment	Strengthen relationship and develop continual meetings
Willamette Family Inc.	Identify specific provider contact	Partner in healthcare environment	Strengthen relationship and develop continual meetings
Women's Care Associates	Identify specific provider contact	Partner in healthcare environment	Strengthen relationship and develop continual meetings
Community Health Centers of Lane County	Ron Hjelm, Division Manager	Partner in healthcare environment	Strengthen relationship and develop continual meetings
Providers, behavioral health, including culturally specific providers as available (list in first column below)			
Benson Health Clinic	Amber Benson, PMHNP	Partner in healthcare environment	Strengthen relationship and develop continual meetings
Emergence	Identify specific provider contact	Behavioral health provider	Strengthen relationship
South Lane Mental Health	Identify specific provider contact	Behavioral health provider	Strengthen relationship
Bethel Health Clinic	Identify specific provider contact	Behavioral health provider	Develop partnership
Creative Spirit Counseling	Identify specific provider contact	Behavioral health provider	Develop partnership

Direction Service Counseling	Identify specific provider contact	Behavioral health provider	Develop partnership
Eugene Pediatric Associates	Identify specific provider contact	Behavioral health provider	Develop partnership
Eugene Therapy	Marc Zola, LMFT	Behavioral health provider	Strengthen relationship
Oasis Mental Health PC	Identify specific provider contact	Behavioral health provider	Develop partnership
Oregon Psychiatric PA	Identify specific provider contact	Behavioral health provider	Develop partnership
The Child Center	Bill Wellard, Executive Director	Behavioral health, mobile crisis provider	Strengthen relationship
Options Counseling	Identify specific provider contact	Behavioral health provider	Strengthen relationship
White Bird Clinic	Identify specific provider contact	Behavioral health, mobile crisis provider	Develop partnership
Serenity Lane	Mike Dyer, CEO	Behavioral health provider	Strengthen relationship
Providers, oral health, including culturally specific providers as available (list in first column below)			
ODS Community Dental	Nancy Avery	DCO partner and oral health provider	Strengthen existing DCO partnership and develop provider contacts
Providers, long term services and supports, including culturally specific providers as available (list in first column below)			
Avalon Healthcare	Identify contact	Provides long term care services and support	Develop partnership and contract for long term care services
Avamere Health Services	Identify contact	Provides long term care services and support	Develop partnership and contract for long term care services
Creswell Health and Rehabilitation Center	Identify contact	Provides long term care services and support	Develop partnership and contract for long term care services
Providers, traditional health workers, including culturally specific providers as available (list in first column below)			
Moda Health in partnership with OSU	Ann Custer at OSU	CHW training program and reimbursement policy	Strengthen existing partnership with OSU to offer CHW certification training to WCCCO members/clinic staff and expand billing policy
Healthcare Providers	Identify current THWs in practice	Expands local healthcare workforce and connect members to resources	Develop partnership with local healthcare providers and support current THWs through reimbursement and continued training
Providers, health care interpreters (list in first column below)			
Moda Health's contracted interpretation vendor	Passport to Languages	Telephonic and in-person interpreter service personnel	Expand and strengthen existing partnership
Early learning hubs (list in first column below)			
Lane Early Learning Alliance	Identify contact	Provide education and information regarding kindergarten readiness	Develop relationship and engage in decision making regarding kindergarten readiness

Local public health authorities (list in first column below)			
Lane County Public Health	Jocelyn Warren, Division Manager	Support communicable disease control, family planning, HIV services, maternity case management, home visiting, tobacco prevention and education, and WIC	Develop partnership, collaborate, and engage with CAC
Local mental health authorities (list in first column below)			
Lane County Behavioral Health	Pauline Martin, Division Manager	Behavioral health input	Establish regular meetings and partnership
Lane County Health and Human Services	Karen Gaffney, Director Local Public Health Administrator	Behavioral health input	Establish regular meetings and partnerships
Other local government (list in first column below)			
Lane County Commissioner	Pete Sorenson	Provide local county input	Develop relationship and engage
Tribes, if present in the service area (list in first column below)			
Coquille Tribe	Identify contact	Provides diverse input	Develop relationship and engage participation
Confederated Tribes of the Coos, Lower Umpqua and Siuslaw Indians	Identify contact	Provides diverse input	Develop relationship and engage participation
Regional Health Equity Coalitions, if present in the service area (list in first column below)			
No Regional Health Equity Coalition present in service area			

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.
1) Integrate CHWs into the community to create economic opportunities that promote health behaviors	WCCCO in partnership with OSU will offer CHW certification training as well as continued education courses to community members in Lane County. This will increase the local workforce and employ diverse individuals in healthcare settings. We will consult and share decision making with current community health workers that are providing services in Lane County by hosting a shared learning collaborative. We will utilize the THW liaison for support in creating training materials in consultation with the THW Commission. WCCCO will provide technical assistance to clinics to encourage the use of CHWs as well as provide training on WCCCO's billing policy. We are working to expand the current billing policy to include telephonic services.
2) Expand the Veggie RX program to address obesity prevention and food insecurity	WCCCO will share decision-making with the CAC on use of Community Benefit Initiative Reinvestment (CBIR) funds to expand the current Veggie RX program that was piloted by Trillium as well as the Produce Plus Program. We will consult with local farmer's markets regarding participation in the Produce Plus Program. We will develop a Veggie Rx Advisory Council and share decision-making with the Advisory Council, comprised of counties where Veggie Rx is already operating. WCCCO will inform the Oregon Food Bank of food insecurity screenings that are to take place and potentially increase referrals to food banks. We will also inform community gardens about the opportunities to participate in these efforts through in-person conversations. Additionally we plan to offer the Diabetes Prevention Program as well as Living Well Classes regarding other chronic diseases related to obesity.
3) Access to tobacco cessation health coaching	WCCCO will inform its members of the in house tobacco cessation health coaching that is available. The health coaching will be on a referral basis, which will be triaged after the health risk assessment (HRA) is sent out with new welcome packets. WCCCO will proactively screen HRAs to identify new members who could benefit from the program.
4) Implement an online pain school to address substance abuse and access to alternative treatment options for chronic pain	Inform the community of the online pain school initiative to expand access to alternative pain management services. Each pain school cohort will consist of four, 90 minute sessions. The sessions will include a pain education component, cognitive behavioral therapy, and movement therapy. Participants will be required to complete both pre and post-test screenings that include self-reported physical and behavior changes. This data will be used to involve participant feedback in the delivery of services.
5) Provide member level data and support to clinic partners to address health equity and quality improvement	WCCCO will provide progress reports on a monthly basis to the entire primary care provider network. These reports will include member rosters with each clinic's patient population including demographic data. The reports will also include data on each claims based incentive measure as well as gap in care rosters. We will inform providers about the structure of these reports and technical assistance available to them in using the data. WCCCO will consult with each clinic to ensure that we optimize the progress reports to the clinic's need. We will also keep the CAC informed of this activity and offer to provide summary information to them
*	
1. **Inform**: Provide the community with information to assist in their understanding of the issue, opportunities, and solutions. Tools include fact sheets, published reports,	

media releases, education programs, social media, email, radio, information posted on websites, and informational meetings.

2. **Consult**: Obtain community feedback on analysis, alternatives, and/or decisions. Tools include issue briefs, discussion papers, focus groups, surveys, public meetings, and listening sessions.
3. **Involve**: Work directly with the community throughout the process to ensure that community concerns and aspirations are understood and considered. Applicant provides feedback to the community describing how the community input influenced the decision. Tools include meetings with key stakeholders, workshops, subject matter expert and stakeholder roundtables, conferences, and task forces.
4. **Collaborate**: Partner with the community in each aspect of the process, including decision points, the development of alternatives and the identification of a solution. Tools include advisory committees, consensus building, and participatory decision making.
5. **Shared decision-making**: To place the decision-making in the hands of the community (delegate) or support the actions of community initiated, driven and/or led processes (community driven/led). Tools include delegated decisions to members of the communities impacted through steering committees, policy councils, strategy groups, Community supported processes, advisory bodies, and roles and funding for community organizations.

Table 3: Engagement with other agencies in the service area that have responsibility for developing community health assessments and community health improvement plans					
All applicants must complete this full table. Applicants may add rows as needed.					
Part 1. Applicants with an existing CCO CHA and CHP will submit their most recent CHA and CHP with the community engagement plan.					
Part 2. List of all local public health authorities, non-profit hospitals, other CCOs that share a portion of the service area, and any federally recognized tribe in the service area that is developing or has a CHA/CHP. Add additional rows as needed.	**Part 3.** The extent to which each organization was involved in the development of the Applicant's current CHA and CHP. Answers***** must be a) competition and cooperation, b) coordination, c) collaboration, or d) not applicable (NA).******	**Part 4.** For any organization that is a collaborator for a shared CHA and shared CHP priorities and strategies, the applicant will list the shared priorities and strategies.******	**Part 5.** For any organization that is not a collaborator for a shared CHA and shared CHP priorities and strategies, the applicant will describe the current state of the relationship between the applicant and the organization(s), including gaps.	**Part 6.** For any organization that is not a collaborator for a shared CHA and shared CHP priorities and strategies, the applicant will describe the steps the applicant will take to address gaps prior to developing the next CHA and CHP, and the dates by which the applicant will complete key tasks.*******	**Part 7.** Applicants **without an existing CHA and CHP or that intend to change their service area** will demonstrate that they have reviewed CHAs and CHPs developed by these other organizations. List the health priorities from existing plans.
Local public health authorities (list in this column below)					
Lane County Public Health	NA	NA	Establish partnership	By March 31, 2020 we will establish a contact and begin partnership with the local public health authorities to collaborate on CHP priorities and strategies	Current: increase economic and social opportunities that promote healthy behaviors through investing in workforce strategies that provide sustainable family wage jobs; encourage a range of safe and affordable housing opportunities; assure availability of affordable healthy food and beverages in every community. Increase healthy behaviors to improve health and well-being through implementation of

					programs to promote positive early childhood development and safe/nurturing environments; support implementation of evidence-based preventative screening and referral policies and services by physical, behavioral, and oral healthcare and social service providers. Strengthen cross sector collaborations and align resources to improve physical, behavioral, and oral health well-being of communities; and encourage organizations across multiple sectors to integrate health criteria into decision making as appropriate. Prior: Health equity, tobacco, obesity, substance abuse and behavioral health, and access to health care.

Non-profit hospitals (list in this column below)					
PeaceHealth Sacred Heart Medical Center at RiverBend	NA	NA	Commercial line of business contracted provider	By March 31, 2020 we will expand our partnership with the hospital to collaborate on CHP priorities and strategies	Ensure effective information exchange and care coordination for children and adults who receive Medicaid and have particularly complex health psychosocial conditions; increase participation in employee wellness program particularly for caregivers at the lower end of the compensation scale; recruit for and support a workforce that reflect changing ethnic, racial, and cultural diversity of the communities served; develop a CHW initiative to empower members of the community to be a liaison between health, social services, and the community to improve the quality and cultural competence of service delivery; increase access to outpatient and residential mental health treatment programs through expanded public health programs and services through primary care integration; promote positive early childhood development and safe nurturing environments;

					increase number of SBHCs in Lane County; and expand safe housing inpatient hospital to home transition options for at risk populations.
PeaceHealth Sacred Heart Medical Center University District	NA	NA	Commercial line of business contracted provider	By March 31, 2020 we will expand our partnership with the hospital to collaborate on CHP priorities and strategies	Bridge gap between primary care and BH office visits and patient management of chronic conditions; reduce rate of new HIV infections; support needle exchange program; train and employ CHWs in behavioral health; increase access to Palliative Care; expand Medical Recuperation Program to place discharged patients in safe housing; partner in Lane County Supportive Housing Grants and development; and expand Courageous Kids Grief support program to decrease isolation, acting out behaviors, sleep and anxiety disorders in children who have experienced death of someone they love.
McKenzie-Willamette Medical Center	NA	NA	Commercial line of business contracted provider	By March 31, 2020 we will expand our partnership with the hospital to collaborate on CHP priorities and strategies	Although McKenzie-Willamette Medical Center is for profit the hospital did contribute to Lane County Regional CHP: increase economic and social opportunities that promote healthy

					behaviors through investing in workforce strategies that provide sustainable family wage jobs; encourage a range of safe and affordable housing opportunities; assure availability of affordable healthy food and beverages in every community. Increase healthy behaviors to improve health and well-being through implementation of programs to promote positive early childhood development and safe/nurturing environments; support implementation of evidence-based preventative screening and referral policies and services by physical, behavioral, and oral healthcare and social service providers. Strengthen cross sector collaborations and align resources to improve physical, behavioral, and oral health well-being of communities; and encourage organizations across multiple sectors to integrate health criteria into decision making as appropriate.

PeaceHealth Peace Harbor Medical Center Florence	NA	NA	Commercial line of business contracted provider	By March 31, 2020 we will expand our partnership with the hospital to collaborate on CHP priorities and strategies	Ensure effective information exchange and care coordination for children and adults who receive Medicaid and have particularly complex health psychosocial conditions; increase participation in employee wellness program particularly for caregivers at the lower end of the compensation scale; recruit for and support a workforce that reflect changing ethnic, racial, and cultural diversity of the communities served; develop a CHW/Community Paramedic initiative that empowers members of the community to be a liaison between health, social services, and the community to improve the quality and cultural competence of service delivery; increase access to outpatient and residential mental health treatment programs through expanded public health programs and services partnerships, telemedicine, and primary care integration; increase Early Pathway and Home-Based Behavioral Health resources; expand safe

					housing options for adults with SPMI; and increase availability of school based primary care and behavioral health services; increase availability of public transportation to facilitate and support individual and community health needs by partnering with regional transportation agencies and specialties; and increase access to primary care.
PeaceHealth Cottage Grove Community Medical Center	NA	NA	Commercial line of business contracted provider	By March 31, 2020 we will expand our partnership with the hospital to collaborate on CHP priorities and strategies	Ensure effective information exchange and care coordination for children and adults who receive Medicaid and have particularly complex health psychosocial conditions; increase participation in employee wellness program particularly for caregivers at the lower end of the compensation scale; recruit for and support a workforce that reflect changing ethnic, racial, and cultural diversity of the communities served; develop a CHW initiative to empower members of the community to be a liaison between health, social services, and the community to improve the quality and cultural

					competence of service delivery; partner with local agencies to ensure ongoing availability and expansion of lactation and weigh checks of babies and childhood immunizations; develop a robust SBHC at Cottage Grove High School; and increase access to outpatient and residential mental health treatment programs through expanded public health programs and services partnerships, telemedicine, and primary care integration.
Current coordinated care organizations, as of 2019 (list in this column below)					
Trillium Community Health Plan	NA	NA	None	None	Current: increase economic and social opportunities that promote healthy behaviors, increase healthy behaviors to improve health and wellbeing. Prior: Health equity, tobacco, obesity, substance abuse and behavioral health, and access to health care.

Federally recognized tribes that have or are developing a CHA/CHP (list in this column below)					
Confederated Tribes of the Coos, Lower Umpqua and Siuslaw Indians	NA	NA	Establish partnership	By March 31, 2020 we will establish a contact to involve in the CAC and the CHP progress reports	Not currently involved in the CHA or CHP
Coquille Tribe	NA	NA	Establish partnership	By March 31, 2020 we will establish a contact to involve in the CAC and the CHP progress reports	Not currently involved in the CHA or CHP

*****

a) Competition and Cooperation: Loose connections and low trust; tacit information sharing; ad hoc communication flows; independent goals; adapting to each other or accommodating others' actions and goals; power remains with each organization; resources remain with each organization; commitment and accountability only to own organization; relational time frame short; low risk and reward.

b) Coordination: Medium connections and work-based trust; structured communication flows and formalized project-based information sharing; joint policies, programs and aligned resources; semi-interdependent goals; power remains with parent organizations; commitment and accountability to parent organization and project; relational time frame medium and based on prior projects; medium risk and reward.

c) Collaboration: Dense interdependent connections and high trust; frequent communication; tactical information sharing; systems change; pooled and collective resources; negotiated shared goals; power is shared between organizations; commitment and accountability to network first, community and parent organization; relation time frame long (3 years or more); high risk and reward.

d) Not applicable

******If the applicant does not have a current CHA and CHP, the applicant will enter not applicable (NA).

*******Engagement activities must begin by March 31, 2020 and applicant will report on progress through the June 2020 CCO CHP progress report.

Table 4: Engagement with social determinants of health and health equity (SDOH-HE) partners for CHA and CHPs Applicants may add rows as needed.					
All applicants must complete Part 1.	**Applicants <u>with an existing CHA and CHP</u> must complete Parts 2, 3 and 4. Applicants <u>that intend to change their service area</u> must also complete Parts 2, 3, and 4.**			**Applicants <u>without an existing CHA and CHP or that intend to change their service area</u> must complete Parts 2a and 4a.**	
Part 1. List of organizations that address the social determinants of health and health equity in the applicant's service area. Add additional rows as needed.	**Part 2.** Applicants **with an existing CHA and CHP** will describe existing partnerships with each identified organization, including whether the organization contributed to the applicant's current CHA and CHP.	**Part 3.** Applicants **with an existing CHA and CHP** will describe gaps in existing relationships with identified organizations.	**Part 4.** Applicants **with an existing CHA and CHP** will describe the steps the applicant will take to address the identified gaps prior to developing the next CHA and CHP and the dates by which the applicant will complete key tasks for engagement.**	**Part 2a.** Applicants **without an existing CHA and CHP or that intend to change their service area** will demonstrate that they have reviewed community partnerships in place for other LPHA/non-profit hospital/tribal/CCO CHAs and CHPs in the service area. For each organization listed in Part 1, the applicant will document the organization's level of involvement in developing any other CHAs or CHPs by entering one of these responses: a) The organization was explicitly involved in developing one or more CHAs or CHPs; b) The organization was not explicitly involved in developing a CHA or CHP; c) unknown.	**Part 4a.** Applicants **without an existing CHA and CHP or that intend to change their service area** will demonstrate that they have reviewed community partnerships in place for other LPHA/non-profit hospital/tribal/CCO CHAs and CHPs in the service area by describing the steps the applicant will take to form relationships and secure participation by each organization prior to developing the first or next CHA and CHP, and the dates by which the applicant will complete key tasks for engagement.**

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.					
Confederated Tribes of the Coos, Lower Umpqua and Siuslaw Indians				Unknown	Reach out to partner to describe intent of relationship in Q4 2019. Engage in a meeting with partner to establish a plan for partnership by December 31, 2019. Confirm partnership plan by March 31, 2020.
Coquille Tribe				Unknown	Reach out to partner to describe intent of relationship in Q4 2019. Engage in a meeting with partner to establish a plan for partnership by December 31, 2019. Confirm partnership plan by March 31, 2020.
All regional health equity coalitions (RHECs) that are present in the service area (list in this column below). If no RHEC is present in the service area, note there are none.					
None in Lane County				NA	NA

Local government, including counties					
Board of County Commissioners				The organization was explicitly involved in developing one or more CHAs or CHPs	Reach out to partner to describe intent of relationship in Q4 2019. Engage in a meeting with partner to establish a plan for partnership by December 31, 2019. Confirm partnership plan by March 31, 2020.
City of Creswell				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
City of Eugene				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

City of Florence				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
City of Oakridge				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
City of Springfield				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify

					key stakeholders by March 31, 2020.
City of Veneta				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Community Health Centers of Lane County				The organization was explicitly involved in developing one or more CHAs or CHPs	Reach out to partner to describe intent of relationship in Q4 2019. Engage in a meeting with partner to establish a plan for partnership by December 31, 2019. Confirm partnership plan by March 31, 2020.
Eugene City Council				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

Lane Council of Governments (LCOG)				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Lane County Behavioral Health				The organization was explicitly involved in developing one or more CHAs or CHPs	Reach out to partner to describe intent of relationship in Q4 2019. Engage in a meeting with partner to establish a plan for partnership by December 31, 2019. Confirm partnership plan by March 31, 2020.
Lane County Government				The organization was explicitly involved in developing one or more CHAs or CHPs	Reach out to partner to describe intent of relationship in Q4 2019. Engage in a meeting with partner to establish a plan for partnership by December 31, 2019. Confirm partnership plan by March 31, 2020.

Lane County Health & Human Services				The organization was explicitly involved in developing one or more CHAs or CHPs	Reach out to partner to describe intent of relationship in Q4 2019. Engage in a meeting with partner to establish a plan for partnership by December 31, 2019. Confirm partnership plan by March 31, 2020.
Lane County Maternal and Child Health Programs				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Lane County Public Health				The organization was explicitly involved in developing one or more CHAs or CHPs	Reach out to partner to describe intent of relationship in Q4 2019. Engage in a meeting with partner to establish a plan for partnership by December 31, 2019. Confirm partnership plan by March 31, 2020.

Organizations that address the four key domains of social determinants of health* (list in this column below).					
Eugene Chamber of Commerce				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Lane County Economic Development				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

Lane Workforce Partnership				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Neighborhood Economic Development Corp. (NEDCO)				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

Upper Willamette Community Development Corporation				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
WorkSource Lane				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

4J Eugene School District				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Bethel School District				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

Creswell School District				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Early Childhood CARES				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

Early Learning Alliance				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Head Start of Lane County				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

Junction City School District				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Lane Community College				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

Lane Community College Health Professions Division				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Northwest Christian University				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

Northwest Youth Corps				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Oregon Health and Science University				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

Oregon State University Extension				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Siuslaw School District				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

South Lane School District				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Springfield Public Schools				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

University of Oregon				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Wilagillespie Elementary School				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Cornerstone Community Housing				The organization was explicitly involved in developing one or more CHAs or CHPs	Reach out to partner to describe intent of relationship in Q4 2019. Engage in a meeting with partner to establish a plan for partnership by December 31, 2019. Confirm partnership plan by March 31, 2020.

Housing and Community Services Agency (HACSA)				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Housing Policy Board				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

Lane County Land Use Planning & Zoning				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Oregon Housing and Community Services				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

Oregon Housing Alliance				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Springfield/Eugene Habitat for Humanity				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

Viridian Management				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Windermere				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

211 Info				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
90by30				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

A Community Together				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Bethel Family Center				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

Brattain House Community Family Center				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
City of Eugene Adaptive Recreation				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

City of Eugene Senior Services				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
City of Eugene: Recreation Services				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

Coaching Parents				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Cottage Grove Family Resource Center				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

Court Appointed Special Advocates (CASA)				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Daisy CHAIN Mothering				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

Department of Human Services				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Eugene Civic Alliance				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

Eugene Family YMCA				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Eugene Public Library				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

Family Forward Oregon				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Family Relief Nursery				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

Fern Ridge Community Dinner				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
FOOD for Lane County				The organization was explicitly involved in developing one or more CHAs or CHPs	Reach out to partner to describe intent of relationship in Q4 2019. Engage in a meeting with partner to establish a plan for partnership by December 31, 2019. Confirm partnership plan by March 31, 2020.
Goodwill Industries				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

HealthFirst Financial				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Healthy Moves				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

Hearing Loss Association of America				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Huerto de la Familia (The Family Garden)				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

Institute for Patient- and Family-Centered Care				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Kids' FIRST Center				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

Lane County Commission for the Advancement of Human Rights				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Lane Independent Living Alliance (LILA)				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

Lane Workforce Partnership				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
League of United Latin American Citizens				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

Marcola Family Resource Center				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Mohawk-McKenzie Grange				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

NAACP - Eugene/Springfield Oregon				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Oakridge Family Resource Center				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

Oakridge Kiwanis Club				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Oregon Food Bank				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

Oregonians for Gambling Awareness Organization				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Parent Partnership Comprehensive Programs				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

Parenting Now!				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Pearl Buck Center				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

Pilas! Family Literacy Program				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Planned Parenthood REVolution				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

Relief Nursery				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
School Garden Project of Lane County				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

Senior and Disability Services				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
ShelterCare				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

South Lane Family Resource Center				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Springfield Public Library				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

St. Vincent de Paul				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Stand For Children				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

Sustainable Cottage Grove				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
United Way of Lane County				The organization was explicitly involved in developing one or more CHAs or CHPs	Reach out to partner to describe intent of relationship in Q4 2019. Engage in a meeting with partner to establish a plan for partnership by December 31, 2019. Confirm partnership plan by March 31, 2020.
Walterville Grange				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

Willamalane Park and Recreation District				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Willamette Farm and Food Coalition				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

WomenSpace				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Youth MOVE Oregon				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Traditional Health Workers (THWs) affiliated with organizations listed in OAR 410-141-3145 (list in this column).					
Oregon State University				The organization was not explicitly involved in developing a CHA or CHP	Reach out to OSU about offering CHW training to WCCCO member/clinic staff by March 31, 2020.

Culturally specific organizations and organizations that work with underserved or at- risk populations (list in this column below).					
Centro Latino Americano				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Downtown Languages				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

Looking Glass Community Services				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Ophelia's Place				The organization was explicitly involved in developing one or more CHAs or CHPs	Reach out to partner to describe intent of relationship in Q4 2019. Engage in a meeting with partner to establish a plan for partnership by December 31, 2019. Confirm partnership plan by March 31, 2020.
Lane County Cultural Coalition				The organization was not explicitly involved in developing a CHA or CHP	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.

CrossCultural Now				The organization was explicitly involved in developing one or more CHAs or CHPs	Organization is involved in the current Live Healthy Lane CHP. WCCCO plans to partner with Live Healthy Lane to serve as the Community Health Plan and collaborate with partners on improvement projects that support WCCCO initiatives. We will also work with the WCCCO CAC to identify key stakeholders by March 31, 2020.
Other organizations (list in this column					
***The four key domains of social determinants of health are economic stability, education, neighborhood and built environment, and social and community health.					
****Engagement activities **must** begin by March 31, 2020 and applicant will report on progress through the June 2020 CCO CHP progress report.					

Table 5: Assessment of existing social determinants of health priorities and process to select Year 1 social determinants of health priorities		
All applicants must complete this full table to describe how the applicant will identify social determinants of health ("SDOH-HE") priorities to meet the CCO SDOH-HE spending requirements. Housing must be included as one of the SDOH-HE spending priorities.		
Part 1. List of existing SDOH-HE CHP priorities* in applicant's proposed service area from its own CHP or other existing CCO, local hospital, local public health authority and/or tribal CHPs, if applicable. Add additional rows as needed.	**Part 1a.** Source for priority (i.e. which CHP it came from).	**Part 1b.** Whether priority describes a health outcome goal (i.e. addressing food insecurity to address obesity as a health issue) **or** priority populations (i.e. addressing early childhood education for children as a priority population) **or** other.
Support economic development and workforce investments	CCO CHP; Lane County Public Health CHP	Health outcome goal to provide sustainable family wage jobs in the community.
Affordable housing opportunities and development of integrated and supportive housing	CCO CHP; Lane County Public Health CHP; PeaceHealth CHA	Health outcome goal to improve housing opportunities.
Healthy food and beverages	CCO CHP; Lane County Public Health CHP	Health outcome goal to provide fresh fruits and vegetables to the community and improve the infrastructure of products processed in the community.
Promote positive early childhood development and safe/nurturing environments	CCO CHP; Lane County Public Health CHP; PeaceHealth CHA	Priority populations to support expand services available to children in early childhood.
Implement evidence based preventative screenings and referral policies by physical, behavioral, and oral health care and social service providers	CCO CHP; Lane County Public Health CHP	Other – to increase access to integrated healthcare and preventative screenings with access to additional resources if indicated as a need.
Develop a CHW initiative to empower members of the community to be a liaison between health, social services, and the community	PeaceHealth CHA	Health outcome goal to improve the quality and cultural competence within the service delivery of healthcare.
Increase access to behavioral health services	PeaceHealth CHA	Priority populations – Increase access to outpatient and residential mental health treatment programs through expanded public health programs and services through primary care integration.

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.
WCCCO Process to Identify and Vet SDOH-HE Priorities: **July – August 2019:** **(Notice of Intent to Award – July 2019)** Implementation activities related to CAC structure for WCCCO Review updated CHA/CHP from existing CAC efforts associated with current CCO including SDOH-HE priorities **August – September 2019:** Continue recruiting and developing CAC structure for WCCCO Conduct outreach to new partners and stakeholders representing underserved populations; use a modified focus group method similar to our protocol in EOCCO to identify new or emerging SDOH-HE needs that have not yet been identified **September – October 2019:** Finalize CAC structure and formal documents/charters Complete focus groups with underserved populations/service providers working with these populations Reach out to housing authority and community action agencies regarding CAC engagement **November – December 2019**: Compile findings from stakeholder process Refresh and augment data from existing CHA/CHP in areas related to SDOH-HE **January – February 2020:** Include housing topic on CAC agenda; engage Homes for Good and Community Action Agencies in meetings Consult with CAC on SDOH-HE priorities **March – April 2020:** March 15 – submit SDOH-HE priorities per OHA guidance
*****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.

WCCCO Community Engagement Plan

1.0 General component:

WCCCO is committed to involving stakeholders in the engagement process in order to ensure that community values, customs, and needs are represented, involved, and embedded. As a new CCO we will focus on collaboration and outreach to OHP members, local government, healthcare providers, and community-based organizations to understand the continually changing needs of our members. We will formalize our community engagement by creating and supporting infrastructure for the Community Advisory Council (CAC) serving Lane County and oversight of the CHA and CHP.

WCCCO will engage multidisciplinary stakeholders including OHP consumers, community based organizations that address SDOH-HE, physical, behavioral, and oral health care providers, traditional health workers, healthcare interpreters, long term services and supports, early learning hub, local public health department, local mental health authorities, local government, and tribes within the Lane County service area. The specific organizations are outlined in Table 1. This engagement will not only be crucial in the delivery of services but also in addressing the SDOH-HE needs of our members.

WCCCO plans to engage OHP consumers in the CAC by comprising half of the membership as well as by encouraging participation in each meeting. WCCCO will also appoint an OHP consumer to sit on the Board of Directors to provide diverse input. Additionally, we plan to support a consumer caucus comprised of people with lived experience. WCCCO has identified community-based organizations that address disparities and SDOH-HE needs such as food insecurity, housing, childcare, education, and kindergarten readiness. WCCCO plans to develop a relationship with each organization and hold continual SDOH-HE meetings.

WCCCO has been actively meeting with local providers and community groups to identify opportunities for collaboration and growth. Those providers as well as other identified physical and behavioral health providers are listed in Table 1. We plan to expand our partnerships with those who we have been working with as well as develop new partnerships with additional providers. We will work with them through continual meetings at their practice as well as shared learning opportunities such as the clinician summit. WCCCO's primary equity partner, Moda has a strong partnership with ODS Community Dental which we plan to strengthen in the Lane County service area. We will also develop partnerships with the other DCOs in Lane County and identify a contact who we can meet with on a continual basis.

WCCCO sees the value in employing THWs and plans to identify current THWs in the Lane County service area to work with. WCCCO will also offer a CHW certification training to any community members or clinic staff who would like to participate. We will continue to strengthen our relationship with all THWs across our service area. Lastly, WCCCO has also identified stakeholders from the local early learning hub, long term services, public health department, mental health authorities, government, and tribes that we plan to develop partnerships with to provide community engagement support. We plan to develop relationships with each organization and host continual meetings.

WCCCO plans to engage the community through five different projects that focus on health priorities outlined in previous CHPs in Lane County. We plan to integrate CHWs into the

community to create economic opportunities for local individuals as well as serve as a health resource to members. The level of community engagement for the CHW project will include informing the community of the training certification opportunities as well as consulting and shared decision-making with current CHWs. In an effort to address food insecurity and obesity prevention, we plan to expand on the current Veggie Rx program in Lane County. We plan to share decision making with the CAC and involve the organizations who participated in the Veggie Rx pilot project. Based on Lane County's high cigarette prevalence rate, WCCCO will improve access to tobacco cessation by offering health coaching to individuals who use tobacco. WCCCO will inform its members of the available service. In order to address substance abuse and alternative treatment options for chronic pain, WCCCO will implement an online pain school. WCCCO will inform the community of this opportunity as well as utilize pre/post-test screenings to involve participant feedback. Lastly, WCCCO will provide member level data and support to clinic partners to address health equity and quality improvement. We will inform providers of these reports and consult each clinic to ensure optimization.

The WCCCO process for gathering input from CAC and non-CAC members (healthcare providers, other community partners, broader community) will be standardized through CAC policies and by-laws. We believe true transparency is essential to health system transformation. All CAC and CAC subcommittee meetings will be open to the public and dates, times, locations of meetings, past meeting minutes, current CHA and CHP documents will be published on the WCCCO website. One representative from the CAC will also be a member of the WCCCO Board of Directors and represent the "voice" of the CAC. This CAC members will be an OHP consumer or parent/guardian of an OHP consumer. The CAC will also provide representation and formal input to the Board of Directors through an Annual Report (submitted yearly in June), which will highlight positive efforts within the WCCCO region as well as areas and recommendations for improvement. The Annual Report, presented by the delegated CAC member, will help influence policy changes and guide adjustments to how OHP resources/services are implemented.

WCCCO believes consumer input is vital to meeting the Triple Aim, ensuring health equity, and driving meaningful change. This requires targeted engagement strategies designed to remove participation barriers and increase member understanding of health system transformation. Our Consumer Caucus will act as an advisory group providing feedback regarding proposed new programs, changes within the delivery system, or ideas for improvement. Formal complaints and appeals collected from WCCCO will be summarized and reported annually to the CAC. This exchange of information will ensure that any changes in WCCCO workflows will be effectively vetted and communicated to the CAC and ultimately shared with our community partners and OHP consumers on a regular basis.

WCCCO will employ qualified, trusted local members of the WCCCO team to provide "boots on the ground" engagement within the community on a regular basis. The CAC will engage community partners by sharing local, regional and statewide health trend data, helping to inform service needs and barriers to quality care in their community. To maintain consistency and continuity of CAC membership (including OHP membership) and meetings, the CAC will initially be allocated $10,000 annually to support a CAC coordinator dedicated to overseeing the day to day functioning of the CAC and recruitment of OHP consumers. Additionally, OHP consumers participating in CAC meetings will be offered a monthly $35 stipend, including

mileage reimbursement and childcare, as an incentive to reduce the barrier of CAC attendance. When transformation or quality pool bonus dollars become available to WCCCO, additional funding can be made available to support CAC-driven initiatives, similar to the EOCCO model of CAC program funding. WCCCO values the diversity of its consumer members and understands the importance of equity, therefore all of the meeting spaces will be accessible to individuals with disabilities and accommodate language needs. CAC orientation sessions have been developed to provide appropriate literacy level information to help consumers understand the organization and operations of the WCCCO.

WCCCO's quality improvement process operates on multiple levels; at the community level through the CACs, at the provider level through data support and at the CCO level through funding opportunities. Member level data as well as incentive measure improvement targets and rates will be shared with clinic staff. WCCCO's designated quality improvement staff will discuss these reports and identify areas of improvement with each clinic biannually. Regional incentive measure performance will also be shared with CAC members and CCO level staff to facilitate improvement. One of the yearly directives tasked to the CAC will be to establish and/or review the CHP based on information from local data sources (i.e. Hospital Community Health Assessment, Public Health Needs Assessment, CCO Community Health Assessment) and community partner or member input. WCCCO will also assign Community Benefit Initiative Reinvestment (CBIR) funds to each CAC to support programs in alignment with the communities CHP and/or CCO Incentive Measures. A less formal quality improvement approach is to establish time during the CAC meetings to address OHP consumer concerns. These concerns, if not resolved locally in collaboration with community partners, will be elevated and will be included in the Annual Report to the WCCCO Board of Directors.

2.0 CAC component:

The WCCCO service area includes Lane County which has a total population size of 374,748 and covers roughly 4,722 square miles. WCCCO will establish a CAC which will meet on a monthly basis and alternate between different towns within the region. The CAC will have a representative that sits on the Board of Directors as a voting member. The CAC members are intended to represent the diversity of their community, including race/ethnicity, age, gender identity, sexual orientation, socio-economic and geographic location. A charter will govern the CAC. Our model in Eastern Oregon will be used as a template, and will include the following language:

"…to the greatest extent possible, membership should reflect individuals or agencies representing the; healthcare provider community (for example a physician, nurse, dentist, etc.); social service agencies including DHS, hospice, local school districts; public health services; publicly funded mental health and substance use treatment; someone representing county government and general community members. For Medicaid members we have age/ gender, zip code (geography) and preferred language."

The recruitment/retention strategies for the CAC will include dedicated WCCCO staff working locally to recruit local healthcare partners (physical, mental and oral), service agencies, early learning partners, OHP consumers and other community partners who service the OHP population. The CAC will devise strategies to incorporate OHP consumers into the CAC and manage meaningful engagement of all community partners. Some of these strategies include the

following: 1) Provide visual displays, public promotion and use of social media to engage membership and understanding of the CAC, 2) development of OHP consumer subcommittees to discuss service/resource issues in each community, 3) alternating meeting schedules to accommodate all CAC members and 4) alternating locations to allow for a more diverse approach to outreach (i.e. input from outlying communities in a rural, underserved area). These approaches have been used in our other service areas such as EOCCO to allow greater opportunity for CAC members to contribute and stay engaged in the CHP prioritization process, input of services/resources, funding discussions for CBIR funds and other tasks as required by the CCO and OHA.

At least one CAC representative, of whom is an OHP consumer, will serve on the WCCCO Board of Directors. We will partner the CAC member who is an OHP consumer with a fellow CAC member to act as a mentor. This partnership will allow for a more succinct understanding of health system transformation and the CCO model, promoting empowerment for OHP consumer members through this process. We will make efforts to include tribal representation from the two federally recognized tribes in Lane County, the Coquille Tribe and the Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians.

WCCCO will ensure collaboration between CACs if there are multiple CCOs covering the region. This will be formally structured through the CAC charter and through joint efforts related to data and information sharing, and collaboration in the development of the CHA and CHP.

3.0 Description of CHA/CHP component:

WCCCO plans to serve Lane County and will submit the CHA and CHP to OHA by June 30, 2021. We will collaborate with a wide variety of partners outlined in the Community Engagement Tables to help us complete these projects. WCCCO will allocate 6% of each year's quality pool funding to the CACs. The CAC will receive these funds in the form of Community Benefit Initiative Reinvestments on an annual basis. The CAC will then be required to use 60-70% of these funds on projects that connect to their CHP. The CAC members will choose what projects to fund and how much funding to put towards each one. The CACs are then required to write up a summary plan which is submitted for feedback and approval. Additionally the CAC will be informed of the health related services request form that members and community organizations are able to utilize to request additional funds for specific projects or member needs.

eocco EASTERN OREGON COORDINATED CARE ORGANIZATION		**Policy & Procedure**			
Company:	EOCCO	**Department Name:**		EOCCO Quality Improvement Committee	
Subject:	Interpreter Services for Non-English Speaking Members				
P & P Original Effective Date:	9/2012	**P &P Origination Date:**	**9/2012**	**P & P Published Date:**	**04/2015**
P & P Revision Effective Date:	8/12/16; 10/13/17	**P & P Revision Published Date:**		8/12/16; 10/13/17; 10/12/18	
Reference Number:	CCO-12	**Next Annual Review Date:**		10/2019	
Division:					

State (select all boxes applicable to this policy)

☐ Alaska ☒Oregon

Product (check all boxes applicable to this policy)

☒Dental ☒ Medical ☐ Pharmacy ☒ Behavior Health

Type of Business (check all boxes applicable to this policy)

☒EOCCO ☒ OHP

I. Policy Statement and Purpose

Eastern Oregon Coordinated Care Organization (EOCCO) and its subcontractors provide access to qualified interpreters for non-English speaking members when communicating telephonically or in-person with respective staff and to on-site interpreter services for member appointments at no charge to the member. EOCCO and its subcontractors translate required written material into the prevalent non-English languages identified in its CCO enrollment.

II. Definitions

A. Prevalent non-English language – all non-English languages that are identified as the preferred written language by the lesser of either 5% of a CCO's total OHP enrollment or 1,000 of the CCO's members.

B. Participating Provider – any practitioner that provides medical, behavioral health or dental services to EOCCO members.

C. Subcontractor – Any individual, partner, entity, facility or organization that has entered into a subcontract or administrative services agreement with EOCCO, or one of its partner organizations, for any portion of work under EOCCO's contract with OHA.

III. Procedures

A. Telephonic or in-person Interpreter Services at the CCO or subcontractor locations:

1. Qualified interpreters are available to communicate in the primary language of non-English speaking members. Such interpreters are linguistically appropriate and are capable of communicating in English and the primary language of the member and are able to translate clinical information effectively.
2. Through respective business agreements with multilingual and multicultural language services agencies, Moda Health, GOBHI and DCOs provide telephonic interpreter services during regular business hours. When a member calls Member Services and requires language assistance, the Member Service representative will access the interpreter services agency where a language service representative will assist in the call to optimize communication.
3. EOCCO and subcontractors also may have Member Services representatives who are bi-lingual and able to translate clinical information effectively.

B. Person-to-Person Interpreter Services at the Provider's Office:
   1. EOCCO and its subcontractors have respective contracted person-to-person interpreter services for on-site provider office visits for members whose preferred language is other than English. The provider's office calls customer service at Moda Health, GOBHI or the DCO to schedule an interpreter at the provider's office. In some cases, the provider can call the language service agency directly to schedule an interpreter.

   2. Provider offices may also have employees who are able to provide linguistically appropriate interpretation during an office visit. These employees are capable of communicating in English and the primary language of the member and are able to translate clinical information. While not a requirement for employees, EOCCO supports the completion of state medical interpreter qualification or certification exams.

C. Translated Written Materials:
   1. EOCCO and its subcontractors translate written material into the prevalent non-English languages identified in the CCO enrollment. Practitioner directories remain in English as names, numbers, streets, cities, etc., are frequently either learned or referred to in English.

      Monthly, EOCCO and its subcontractors monitor the number of prevalent non-English languages in their enrollment to determine the languages that meet the criteria for translation of written material. EOCCO and its subcontractors contract respectively with multilingual and multicultural language services agencies to translate written material.

   2. In the event EOCCO and its subcontractors receive member correspondence, such as general correspondence, appeals and complaints, written in the member's primary language that is not English, EOCCO and its subcontractors will respond accordingly in the member's primary language by accessing their contracted multilingual and multicultural language services agencies for translation.

IV. Communicating the Availability of Interpreter Services

EOCCO and subcontractor member handbooks and participating provider manuals include information and instructions on how to request interpreter services, and the timeframes involved.

V. Monitoring

The EOCCO Quality Improvement committee review member complaints quarterly for persistent or significant problems regarding access to interpreter services. The committee identifies areas for improvement and implements appropriate interventions.

VI. Related Policies & Procedures, Forms and References

VII. Revision Activity

New P & P /Change / Revision and Rationale	Final Review/Approval	Approval date	Effective Date of Policy/Change
Revised to EOCCO policy	EOCCO Quality Improvement Committee	04/10/15	04/10/15
Annual review	EOCCO Quality Improvement Committee	08/12/16	08/12/16
Annual review; updated to make more inclusive	EOCCO Quality Improvement Committee	10/13/17	10/13/17
Annual review; updated definitions: removed provider partner and replaced with participating provider and subcontractor definitions; updated text with new definitions	EOCCO Quality Improvement Committee	10/12/18	10/12/18

VIII. Affected Departments:

Request for Applications

LCAC Community Benefit Initiative Reinvestments

Table of Contents

Application Deadline: January 31, 2019

Background

Thanks to successful efforts in 2017 to improve care, Eastern Oregon Coordinated Care Organization (EOCCO) met 14 of the 17 CCO quality measures enabling the Board of Directors to reinvest approximately $726,000 in Local Community Advisory Council projects (see Appendix 2 for allocated amounts by county). Your LCAC can use this funding to develop and implement an innovative project to improve the health of your community.

Focus Area: 60 – 70 % of each LCAC's funds may be allocated to be used on projects that address the LCAC's CHP plan, including CHP-identified projects that address social determinants of health needs and enrollment in health insurance. 30 – 40% of each LCAC's funds must be allocated to be used to address CCO incentive measures, must focus on at least one incentive measure that the county isn't meeting, and must include a description of how the LCAC plans to address that deficiency.

Proposed projects must be distinct from all other applications. See **Appendix 4** for the latest EOCCO results by county on the incentive measures. A collaborative approach should be used to develop these proposals with the LCAC working to reach consensus on key issues using the LCAC Charter as a guideline.

Timeline: The earliest start date for projects is March 15, 2019 and all projects should end by March 14, 2020.

Application Instructions

Requirements for all Applications

1. Proposals that are not fully described or are otherwise incomplete may be returned to the applicant.

2. Proposals that substantially overlap in purpose and budget will not be considered for funding. A committee appointed by the EOCCO Board will make the final funding decisions, subject to approval by the EOCCO Board.

3. Support from the CBI program can be used to establish new roles within a community that are substantially devoted to improving the health and health care of EOCCO members. These positions should not be primarily administrative, with the exception of administrative support of LCAC activities. Grantees will be required to request decreasing amounts of funds over time and funds for such positions will not be provided beyond three grant cycles unless applicants can document the position is directly related to successful performance on EOCCO initiatives.

Submission Process:

1. **Application Forms:** To request EOCCO reinvestment funds, please follow the directions in this Request for Applications (RFA). Applications should include the Application Coversheet, a Project Narrative covering all questions described in the RFA, a Budget and a Budget Justification, and any required Letters of Commitment.

2. **Submission:** Send your full application in a **single** PDF to Sankirtana Danner at danners@ohsu.edu and Anne King at kinga@ohsu.edu **by 5 pm PDT on January 31, 2019**.

Important Note: You will receive an email indicating that your application has been received. If you do not receive that email within 24 hours, please contact Sankirtana or Anne.

3. **Timeline:** Applicants should hear about the status of their requests in March 2019. The earliest start date for projects is March 15, 2019 and all projects should end by March 14, 2020. A committee appointed by the EOCCO board will make the final funding decisions subject to approval by the EOCCO Board.

4. **Technical Assistance:** OHSU staff members are available to answer questions and to provide feedback on your project design and evaluation plan. Please contact Sankirtana Danner danners@ohsu.edu or Anne King kinga@ohsu.edu and they will provide help or find the best person to provide assistance.

LCAC Community Benefit Initiative Project Application Coversheet

Name of LCAC: _____

Project Director (person who will be responsible for the overall project):

Name: _____

Title: _____

Organization: _____

Address: _____

Phone Number: _____ Email: _____

Name of Organization to Receive and Manage Funds:

Organization Name: _____

Address: _____

Name of Employee Managing Funds: _____

Phone Number: _____ Email: _____

County Coordinator Name: _____ Email: _____

Total Amount Requested (can be less than the amount allocated, but not more): **$**_____

Project Title: _____

Start Date: _____/_____/_____ **End Date:** _____/_____/_____

Project Purpose (do not exceed space below):

Signatures:

I hereby certify that this proposal has been developed and fully approved by our LCAC for submission to the EOCCO. The statements contained in this application are true and complete to the best of the applicant's knowledge and the applicant accepts as a condition of the grant the obligation to comply with all applicable state and federal requirements, policies, standards, and regulations.

Signature of LCAC Chair: _____

Name: _____ Date: _____

Phone: _____ Email: _____

LCAC Community Benefit Initiative Project Narrative

*Please follow the instructions below to complete your project narrative, providing complete answers to each question. Project narratives may be **up to 5 pages**.*

A. Provide a detailed description of the project plan, including:

I. Project goals
II. Targeted incentive measures and CHIP goals. *Note:* at least one incentive measure that the county has historically struggled to meet must be addressed.
III. A detailed description of the planned activities
IV. A detailed timeline of activities

B. Describe the data you will collect to measure success of your project and how you will obtain the data. **Note:** If funded, you will be required to report on these data on interim progress reports and a year-end final report. Applicants must report on the **number of EOCCO and non-EOCCO members served**.

C. Complete the table below, including baseline data and goals you will use to measure success.
Note: This table has been revised from prior years. Please be sure to include actual available baseline data and create goals that take into account available data, such as your county's prior year rate, the numerator and denominator of patients if available, EOCCO targets, and the estimated number of members needed to reach the EOCCO target. Baseline data should be the prior year's final rate for the target population.

Targeted Metric	**Activity Planned**	**Metrics**	
EXAMPLE: *Dental sealants*	*AWC event with onsite dental sealant services*	*Baseline* *20/150 (number of kids who received sealants last year out of number eligible)*	*Goal* *75/150 (number of kids you aim to receive sealants this year out of number eligible)*
		Baseline	*Goal*
		Baseline	*Goal*
		Baseline	*Goal*

D. Please list each member of the project team, their organization (if applicable), and thoroughly describe their roles and responsibilities on the project. All activities that are proposed in Question A should be represented.

E. What could cause this project to have trouble or fail and how could you reduce this risk?

F. Please list the any collaborating organizations involved in your project and submit a Letter of Commitment from each collaborating organization. Any organization that is listed must submit a letter (see Appendix 3 for a template)

G. Describe a detailed plan for sustaining this effort once the project ends.

Appendix 1: LCAC Community Benefit Initiative Budget Template

Please use the template below for your budget. Funded activities may include, but are not limited to: personnel, travel expenses, meetings and supplies and consultants. Indirect costs are capped at 10%. Non-project related indirect expenses, funds for capital expenditures (e.g. major non-technology equipment, building renovations) and costs related to enhancing reimbursements or supporting state-covered services cannot be funded through these grants.

Note that 30-40% of funds must be used toward incentive measure(s) and 60-70% may be used toward CHIP related activities. **In the budget table below, indicate if this is an IM or CHIP related expense**.

Start date of project: _____ ***End date of project:*** _____

Budget Table

Budget									
Personnel:						**In-Kind Cash Contribution**	**In-Kind non-Cash Contribution**	**IM**	**CHIP**
Name	**Role**	**FTE**	**Salary Requested**	**Benefits Requested**	**Total Requested**				
Example: Jane Smith	*MA*	*.10*	*$5000*		*$5000*			*X*	
Equipment and Supplies:									
Name of Item	**Description**				**Total Requested**				
Travel:									
Location	**Description**				**Total Requested**				
Other Expenses:									
Name of Item	**Description**				**Total Requested**				
Total IM									

Funds						
Total CHIP Funds						
GRAND TOTAL		**$**				

Budget Justification

Please provide a narrative budget justification detailing the costs included in your budget. If in-kind contributions are budgeted, please provide a list of the source of each contribution, the name of the organization providing it and whether the donation is in cash or non-cash (e.g. labor, etc.)

Appendix 2: 2019 LCAC Funding Amounts

County	Membership as of 6/1/18	40% Distributed Equally	60% Membership Distribution	Totals
Baker	3,781	$24,211	$35,115	**$59,326**
Gilliam	332	$24,211	$3,083	**$27,294**
Grant	1,390	$24,211	$12,909	**$37,120**
Harney	1,952	$24,211	$18,129	**$42,339**
Lake	1,727	$24,211	$16,039	**$40,250**
Malheur	9,615	$24,211	$89,297	**$113,507**
Morrow	2,732	$24,211	$25,373	**$49,583**
Sherman	310	$24,211	$2,879	**$27,090**
Umatilla	17,374	$24,211	$161,356	**$185,567**
Union	5,806	$24,211	$53,922	**$78,132**
Wallowa	1,621	$24,211	$15,055	**$39,265**
Wheeler	284	$24,211	$2,638	**$26,848**
TOTALS	**46,924**	**$290,529**	**$435,794**	**$726,323**

Appendix 3: Letter of Commitment Template

Agreement to Participate in EOCCO Project

Dear ***Name of project director,***

We look forward to participating in the ***Project Name*** starting ***date*** and ending ***date.***

Our organization agrees to ***describe what the collaborating organization is expected to do including any staff responsibilities.*** We understand that we will receive ***list any funds being provided to the collaborating organization.***

Thank you for including us in this important project.

Sincerely,

Signature
Name spelled out
Organization name
Email address
Phone number

Appendix 4: EOCCO 2017 Incentive Measure Performance by County

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Progress Report- County Summary

2017 Final Results

Current Reporting Period: Services Incurred 1/1/2017-12/31/2017 as of 3/31/2018

Prior Reporting Period: Services Incurred 1/1/2017-12/31/2016 as of 3/31/2017

Measure Compliance Rate								
County	Adolescent Well Care Visits	Childhood Immunizations	Colorectal Cancer Screening	Dental Sealants	Developmental Screening	Effective Contraceptive Use	Ambulatory Care & ED Utilization	Alcohol and Drug Misuse
Baker	33.1%	84.0%	41.7%	29.1%	69.1%	54.6%	51.1	11.0%
Gilliam	50.0%	85.7%	29.6%	32.2%	50.0%	30.3%	37.3	8.4%
Grant	29.8%	66.7%	25.1%	40.6%	43.3%	44.1%	63.0	5.3%
Harney	36.5%	79.2%	48.4%	42.5%	90.0%	51.3%	45.8	17.2%
Lake	36.4%	77.3%	45.1%	32.1%	39.7%	56.9%	40.1	18.1%
Malheur	36.7%	82.4%	43.6%	23.0%	84.0%	47.0%	55.7	13.4%
Morrow	46.2%	68.8%	40.5%	24.4%	43.6%	49.6%	50.0	24.0%
Sherman	42.2%	50.0%	41.9%	30.4%	62.5%	33.3%	32.1	17.8%
Umatilla	39.5%	79.1%	44.1%	24.0%	47.2%	49.1%	53.6	15.1%
Union	39.0%	66.7%	39.1%	17.8%	82.8%	48.2%	62.8	21.7%
Wallowa	47.9%	78.3%	53.7%	16.8%	80.0%	44.7%	30.7	7.6%
Wheeler	24.0%	50.0%	41.0%	62.5%	80.0%	63.3%	35.1	38.5%
EOCCO Rate	38.6%	77.3%	42.7%	24.6%	62.8%	49.0%	53.1	15.3%
EOCCO 2017 Target Rate	37.3%	72.9%	43.9%	20.0%	57.3%	48.1%	51.8	15.0%

Numerator/Denominator Counts								
County	Adolescent Well Care Visits	Childhood Immunizations	Colorectal Cancer Screening	Dental Sealants	Developmental Screening	Effective Contraceptive Use	Ambulatory Care & ED Utilization	Alcohol and Drug Misuse
Baker	145/438	42/50	149/357	173/595	123/178	219/401	2283/44668	235/2142
Gilliam	17/34	6/7	8/27	19/59	6/12	10/33	147/3937	17/202
Grant	57/191	14/21	42/167	78/192	26/60	67/152	1095/17379	50/936
Harney	69/189	19/24	92/190	99/233	99/110	100/195	1004/21899	127/739
Lake	67/184	17/22	78/173	72/224	31/78	99/174	809/20197	138/764
Malheur	489/1334	136/165	252/578	397/1728	488/581	439/935	6130/110109	670/5001
Morrow	180/390	44/64	68/168	109/447	92/211	117/236	1547/30927	284/1185
Sherman	19/45	1/2	13/31	14/46	5/8	10/30	125/3898	37/208
Umatilla	942/2384	258/326	482/1094	725/3027	532/1126	833/1697	11127/207517	1290/8521
Union	299/767	64/96	149/381	179/1007	280/338	326/677	4394/69962	655/3020
Wallowa	90/188	18/23	102/190	40/238	52/65	68/152	593/19302	83/1088
Wheeler	6/25	1/2	16/39	20/32	12/15	19/30	115/3278	77/200
Total	2380/6169	620/802	1451/3395	1925/7828	1746/2782	2307/4712	29369/553073	3663/24006

Progress Report- Baker County
2017 Progress

Current Reporting Period: Services Incurred 1/1/2017-12/31/2017 as of 3/31/2018
Prior Reporting Period: Services Incurred 1/1/2017-12/31/2016 as of 3/31/2017

Measure	2017 Target	Rate	Numerator/ Denominator	Member count needed to meet target*
Adolescent Well Care Visits	37.3%	33.1%	145/438	18
Childhood Immunizations	72.9%	84.0%	42/50	-
Colorectal Cancer Screening	43.9%	41.7%	149/357	8
Dental Sealants	20.0%	29.1%	173/595	-
Developmental Screening	57.3%	69.1%	123/178	-
Effective Contraceptive Use	48.1%	54.6%	219/401	-
Ambulatory Care & ED Utilization	51.8	51.11	2283/44668	
Alcohol and Drug Misuse	15.0%	11.0%	235/2142	86

**For all measures except ED Utilization, this represents the estimated number of additional members needed in the numerator to meet the target.*

Progress Report- Gilliam County

2017 Progress

Current Reporting Period: Services Incurred 1/1/2017-12/31/2017 as of 3/31/2018

Prior Reporting Period: Services Incurred 1/1/2017-12/31/2016 as of 3/31/2017

Measure	2017 Target	Rate	Numerator/ Denominator	Member count needed to meet target*
Adolescent Well Care Visits	37.3%	50.0%	17/34	-
Childhood Immunizations	72.9%	85.7%	6/7	-
Colorectal Cancer Screening	43.9%	29.6%	8/27	4
Dental Sealants	20.0%	32.2%	19/59	-
Developmental Screening	57.3%	50.0%	6/12	1
Effective Contraceptive Use	48.1%	30.3%	10/33	6
Ambulatory Care & ED Utilization	51.8	37.34	147/3937	
Alcohol and Drug Misuse	15.0%	8.4%	17/202	13

**For all measures except ED Utilization, this represents the estimated number of additional members needed in the numerator to meet the target.*

Progress Report- Grant County

2017 Progress

Current Reporting Period: Services Incurred 1/1/2017-12/31/2017 as of 3/31/2018
Prior Reporting Period: Services Incurred 1/1/2017-12/31/2016 as of 3/31/2017

Measure	2017 Target	Rate	Numerator/ Denominator	Member count needed to meet target*
Adolescent Well Care Visits	37.3%	29.8%	57/191	14
Childhood Immunizations	72.9%	66.7%	14/21	1
Colorectal Cancer Screening	43.9%	25.1%	42/167	31
Dental Sealants	20.0%	40.6%	78/192	-
Developmental Screening	57.3%	43.3%	26/60	8
Effective Contraceptive Use	48.1%	44.1%	67/152	6
Ambulatory Care & ED Utilization	51.8	63.01	1095/17379	
Alcohol and Drug Misuse	15.0%	5.3%	50/936	90

**For all measures except ED Utilization, this represents the estimated number of additional members needed in the numerator to meet the target.*

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Progress Report- Harney County
2017 Progress

Current Reporting Period: Services Incurred 1/1/2017-12/31/2017 as of 3/31/2018
Prior Reporting Period: Services Incurred 1/1/2017-12/31/2016 as of 3/31/2017

Measure	2017 Target	Rate	Numerator/ Denominator	Member count needed to meet target*
Adolescent Well Care Visits	37.3%	36.5%	69/189	1
Childhood Immunizations	72.9%	79.2%	19/24	-
Colorectal Cancer Screening	43.9%	48.4%	92/190	-
Dental Sealants	20.0%	42.5%	99/233	-
Developmental Screening	57.3%	90.0%	99/110	-
Effective Contraceptive Use	48.1%	51.3%	100/195	-
Ambulatory Care & ED Utilization	51.8	45.85	1004/21899	
Alcohol and Drug Misuse	15.0%	17.2%	127/739	-

**For all measures except ED Utilization, this represents the estimated number of additional members needed in the numerator to meet the target.*

Progress Report- Lake County
2017 Progress

Current Reporting Period: Services Incurred 1/1/2017-12/31/2017 as of 3/31/2018
Prior Reporting Period: Services Incurred 1/1/2017-12/31/2016 as of 3/31/2017

Measure	2017 Target	Rate	Numerator/ Denominator	Member count needed to meet target*
Adolescent Well Care Visits	37.3%	36.4%	67/184	2
Childhood Immunizations	72.9%	77.3%	17/22	-
Colorectal Cancer Screening	43.9%	45.1%	78/173	-
Dental Sealants	20.0%	32.1%	72/224	-
Developmental Screening	57.3%	39.7%	31/78	14
Effective Contraceptive Use	48.1%	56.9%	99/174	-
Ambulatory Care & ED Utilization	51.8	40.06	809/20197	
Alcohol and Drug Misuse	15.0%	18.1%	138/764	-

**For all measures except ED Utilization, this represents the estimated number of additional members needed in the numerator to meet the target.*

Progress Report- Malheur County
2017 Progress

Current Reporting Period: Services Incurred 1/1/2017-12/31/2017 as of 3/31/2018
Prior Reporting Period: Services Incurred 1/1/2017-12/31/2016 as of 3/31/2017

Measure	2017 Target	Rate	Numerator/ Denominator	Member count needed to meet target*
Adolescent Well Care Visits	37.3%	36.7%	489/1334	9
Childhood Immunizations	72.9%	82.4%	136/165	-
Colorectal Cancer Screening	43.9%	43.6%	252/578	2
Dental Sealants	20.0%	23.0%	397/1728	-
Developmental Screening	57.3%	84.0%	488/581	-
Effective Contraceptive Use	48.1%	47.0%	439/935	11
Ambulatory Care & ED Utilization	51.8	55.67	6130/110109	
Alcohol and Drug Misuse	15.0%	13.4%	670/5001	80

**For all measures except ED Utilization, this represents the estimated number of additional members needed in the numerator to meet the target.*

EASTERN OREGON COORDINATED CARE ORGANIZATION

Progress Report- Morrow County

2017 Progress

Current Reporting Period: Services Incurred 1/1/2017-12/31/2017 as of 3/31/2018

Prior Reporting Period: Services Incurred 1/1/2017-12/31/2016 as of 3/31/2017

Measure	2017 Target	Rate	Numerator/ Denominator	Member count needed to meet target*
Adolescent Well Care Visits	37.3%	46.2%	180/390	-
Childhood Immunizations	72.9%	68.8%	44/64	3
Colorectal Cancer Screening	43.9%	40.5%	68/168	6
Dental Sealants	20.0%	24.4%	109/447	-
Developmental Screening	57.3%	43.6%	92/211	29
Effective Contraceptive Use	48.1%	49.6%	117/236	-
Ambulatory Care & ED Utilization	51.8	50.02	1547/30927	
Alcohol and Drug Misuse	15.0%	24.0%	284/1185	-

**For all measures except ED Utilization, this represents the estimated number of additional members needed in the numerator to meet the target.*

Progress Report- Sherman County

2017 Progress

Current Reporting Period: Services Incurred 1/1/2017-12/31/2017 as of 3/31/2018

Prior Reporting Period: Services Incurred 1/1/2017-12/31/2016 as of 3/31/2017

Measure	2017 Target	Rate	Numerator/ Denominator	Member count needed to meet target*
Adolescent Well Care Visits	37.3%	42.2%	19/45	-
Childhood Immunizations	72.9%	50.0%	1/2	1
Colorectal Cancer Screening	43.9%	41.9%	13/31	1
Dental Sealants	20.0%	30.4%	14/46	-
Developmental Screening	57.3%	62.5%	5/8	-
Effective Contraceptive Use	48.1%	33.3%	10/30	4
Ambulatory Care & ED Utilization	51.8	32.07	125/3898	
Alcohol and Drug Misuse	15.0%	17.8%	37/208	-

**For all measures except ED Utilization, this represents the estimated number of additional members needed in the numerator to meet the target.*

Progress Report- Umatilla County

2017 Progress

Current Reporting Period: Services Incurred 1/1/2017-12/31/2017 as of 3/31/2018

Prior Reporting Period: Services Incurred 1/1/2017-12/31/2016 as of 3/31/2017

Measure	2017 Target	Rate	Numerator/ Denominator	Member count needed to meet target*
Adolescent Well Care Visits	37.3%	39.5%	942/2384	-
Childhood Immunizations	72.9%	79.1%	258/326	-
Colorectal Cancer Screening	43.9%	44.1%	482/1094	-
Dental Sealants	20.0%	24.0%	725/3027	-
Developmental Screening	57.3%	47.2%	532/1126	113
Effective Contraceptive Use	48.1%	49.1%	833/1697	-
Ambulatory Care & ED Utilization	51.8	53.62	11127/207517	
Alcohol and Drug Misuse	15.0%	15.1%	1290/8521	-

**For all measures except ED Utilization, this represents the estimated number of additional members needed in the numerator to meet the target.*

EASTERN OREGON COORDINATED CARE ORGANIZATION

Progress Report- Union County

2017 Progress

Current Reporting Period: Services Incurred 1/1/2017-12/31/2017 as of 3/31/2018

Prior Reporting Period: Services Incurred 1/1/2017-12/31/2016 as of 3/31/2017

Measure	2017 Target	Rate	Numerator/ Denominator	Member count needed to meet target*
Adolescent Well Care Visits	37.3%	39.0%	299/767	-
Childhood Immunizations	72.9%	66.7%	64/96	6
Colorectal Cancer Screening	43.9%	39.1%	149/381	18
Dental Sealants	20.0%	17.8%	179/1007	22
Developmental Screening	57.3%	82.8%	280/338	-
Effective Contraceptive Use	48.1%	48.2%	326/677	-
Ambulatory Care & ED Utilization	51.8	62.81	4394/69962	
Alcohol and Drug Misuse	15.0%	21.7%	655/3020	-

**For all measures except ED Utilization, this represents the estimated number of additional members needed in the numerator to meet the target.*

Progress Report- Wallowa County

2017 Progress

Current Reporting Period: Services Incurred 1/1/2017-12/31/2017 as of 3/31/2018
Prior Reporting Period: Services Incurred 1/1/2017-12/31/2016 as of 3/31/2017

Measure	2017 Target	Rate	Numerator/ Denominator	Member count needed to meet target*
Adolescent Well Care Visits	37.3%	47.9%	90/188	-
Childhood Immunizations	72.9%	78.3%	18/23	-
Colorectal Cancer Screening	43.9%	53.7%	102/190	-
Dental Sealants	20.0%	16.8%	40/238	8
Developmental Screening	57.3%	80.0%	52/65	-
Effective Contraceptive Use	48.1%	44.7%	68/152	5
Ambulatory Care & ED Utilization	51.8	30.72	593/19302	
Alcohol and Drug Misuse	15.0%	7.6%	83/1088	80

**For all measures except ED Utilization, this represents the estimated number of additional members needed in the numerator to meet the target.*

Progress Report- Wheeler County

2017 Progress

Current Reporting Period: Services Incurred 1/1/2017-12/31/2017 as of 3/31/2018

Prior Reporting Period: Services Incurred 1/1/2017-12/31/2016 as of 3/31/2017

Measure	2017 Target	Rate	Numerator/ Denominator	Member count needed to meet target*
Adolescent Well Care Visits	37.3%	24.0%	6/25	3
Childhood Immunizations	72.9%	50.0%	1/2	1
Colorectal Cancer Screening	43.9%	41.0%	16/39	1
Dental Sealants	20.0%	62.5%	20/32	-
Developmental Screening	57.3%	80.0%	12/15	-
Effective Contraceptive Use	48.1%	63.3%	19/30	-
Ambulatory Care & ED Utilization	51.8	35.08	115/3278	
Alcohol and Drug Misuse	15.0%	38.5%	77/200	-

**For all measures except ED Utilization, this represents the estimated number of additional members needed in the numerator to meet the target.*

Attachment 11 - Behavioral Health Questionnaire

A. Behavioral Health Benefit (recommended page limit 8 pages)

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?**

   As a newly forming coordinated care organization, WCCCO knows that its foundation must be community partnership and keen focus on the integration of Member care. WCCCO equity partners will join together collaboratively and financially to ensure seamless integration of Behavioral Health and physical health—putting the Member first.

   To do this, WCCCO will leverage the unique strengths of its equity partner – Moda Health (Moda), and its comprehensive forethought of integrating behavioral and medical benefits. By way of background, Moda anticipated the growing emphasis on behavioral and medical integration and in 2003 it purchased an external Managed Behavioral Health Organization (MBHO) that administered its Behavioral Health benefits for the purpose of integrating the services with its medical services. Moda did this because it knows that the key to ensuring a seamless system for *members* is to ensure a seamless system for *providers.* Here are some of the concrete steps Moda has taken to strengthen integration of services from a network perspective:

   - Merging medical and Behavioral Health contracting, claims and customer service;
   - Retiring the original separate “brand” under which Behavioral Health benefits were administered on behalf of Moda;
   - Eliminating barriers to Primary Care homes billing for Behavioral Health providers and services;
   - Integrating Moda’s medical and behavioral leadership structure; and
   - Integrating Moda’s medical and behavioral clinical documentation systems.

   A seamless system for members requires that all of their interactions with WCCCO must be integrated, coordinated and communicated to ensure that Members are the focus across the care continuum. On a practical level this will be evident through:

   - An integrated WCCCO handbook that describes all of the Members benefits (physical, behavior and oral health as well as transportation).
   - Customer service staff that answer Member inquiries about all services.
   - External member communications branded for the WCCCO.
   - An integrated WCCCO website, including a combined behavioral, physical and dental provider searches.
   - Pilot projects and compensation models designed so that Members can receive services in one location.
   - Care coordination services that provide a single point of contact for a Member and their family
   - Data that is available to all WCCCO partners, to improve communication and coordination, reduce redundancies, and drive performance improvement.

We are excited about the opportunity to bring this integrated structure and experience to CCO membership in a new way in Lane County. In contrast to the structure of many CCOs which have had to work at cobbling together a dis-integrated set of structures, processes and cultures, Moda on behalf of WCCCO looks forward to bringing an integrated structure, process and culture to serve a new population.

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?**

   WCCCO will be structured as a limited liability company (LLC) with equity partners that include Moda Health and other provider organizations within the community. The equity partners will take full responsibility for the entire benefit package, including Behavioral Health. WCCCO will fully fund Behavioral Health provided in a primary care setting and will fully fund primary care delivered in a Behavioral Health setting.

   Under this governance structure each of the partners will share the risks and rewards that result from WCCCO's performance in relation to the Global Budget. On an annual basis WCCCO's financial and actuarial teams will develop a global budget which will be approved by the WCCCO Board. The global budget will be developed using a ground-up approach to ensure adequate funding is available to cover all services required to provide to the WCCCO population. WCCCO will produce cost and utilization reports that show spending and utilization patterns by member category and by service category including Behavioral Health care on a routine basis. This reporting is one tool used to ensure oversight of the Behavioral Health benefit. The cost and utilization reports are also used to inform WCCCO's annual global budget to ensure the appropriate allocation of funding for all covered services. WCCCO's governance structure will allow for close integration and coordination of service to our members, while benefitting from the expertise provided by the partner organizations.

   WCCCO will develop a payment methodology to assure that Behavioral Health services delivered in a primary care setting, and primary care delivered in a Behavioral Health setting will be reimbursed utilizing a structure that aligns with our VBP goals. Incentives (quality-based value-based payments, additional PMPM payments, grant funds, etc.) and support, are provided for those clinics that deliver co-located and integrated services.

   Moda Health will manage the global budget as a single, integrated entity that blends, rather than separates, medical and behavioral expenses. We will not cap Behavioral Health or medical expenses, delegate Behavioral Health risk or carve out Behavioral Health funding. We will draw on our extensive experience managing a global budget that includes both behavioral and medical services; this experience has taught us to view Behavioral Health and medical services as complementary, not competing interests. As an example of this, there is no need to identify "whose bucket" a psychologist's service in primary care comes out of. This integration allows for the frictionless provision of Behavioral Health services in whatever setting is most appropriate for the member.

3. **How will Applicant fund Behavioral Health for its Service Area in compliance with the Mental Health Parity and Addiction Equity Act of 2008?**

   WCCCO's equity partner, Moda Health, has extensive experience administering benefits in full compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Moda uses the Self Compliance Tool issued by the Departments of Labor and Health and Human Services to audit our compliance with MHPAEA. A 2018 internal audit of our commercial lines of business found full compliance with NQTL requirements and minor adjustments which needed to be made to ensure full compliance with QTL requirements; those adjustments have been made. As the administrator for EOCCO, Moda Health also participates in monitoring MHPAEA compliance for the CCO; our 2018 review found full compliance also for this line of business.

   From a financial perspective, Moda will ensure appropriate funding for Behavioral Health through the integrated management of the global budget. Behavioral Health spending will not be capped at a dollar limit or proportion of spend; instead, spending will be apportioned by identified need and actual utilization. We will neither sub-capitate Behavioral Health nor put arbitrary limits on the numbers of members providers may serve.

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?**

   Prevalence will be monitored through a variety of real time and retrospective reviews including: requests for authorizations, emergency department notifications, out-of-network usage, single case agreements, complaints and grievances, Collaborative Care Model (behavioral services provided in PCPCH) data collection and claims data. Benchmark data is also reviewed for comparisons regarding penetration rates (reach), costs per member, and types of services provided. Real time analytics are used to determine if screenings and preventative care are being delivered according to best practices. Utilization is viewed at the individual, provider and system levels to look for improvement opportunities. Data reviews include: viewing difference in utilization based on demographics, gaps during transitions of care, areas of need within the Network.

   Lane County's 2019-2021 Biennial Improvement Plan (BIP) for behavioral health services reports that:

   > ***CCO funding is inconsistent with community needs***
   >
   > *Respondents described the CCO as having moved from a system improvement and community based approach to a cost containment model with the result that reimbursement rates are lower than provider costs and providers cannot bill appropriately for community based services, particularly in rural areas (p. 43).*

   WCCCO strongly believes in not only the effectiveness but also the cost-effectiveness of providing comprehensive behavioral supports to individuals experiencing mental health and SUD challenges. As both a health equity issue and a pragmatic strategy, WCCCO intends to fund Behavioral Health services fully and continue transformational work to ensure that the funds spent achieve the maximal outcomes.

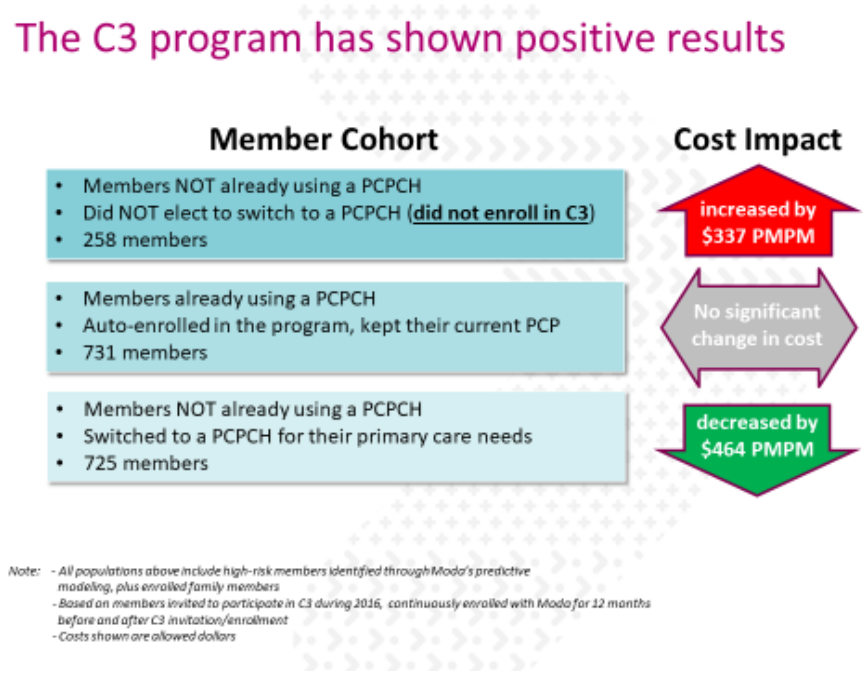
As discussed in Question 2 above, WCCCO's global budget will be annually developed using a ground up approach to ensure adequate funding is available to cover all services we are required to provide to the CCO population. We will produce cost and utilization reports that show spending and utilization patterns by member category and by service category including Behavioral Health care on a routine basis. This reporting is one tool used to ensure oversight of the Behavioral Health benefit. The cost and utilization reports are also used to inform the CCO's annual global budget to ensure the appropriate allocation of funding for all covered services.

WCCCO plans to contract with Lane County Behavioral Health for utilization management and case management and will review data from these programs as well. Within the WCCCO service region, WCCCO will conduct an annual population assessment and provider availability report using processes and data sources Moda has developed in its work as a commercial plan and as administrator of EOCCO. The population assessment will include diverse data sources including claims, health screening data, and data on social determinants of health. The provider availability report will include quantitative and qualitative data sources and identify areas for improvement.

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?**

   WCCCO in partnership with its community, will expand access to Behavioral Health care and provide a more person centered approach to care by supporting integrated Behavioral Health and physical health in a variety of ways. We will use a prospective primary care payment system in which clinics will receive an enhanced payment up front for agreeing to provide integrated Behavioral Health services and adhering to a set of evidence-based standards for providing that care. These standards will include universal screening and referral to brief Behavioral Health interventions as well as bridges to higher levels of care when indicated. We will also make available technical support and consultation when needed to improve the quality of care and effective implementation of integration.

   WCCCO will build on Moda's existing model of integrated medical and Behavioral Health contracting by providing PMPM payments to primary care medical homes according to the level of certification the clinic has attained. In addition, we will pay fee-for-service for specific Behavioral Health services provided within a medical home, such as assessment, psychotherapy, and health and behavior interventions. Within this framework, PMPM payments can be used as intended for enhanced care coordination, rather than backfilling otherwise unreimbursed Behavioral Health services. WCCCO will recognize Behavioral Health homes already contract with providers for primary care services within Behavioral Health homes. Due to our integrated funding and contracting processes, there are no structural barriers to overcome in providing Behavioral Health care in a medical setting and medical care in a Behavioral Health setting.



WCCCO's equity partner Moda has a robust appreciation for the benefits of fully integrated medical homes that include Behavioral Health. Through its commercial lines of business, Moda has implemented programs to improve the health of those with complex chronic conditions. This Table shows that use of an integrated setting through a PCPCH results in significant savings and improved health for members with complex medical conditions, including Behavioral Health.

As WCCCO's equity partner, Moda has extensive experience administering a comprehensive behavioral benefit package including the full spectrum of levels of care (including residential and other intermediate levels) and diverse service types including eating disorder treatment, Applied Behavior Analysis and Medication Assisted Treatment. WCCCO will build on that knowledge and experience in fully funding and managing the complete Behavioral Health benefit package in accordance with the Prioritized List of Health Services.

6. How will Applicant ensure the full Behavioral Health benefit is available to all Members in Applicant's Service Area?

Lane County is large and geographically diverse. One of only two Oregon counties to stretch from the coast to the Cascades, it also contains Oregon's third-largest metropolitan area; as such, it is simultaneously rural and urban. As a state-wide commercial payer and an equity partner and administrator of EOCCO, Moda Health has extensive experience serving both rural and urban populations and is attuned to the needs of each. Ensuring appropriate geographic distribution of providers is a key to ensuring availability of services to all members in the service area. Moda Health uses geo-access reporting to analyze the distance members must travel in order to access services. In addition, we set standards for the numbers of practitioners in our network and measure our performance annually against those standards. Such aggregate data must also be viewed in the context of the experience of individual members seeking services. Experience has taught us that we may exceed our standards for number and distribution of practitioners, and yet members may still struggle to access certain services. As such, we closely monitor single case agreement requests to identify potential areas of need, and also monitor the experience of our care coordinators in seeking to connect members with specific services. These sources of data are invaluable in

identifying specific gaps in our network that would not be apparent using only statistical methods.

On behalf of WCCCO, Moda will draw on its extensive relationships in developing a Behavioral Health network for our Lane County CCO membership. We know that it is critical to ensure access to members whether they live rurally or in a city-center.

For example, an important issue affecting the availability of Behavioral Health services for rural members is stigma. In places where "everyone knows everyone," the simple fact of your car being seen the parking lot of the treatment center can be enough to deter people from services. Because of this, the integration of Behavioral Health services in primary care takes on even greater importance in rural areas, and the option of telemedical services with the patient located at home or in their regular doctor's office can address not only the availability of services but also reduce the perceived social cost of seeking help.

Telemedical psychiatric services is an important solution for addressing not only the needs of rural members, but also people who are simply unable to visit a provider for a myriad of reasons. WCCCO will use Moda's relationships with several telemedical providers, including providers who offer Medicated Assisted Treatment (MAT) via telemedicine. Telemedical technology has advanced to the point where many people can be served in their homes using secure, HIPAA-compliant technology. Our network of Behavioral Health facilities will also ensure access to higher levels of care such as IOP, PHP and residential treatment. Local facilities in our network include Madrone Mental Health, Serenity Lane, Monte Nido (Rainrock), and Willamette Family, Inc.

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

We are committed to continually improving access to a full continuum of behavioral health services. To that end, WCCCO will not sub-capitate contracts with Behavioral Health providers or create limits on the number of patients that may be served. While a popular cost containment feature for some, WCCCO knows that this approach is unethical and has led to egregious outcomes for the region's most vulnerable citizens—including long provider waitlists and other challenges with timely access to services. We understand the critical importance of timely access and will work collaboratively with the LMHA and providers to develop common solutions that ensure the front door to services remains open.

WCCCO will monitor access through a number of vehicles, including provider-reported data, member surveys and complaints and appeals. Where timeliness standards are not met, we will perform root cause analysis and implement remedial steps in collaboration with providers and the LMHA. Such steps may include increasing the provider panel, moving resources from one area or type of care to another, increasing flexibility in service models, developing provider-level corrective action plans, and/or resolving barriers to moving patients to lower levels of care more efficiently.

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?**

   WCCCO Members will have access to all medically appropriate, behavioral health services that are covered under the Oregon Health Plan or WCCCO's behavioral health benefit. We have extensive experience arranging and coordinating care for members who are placed outside of the local service area. In these circumstances we can draw on our relationships with providers statewide to complete single case agreements and overcome barriers to members receiving services.

   Through our equity partner, Moda, WCCCO has an extensive network of out-of-area service providers who offer specialty care when not readily available locally. We will draw on this network of relationships to ensure members have access to specialized treatment.

   While appropriate treatment for most conditions is available locally, the challenges may increase when considering certain co-occurring conditions or age groups. For example, it can be difficult for an individual needing residential treatment for eating disorder and co-morbid SUD to find an appropriate facility. Drawing on our network of out-of-state facilities, we can access providers who have a proven record treating people with this combination of diagnoses. Another example is chemical dependency services for older adults, which can be particularly challenging to find, given that Medicare does not recognize most SUD treatment facilities. WCCCO via Moda's Care Coordination team has extensive experience working with both contracted and non-contracted out of area facilities to arrange for care not available locally and is able to arrange single case agreements when no in-network provider is available.

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?**

   Similar to EOCCO, our contracted physical health and behavioral health providers will be incentivized to provide evidence-based alcohol and drug misuse screening and follow-up using Screening Brief Intervention and Referral to Treatment (SBIRT) protocols. Additionally, they will be incentivized to utilize evidenced-based screening tools to screen for depression, which includes the PHQ-2 as well as the PHQ-9. Depression Screening and Alcohol and Drug Misuse Screening are both EHR based incentive measures that will be included in the quality bonus formula. Each clinic will be eligible to receive funds for each measure if they meet the targets. WCCCO will utilize Moda's quality improvement staff who educate clinics on these measures and share best practices/workflow examples to incorporate these evidence-based screening tools into their EHR platforms. WCCCO, through Moda, intends to make use of an HIE platform called Arcadia Analytics to clinics who are interested in onboarding. This platform allows them to see real time data on the completion of both of these evidence-based screening tools. At the end of each measurement year, quality improvement staff work with each clinic to collect this data from either their EHRs or the Arcadia Analytics platform to report their rates to OHA.

   WCCCO will work with our clinical advisory panel to develop recommended screenings, identify needs for training and technical assistance and assess the adequacy of existing

practices. WCCCO, through our equity partner Moda, has provided extensive training and support for providers to implement SBIRT screenings in primary care including developing a feedback loop that identified problems in data collection and reporting. This has required working with clinics on an individual level as our experience shows the readiness, barriers, and most effective solutions vary from one clinic to another; one size does not fit all. We will take the same approach in Lane County, addressing needs at both the system-wide and individual clinic level.

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?**

    Lane County benefits from a strong system of mobile crisis provided by White Bird Clinic and the Child Center. WCCCO appreciates the essential roles that such providers play in providing safety net services. Our equity partner Moda has been a leader among commercial payers in reimbursing CMHPs for these services at the in-network level of benefits, and has facilitated a work group among commercial payers and CMHPs. We believe these services are strengthened further when supported appropriately by commercial as well as public payers. As such, goals of the work group are to increase access to CMHP services for commercially insured members and decrease barriers to CMHPs receiving reimbursement from commercial carriers. As WCCCO, we will structure our contracts and payment mechanisms to support and strengthen the existing array of crisis services offered by agencies including Lane County Behavioral Health, White Bird Clinic, The Child Center, Options Counseling Services, and others. Contracts and payment mechanisms will be structured in a way that recognizes the overhead costs associated with maintaining 24/7 availability and reinforces the expectations for appropriate and timely crisis response in accordance with OAR 309-019-0150.

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

    WCCCO's equity partner, Moda, has been a pioneer among commercial payers in recognizing and reimbursing peer-delivered services. As WCCCO, we will reimburse Peers for the service array identified by OHA as within scope for this provider type (HCPCS G0177, H0039, H2014, H2023, T1016, H0046 and H0038). Peer-delivered services are essential components of team based treatment models such as EASA, ACT and CATS programs; in some cases peer-delivered services will be folded in as a required component for per-diem or bundled payments. Peer-delivered services will also be made available to individuals seeking less intensive forms of treatment. WCCCO will engage Peer Support Specialists and Peer Wellness Specialists as defined in OAR 410-180-0310 and OAR 410-180-0312 to assist members, de-stigmatizing Behavioral Health challenges, reducing trauma associated with interacting with the "system," and empowering consumers of Behavioral Health services.

    As part of its corporate social responsibility program, Moda works closely with Oregon Family Support Network, and the Moda Behavioral Health manager serves on the advisory board to OFSN's "Reach out Oregon" program. We will support the partnerships Lane County Behavioral Health has developed with OFSN, National Alliance on Mental Illness

(NAMI) and Lane Independent Living Association (LILA). WCCCO and Moda appreciate the unique role that peers play in the continuum of care and looks forward to the ongoing development of this role.

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**

Through our equity partner Moda, we recognize that a core strength of the CCO model is its ability to bring together diverse entities and service systems that otherwise may fragment and not achieve their potential. Moda's success in weaving together these supports in EOCCO gives us confidence in WCCCO's ability to do so in Lane County as well. We recognize that in Lane County we will not be starting from scratch; our approach will be to assess the strengths and weaknesses of the collaborative efforts that are already in place and work as a facilitator to help find new ways to strengthen these efforts. Some specific actions include:

- Ensure broad representation in the CAC;
- Evaluate the use of peers to fidelity in programs where they serve an integrated role, such as ASA, ACT, CATS;
- Work within the CHA/CHP and local plan structures to evaluate the integration of community supports in the delivery system;
- Provide funding and training to expand the availability of Community Health Workers;
- Fund community reinvestment initiatives that enhance the availability of community supports; and
- Ensure contracted programs are providing case management and care coordination that connect members with appropriate community supports.

B. Billing System and Policy Barriers to Integration (recommended page limit 2 pages)

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.**

"Warm Handoffs" has a specific meaning as defined in OAR 309-032-860 (30) and a different meaning in the context of integrating physical and mental health services. WCCCO will ensure successful Warm Handoffs in both contexts.

SPMI: Related to OAR 309-032-860 (30), WCCCO will coordinate with Lane County Behavioral Health and support processes already in place to ensure appropriate transitional supports to individuals with SPMI as they transition from inpatient treatment to lower levels of care. Lane County Behavioral Health has expressed its clear desire to continue to provide UM and CM services under whatever CCO structure is put in place for CCO 2.0 and WCCCO supports maintaining this continuity. We appreciate the critical nature of the initial days post-discharge. We use PreManage to ensure we are aware of discharges in real time; this serves as a backstop in case the hospital does not notify us timely. Also, we expect to

replicate services provided by Moda's commercial lines of business: Our care coordinators work closely with hospitals and trusted clinics to ensure a smooth transition to outpatient or intermediate care.

With Moda as our equity partner, WCCCO is strongly positioned to truly integrate behavioral and physical health services for CCO members in Lane County. This opportunity grows out of Moda's long history and experience of integrating behavioral and physical health in its commercial lines of business as well as Moda's existing relationships with CMHPs.

With no pre-existing carve-outs or sub-capitation arrangements, WCCCO will structure contracts and funding to fully support behavioral integration in primary care. Under this model, a primary care clinic has one contact through WCCCO for contracting medical and Behavioral Health services; one process for credentialing medical and Behavioral Health clinicians; one claims address for behavioral and medical claims; one provider relations representative to address issues related to behavioral and medical services. Our tiered PMPM stipends for PCPCHs according to level of certification provide additional support for warm handoffs and integration by providing financial resources for developing the processes for successful warm handoffs that may not themselves be billable services.

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?**

WCCCO will work with each Member to determine needed behavioral health services. When appropriate and desired, WCCCO will provide a variety of in-home behavioral health care services, including but not limited to:

- Certified Home Health Agencies for members who are medically homebound.
- Applied Behavior Analysis for members with Autism Spectrum Disorder.
- In-home skills training for children, youth and families in wrap-around or IOSS.
- Telemedical psychiatric, mental health, and SUD services.
- ACT, EASA, and Peer-delivered services

We will assess the need and utilization of these services through screening, care coordination, case management and utilization management processes. Screening, care coordination and case management involve the proactive identification of needs and resources. WCCCO will conduct these activities directly, will collaborate with community partners, and will ensure that contracted providers are conducting these activities.

When the need for home-based care is identified through these processes, the responsible party will refer the member directly to the appropriate service provider or to WCCCO for assistance with establishing the appropriate service. In-home services that require authorization (for example ABA, IOSS) will be monitored through the UM process as well as annual reports. Services that don't require authorization (for example, telemedicine, and case management) will be monitored through claims review.

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.**

   WCCCO's equity partner, Moda Health, took an active role in helping develop HB 3090 and HB 3091 (2017 legislature) which set statewide standards for discharge planning and transitions, and has taken a leadership role in developing infrastructure to effectively implement these requirements.

   WCCCO will require contracted providers to initiate discharge planning at the beginning of an episode of care. For services requiring authorization, WCCCO care coordinators will assess the status of discharge planning beginning with the initial authorization request and offer assistance to providers in identifying resources for post-discharge. For members with SPMI, the Warm Handoff process described above will ensure members are involved in developing and implementing a supportive discharge plan. For all members utilizing inpatient care, WCCCO will follow up with members after discharge to ensure engagement with appropriate supports and services to provide for a successful transition.

   In Wraparound, the team will create a mission statement that utilizes the plan of care, individual goals, and includes a statement of what success would look like for that individual. In addition, the team will use a Wraparound Transition Checklist to assist members in their discharge planning. From the beginning of services through the transition, Youth Partner and Family Partners will be engaged and supporting members through the process.

   EASA starts the discharge planning 3- 6 months prior to the client completing the EASA program. The clinician meets with the client and family to review the transition check- list. A wellness plan, a relapse prevention plan, and a Crisis & Safety plan is created. Warm handoffs are completed to primary and continued outpatient mental health support.

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.**

   WCCCO will establish practices and policies, such as Medicare by-pass allowances and out-of-network policies, to allow all members, including those fully dual eligible to receive all benefits covered under the Oregon Health Plan. Through our equity partner, Moda's Medicare Advantage plan will be the affiliated Medicare Advantage plan so all coordination can happen internally. There are no barriers to covered services for fully dual eligible members because we utilize regulatory allowances and provide technical assistance to network providers on billing for Behavioral Health care under OHP. For out-of-network providers, we have policies which allow for services to be paid expeditiously without inconvenience to either the provider or the member.

C. MOU with Community Mental Health Program (CMHP) (recommended page limit 6 pages)

WCCCO has met with leadership from Lane County Health and Human Services (HHS) and looks forward to completing an MOU with the department. We have discussed our shared goal of developing a truly collaborative community partnership in which we leverage Health and Human Services' expertise and intimate knowledge of providers, local conditions and the existing delivery system with our expertise and success in implementing a ground-up CCO model elsewhere in the state.

1. **Describe how Applicant plans to develop a comprehensive Behavioral Health plan for Applicant's Service Area. Please include dates, milestones, and Community partners.**

   WCCCO will work with Lane County Health Human Services, community Behavioral Health providers, the CAC, the Rural Advisory Council, the Mental Health Advisory/Local Alcohol and Drug Planning Committee (MHA/LADPC), community members and consumers to develop a comprehensive Behavioral Health Plan. Details of the process will be developed in collaboration with these partners. We expect development of the Behavioral Health plan to be integrated to the extent feasible with the CHA, CHP and local plan.

   We will deliver a new comprehensive Behavioral Health Plan by June 30, 2021. To meet that date the following milestones will be met:

   - Initiate planning process with HHS; begin planning for transitioning, reestablishing, or joining the CAC: **Upon award of contract.**
   - Develop detailed plan for completing the needs and strengths assessment and the Behavioral Health plan: **March, 2020**
   - An assessment of the level of behavioral health integration will be undertaken using Kessler's Practice Integration Profile model. Each primary care practice and community mental health program will be evaluated to determine how much behavioral and mental health is being delivered in primary care and the referrals needed to the CMHP. This includes involvement of Certified Community Behavioral Health Clinics (CCBehavioral HealthC) and Patient Centered Primary Care Homes (PCPCH). **Completion: June 30, 2020.**
   - Substantially complete the needs and strengths assessment, incorporating input from consumers, systems partners and data analysis: **November, 2020**
   - Develop key goals, objectives, actions and responsible parties: **March, 2021**
   - Obtain approval by Lane County HHS, the CAC and the CCO board: **May, 2021**

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.**

   The Local Mental Health Authority (LMHA) will have representation on WCCCO's board in order to ensure coordination at the highest levels. We will also ensure close coordination at management and staff levels, giving the LMHA a strong voice in development of the CHA and CHP.

   WCCCO appreciates that the existing CHA and CHP for Lane County involved numerous stakeholders with key involvement from Lane County HHS. We understand that we will be

the new partner in the process and look forward to the opportunity for collaboration and partnership with these important stakeholders. Because we expect an integrated process for developing the Behavioral Health Plan and the CHP, we expect to follow the same timeline outlined above.

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.**

   WCCCO will support the LMHA in the development of the comprehensive local plan as required under ORS 430.630. While WCCCO recognizes the ultimate authority and responsibility for the local plan rests with the LMHA, we also understand the inextricable linkage between the local plan and the CHA/CHP and the braided perspective that needs to inform these processes and documents. WCCCO's role in supporting the development of the local plan includes our leadership and collaboration in developing the CHA and CHP, as well as identifying CCO resources that can be brought to bear on the local plan. For example, what kinds of preventive services can WCCCO fund; what kinds of material and technical support can we provide in filling identified needs; how can we partner with our equity partner's commercial plan to leverage strengths and resources? The following milestones reflect work that WCCCO will do related to this effort beginning January 2020 (dates subject to revision once guidance is provided by OHA):

   - Upon award of contract: Begin planning process with LMHA.
   - December, 2019: Complete review of current and previous local plans.
   - March 2020: Begin gathering input from CAC and community partners.
   - June 2020 (or soon after OHA guidance is released): Identify resources to be contributed by the CCO to the planning process.
   - July 2020 and through Local Plan submission: Continue gathering input on the needs, gaps, opportunities for better coordination, and shared goals; continue identifying CCO resources to contribute toward the plan; continue to assist the LMHA in identifying goals, objectives and responsible partners.

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.**

   WCCCO has met with leadership from Lane County's LMHA and discussed our respective visions for WCCCO. We share an interest in a deeply collaborative relationship that respects the expertise of Lane County's existing Behavioral Health program and leverages WCCCO's expertise through Moda in administering benefits under a CCO model. WCCCO supports Lane County's intent to continue providing UM and CM services under our shared responsibility for the well-being of WCCCO members. We expect that with this shared vision we will not experience barriers to completing an MOU with the County.

D. Provision of Covered Services (recommended page limit 6 pages)

1. Please provide a report on the Behavioral Health needs in Applicant's Service Area.

Through close coordination with the LCACs, CMHPs, Early Learning Hubs, educational services districts, local justice partners, hospitals, primary care clinics and data analysis strategy, WCCCO will strive to maintain a constant pulse on the behavioral health needs in the region, including the adequacy, diversity and cultural competence of the behavioral health network.

Behavioral Health needs within Lane County must be viewed through a number of lenses, both demographic and clinical. With an estimated population of 375,000 (US Census Bureau, 2018) Lane County has 95,000 OHP members, of which about 84,000 are enrolled in a CCO. Of those members, about 4,100 are dually eligible with Medicare.

Racial and ethnic identification:
The Census Bureau estimates 89% of Lane County residents identify as "white alone," which is about ten percentage points higher than in Multnomah and Washington Counties but similar to other counties west of the Cascades, such as Marion, Clackamas and Jackson. Nine percent identify as Hispanic or Latino, which is low for the region. Other racial groups comprise less than five percent of the population each; summary statistics for the county are presented in the table below:

Racial/ethnic identification	Percent
White alone	89.3%
Black or African American alone	1.2%
AI/AN alone	1.5%
Native Hawaiian, other Pacific Islander	0.3%
Two or more races	4.6%
Hispanic or Latino	8.9%

Source: US Census Bureau

With relatively low numbers of African American, AI/AN and Latino residents, the demand for services specifically attuned to these populations may be relatively low but it may also be more challenging to find providers with appropriate cultural and linguistic competence. Lane County leans slightly older than the state as a whole and is roughly gender balanced (50.7% identifying as female).

Economic indicators:
Median income at $47,710 is low and the poverty rate at 16.6% is high among comparable western Oregon counties. Rent and mortgage costs, while relatively low, are high compared to median income. The unemployment rate as of January, 2019 was 5.1%, slightly higher than the state as a whole. It peaked at 14% in 2009, higher than the 12.6% for the state as a whole (source: FRED/St. Louis Fed). This suggests Lane County may be more vulnerable to economic fluctuations than the state as a whole.

Clinical needs:
Available data are somewhat dated but provide a sense of the scope of Behavioral Health treatment needs and tell us that the needs of children and young adults are groups for initial assessment and focus.

Lane County, Oregon	**Estimated Prevalence (2015)**
Children with a MH condition	30.01%
Youth with identified SU condition	7.54%
Adults with mild to moderate MH condition	24.80%
Adults with serious MH condition	17.82%
Young adults with SU condition	20.16%
Adults with SU condition	7.04%

Source: OHA, Behavioral Health mapping tool: http://oregonhealth.maps.arcgis.com/apps/webappviewer/index.html?id=b2f00085dea24598af9a1fc60e43e705

The following data are for the Oregon Medicaid population as a whole; most recent data available are from Q2 2014:

Oregon Medicaid Population	**Members receiving outpatient treatment**	**Members receiving residential treatment**	**Ratio of outpatient to residential**
MH treatment for Children under 18	29,043	260	112:1
MH treatment for adults	63,167	2,130	30:1
SUD treatment for youth	1,504	180	8:1
SUD treatment for adults	21,317	3,008	7:1

Source: OHA: https://www.oregon.gov/oha/HSD/AMH/Pages/Behavioral Health-Metrics.aspx#mh

These data show a striking difference in the amount of residential treatment provided in proportion to outpatient for SUD services vs. MH services. While caution must be exercised in comparing the two, the data suggest an opportunity to be more proactive in engaging youth and adults in SUD services earlier in the disease process with the aim of preventing members' condition from progressing to the point where a higher level of care is necessary.

The following data represent the most prevalent diagnoses for the Oregon Medicaid population; most recent data available are from Q2 2014:

Children in treatment for:	Prevalence
ADHD	31.4%
Adjustment Disorders	30.9%
Disorders of infancy, childhood and adolescence	15.5%
Anxiety disorders other than PTSD	14.6%
Mood Disorders – Other	14.4%
PTSD	9.8%

Adults in treatment for:	Prevalence
Anxiety disorders other than PTSD	28.0%
Mood disorders – other	28.0%
Major Depressive disorders	20.5%
Mania/Bipolar disorders	14.0%
PTSD	13.8%
Schizophrenia, other psychotic disorders	13.6%

Source: OHA: https://www.oregon.gov/oha/HSD/AMH/Pages/Behavioral Health-Metrics.aspx#mh

The prominence of ADHD among children suggests the importance of ensuring evidence-based behavioral treatment is widely available for children with this condition. In the adult population, it is notable that mood disorders collectively account for 62.5% of the population in treatment. The prevalence of schizophrenia and other psychotic disorders is also relatively high and confirms the need for a comprehensive service array for these disorders.

Mortality from suicide and substance use
The Lane County Biennial Implementation Plan (BIP) identifies two behavioral health-related domains in which mortality locally is comparatively high: Deaths by suicide are 30%-40% higher than national averages and drug-induced deaths were more than a third higher than the state average of 15 per 100,000.

Trauma-informed and trauma-specific treatment
The prevalence of PTSD in the tables above confirms the need for trauma-specific services for a sizeable subset of the population. Consequently, the need for trauma-informed services is much broader. Thirty-two percent of Oregon adults under 100% of the poverty level and 17% of adults above 100% of the poverty level reported a high ACE score (4+ ACEs) in the 2016 Behavioral Risk Factor Surveillance System (BRFSS) survey (source: Trauma Informed Oregon). Many consumers describe interacting with a system that disempowers and re-traumatizes them. Services at all levels must respect the agency of consumers and provide a safe and welcoming environment. Moving our system of care to become more trauma-informed at every touch point is urgent; it is also a marathon and not a sprint.

Specific types of treatment
Many of the specific types of treatment needed by CCO members are described elsewhere in this application, including ACT, EASA, ICC, wraparound, PCIT, CATS, mobile crisis response, ABA, MAT, and all levels of care from routine outpatient through intensive inpatient. Additional specific modalities needed include but are not limited to Dialectical

Behavior Therapy (DBT), Exposure and Response Prevention (ERP), treatment for eating disorders, and services specific to gender identity.

Comprehensive treatment
Treatment at all levels must address the multifaceted context that individuals with MH and SUD concerns live in. Social, family, economic and other stressors have a profound impact on the expression and experience of Behavioral Health concerns. Behavioral Health treatment must be coordinated with other services including medical, social services, and education—the importance of all providers working toward common goals with compatible, coordinated interventions cannot be overstated. Case management must effectively address stressors that may otherwise impede recovery. Service teams often need to include a variety of professionals and others including peers and natural systems of support.

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.**

   Through our equity partner Moda, WCCCO has an extensive Behavioral Health network in Oregon and in Lane County specifically. Moda is already contracted through its commercial products with the following key entities and are confident that we will be able execute Medicaid contracts with them:

   - Adapt/Compass Health
   - Benson Health Clinic
   - Cascade Health Solutions
   - Center for Family Development
   - Christians as Family Advocates
   - Emergence
   - Eugene Therapy
   - Lane County Behavioral Health (including its methadone treatment program)
   - Looking Glass Youth and Family Services
   - Madrone Mental Health
   - Options Counseling
   - PeaceHealth
   - Serenity Lane
   - South Lane Mental Health
   - Strong Integrated Behavioral Health
   - The Child Center
   - Willamette Family, Inc.

   We also have contracts with a dozen residential chemical dependency facilities in other areas of the state which we will draw on in order to ensure rapid access to this level of care. We do not currently have a contract with Integrated Health Clinic (methadone) or White Bird Clinic but do not anticipate any barriers to contracting with them.

   Moda Health's network adequacy standards require that in each county we have a minimum of:

   - One Masters Level Therapist for every 400 members;
   - One Psychologist for every 1,000 members; and

- One Psychiatrist or Psychiatric Nurse Practitioner for every 1,000 members.

The following table summarizes the number of practitioners needed to serve 85,000 OHP members in Lane County and the number of practitioners currently contracted with Moda Health in Lane County:

Provider Type	Required for Network Adequacy	Currently contracted with Moda Health	Standard met or not met
Masters level	200	403	Met
Psychologist	85	126	Met
Psychiatric	85	196	Met

Moda maintains detailed data on providers so that we are able to help members connect with providers meeting their specific clinical needs including language, religious orientation, race/ethnicity and specific specialties such as DBT, eating disorders, etc. Based on these data and our long history of providing services in Lane County, we are confident of our ability to meet the diverse clinical needs of the population.

Data and analysis from Lane County's 2019-2021 Biennial Implementation Plan (BIP) provide additional understanding of the available workforce including unmet needs. The BIP notes that overall, the county is in the top 10% nationally for the ratio of MH providers to residents but that services are heavily concentrated in the metro region and less accessible in rural areas. An additional need is for crisis respite services for youth and adults. The BIP also notes a need for cross-training providers—for example in addictions and mental health—due to the high number of providers with expertise in "one domain."

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?**

We recognize that workforce development requires a collaborative and sustained effort. It requires both adequate reimbursement for Behavioral Health services and educational and training opportunities to ensure specific competencies, including providing pathways for advancement.

We support the use of Peers not merely as workforce extenders but because of the unique perspective they bring and the ability to connect with members in ways that may not be available to professionals. At the same time, we recognize the need for consistent training and supervision of peers. As such, WCCCO through Moda supports Oregon Family Support Network (OFSN) which offers numerous trainings throughout Oregon, and serve on the advisory board of its Reach-Out Oregon initiative. We believe the certification of QMHAs and QMHPs through Mental Health & Addiction Certification Board of Oregon (MHACBO, formerly ACCBO) is a positive development that will add accountability and ensure competency standards for these providers.

WCCCO looks forward to completion of the Behavioral Health Care Workforce Assessment and recruitment and retention plan, scheduled for completion this spring. We will review

these items collectively with our system partners as well as drawing on their direct experiences and challenges with workforce development in coming up with a joint plan to address these needs.

We also believe that providing support and resources for provider organizations to become more trauma-informed is of crucial importance in workforce retention. Research on workforce retention is clear that adequate compensation is essential but not sufficient to retaining qualified staff. The quality of the work environment and relationships with co-workers and supervisors are essential. Given the high stress, vicarious trauma and multiple demands of working in public Behavioral Health, providing a trauma-informed work environment in which staff are physically and emotionally safe and empowered is both challenging and necessary. As we continue along our own path to becoming a more trauma informed organization we intend to collaborate with and provide substantive assistance to partner organizations to do the same.

4. **What is Applicant's strategy to ensure workforce capacity meets the needs of Applicant's Members and Potential Members?**

   Lane County is fortunate to have a robust mental health workforce compared with national norms. WCCCO will work with Lane County HHS to address the identified need for more providers to become cross-trained to serve individuals with diagnoses in multiple domains (e.g., MH, SUD, and Developmental Disorders). WCCCO will monitor workforce capacity in terms of both workforce size and the availability of specific services. We will measure the overall capacity of our provider panel by monitoring timeliness of appointments and adherence to caseload requirements such as the 15:1 ratio for ICC. We will monitor the availability of services requiring specific expertise (e.g., wraparound, DBT, ACT) in the same manner, i.e., by timeliness and caseload size. In addition, we monitor requests for out-of-network and out-of-area services to alert us of potential gaps in our capacity. We will work collaboratively with our provider organizations to identify training needs and staffing needs. We will recruit additional providers as needed. We also are contracted with several tele-psychiatric providers and will employ tele-medical services as needed to augment capacity.

5. **What strategies does Applicant plan to use to support the workforce pipeline in Applicant's area?**

   As noted above, supporting workforce pipeline requires sustained collaborative effort. WCCCO will consult with local and regional partners to explore barriers and opportunities. One area of focus will be to find opportunities for ongoing development from paraprofessional to professional to licensed professional within a continuous course of employment as well as development from direct clinical service to supervision and program leadership. In addition, we will work with providers to explore opportunities for internships and externships.

   WCCCO will place a priority on strategic recruitment and retention efforts for professionals that are both bi-lingual and bi-cultural. Efforts at attracting and retaining these professionals include, advertising in publications, internet domains, and locations commonly frequented by these professionals, along with sign-on bonuses, further education cost reimbursement, and loan repayment programs.

Other miscellaneous areas of workforce development involve conducting candidate satisfaction surveys. The objective is to determine the limitations in our recruitment efforts and how we can make the positions more attractive. These efforts reflect WCCCO's commitment to promoting quality and available care for our membership.

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?**

   Moda will analyze data regarding ACT, ICC, acute and ED services to identify opportunities for service delivery improvement. ACT data will be used to monitor access to services and add capacity if needed, as well as review the appropriateness of denials and require corrective action if patterns of inappropriate denials are noted. Patterns of acute admissions and readmissions will be reviewed through a number of lenses including identifying individual members who may need more intensive supports and identifying common factors that may be leading to destabilization. ED data will be used in the same way. Data regarding transitional supports from ED and acute care will be used to identify systemic needs and performance. These data may also be used to identify high performing or underperforming organizations and identify opportunities to apply best practices from one location to another. Outcomes data such as PROMIS or ACORN will similarly be used to identify individual members needing additional assistance and high performing organizations. Organizational providers will be encouraged to use outcomes data in individual service planning and supervision.

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?**

   There are two federally recognized tribes in Lane County: 1) The Coquille Indian Tribe live in the Tribe's five county service area including Lane County as well as Coos, Curry, Douglas, and Jackson counties; 2) The Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians are made up of three tribes (four Bands): two bands of Coos Tribes: Hanis Coos (Coos Proper), Miluk Coos; Lower Umpqua Tribe; and Siuslaw Tribe. The five-county service area is made up of Coos, Curry, Lincoln, Douglas and Lane counties.

   WCCCO is committed to ensuring that Tribal members have access to services provided by Native American Providers, for both outpatient and inpatient behavioral health services. Since many of these services are located outside of the WCCCO region, efforts will be made to utilize tele-behavioral health if Members would prefer not to make the drive into Portland. WCCCO will continually monitor out-of-network utilization to identify opportunities to further contract with Native American providers being utilized by our Members.

E. Covered Services Components (recommended page limit 36 pages)

1. Substance Use Disorder (recommended page limit 2 pages)

How will Applicant support efforts to address opioid use disorder and dependency? This includes:

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?

Through Moda, WCCCO will continue to provide a full array of SUD services including detox, outpatient, intensive outpatient, residential, MAT, crisis, outreach/engagement and peer services. We will focus on meeting members where they are in terms of stage of readiness, location, culture, trauma history and socioeconomic circumstances. Further, we will improve coordination and connection with members transitioning between levels of care.

WCCCO will use data to assess for continuity between levels of care and strategize to fill identified system gaps or barriers associated with effective transitions. Certified Peer Recovery Mentors will be utilized to broaden the spectrum of care beyond traditional walls and provide care to all who need it, including people in the ambivalent or pre-contemplative stage of readiness. Expansion of MAT will also be a major focus in the service area.

Attention will be paid to staff diversity to reflect the diversity of the community as well as training staff in cultural competence, customer service and trauma-informed approach to all who come for care. WCCCO staff will be trained to either connect members to staff who speak their language or to utilize language lines for translation. We will maintain data on member preferred languages to identify need for staff and printed materials to reflect the members' preferred languages. Contracted providers will be required to similarly employ bilingual staff and utilize language lines.

We will ensure Spanish language services are available through providers such as Centro Latino Americano and Center for Family Development. Members can utilize the provider directory (on-line or hard copy) to find the best provider match to meet their needs. This information will be available in English and Spanish, and includes information on how to access it in 15 additional languages.

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?

WCCCO intends to dedicate a specific PMPM to funding evidence-based primary prevention services. In addition, we will make community reinvestment funds available for system partners to apply for grants for specific projects building upon the model Moda has developed for EOCCO. WCCCO will partner with the Health Department, SUD providers, primary care providers, schools and other stakeholders to ensure alcohol, tobacco and other drug prevention and education services are available and provided in multiple settings. We will learn from EOCCO's success in using the CAC to help coordinate and target these efforts. As we partner with stakeholders to complete the CHA

and CHP, we will gather information on where preventive services may be most needed and effective. Medical and Behavioral Healthcare providers will be responsible for providing appropriate screenings in all settings. We will continue to partner with primary care providers in implementing SBIRT protocols, providing training, incentives, data and technical assistance according to identified need and interest.

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?

WCCCO views informing members of the availability of SUD services as a shared community responsibility that will be most effective when schools, agencies and providers know in advance what resources are available and can provide that information to members in real time when a need is identified. Such identification can happen in any setting at any time, so it is essential that WCCCO inform providers and community partners of the availability of services and facilitate access to those services in real time.

This means that WCCCO will allow providers, family members, schools and other partners to refer members directly to treatment providers rather than waiting for a prior authorization process. WCCCO will also provide this information directly to members through the provider directory in print or online; the directory will designate programs with specific cultural and language competencies and will include instructions on how to get help in multiple languages. The member handbook will be available in English and Spanish, with information on how to access it in 15 additional languages. WCCCO will also disseminate information to community Members and referral sources via a number of venues including CACs and the CAP.

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.

As a newly developed CCO, WCCCO intends to model the work around opioid programs that are developed out in Eastern Oregon. WCCCO plans on engaging with local clinicians to create a multi-disciplinary team that uses data and current clinical guidelines to build programs for members in need of SUD and recovery services, as well as decrease the overall utilization of opioids.

We plan to adopt the strategy of "remove and replace" for the treatment of members with opioid use. This plan is a physician led treatment that identifies members who have high risk opioid utilization and works to remove the opioid and replace it with more clinically appropriate care, such as movement therapy.

WCCCO will work to support the clinical community by providing taper plan support, peer to peer engagement, and various ways to implement current prescribing guidelines in clinical practice. WCCCO will provide ongoing analytics support to help identify areas of opportunity and provide clinics and physicians a roster of members on opioids and how the overall incidence rate benchmarks against their peers. We will encourage the use

of the PDMP prior to any visit with a member who has been identified on their population roster.

To ensure adequate workforce, provider capacity, and recovery support services, WCCCO will also look to adopt new payment methodologies to provide more access to treatment. We will also look to ensure the appropriate level of Waiver X providers within the community and provide trainings for physicians if necessary.

Additionally, WCCCO is focused on meeting members where they are in terms of readiness, location, culture, and socioeconomic circumstances, and improving coordination and connection with members transitioning between levels of care.

e. Coordinate with Providers to have as many eligible Providers as possible be DATA Waived so they can prescribe MAT drugs.

Efforts are ongoing to increase the availability of MAT services including encouraging providers to acquire a data waiver. MAT services are currently available in Lane County but there is a need to increase the ease of access. One avenue is the increased use of telemedicine. WCCCO through Moda's opiate service planning group will work to identify the most effective locations to create new capacity in the county. We will seek to replicate the success we have had in Eastern Oregon by identifying physician "champions" who can provide consultation and training and encourage their peers to become DATA waived.

WCCCO members under the OPDP Consortium will have access to MAT products, buprenorphine and naloxone, as a covered benefit without the additional barrier of a prior authorization.

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.

WCCCO will build on the model of community collaboration that we have developed in EOCCO, bringing diverse stakeholders to the table to develop collective solutions. One key element in coordination with hospitals and EDs is PreManage. WCCCO will use it to identify members with repeat ED visits and any admissions related to SUD. These notifications will allow us to reach out to members in real time and work to engage them in services at the most appropriate level. We will also add contact and care plan information into PreManage so that EDs have access to care plans and recommendations that may already be in place for members. We will partner with housing coordinators, peers and other local partners to identify both individual and systemic needs across the continuum.

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**

> We intend to devote a PMPM allocation to primary prevention; use of these funds will be coordinated with HHS and schools to implement evidence-based primary prevention programs.
> We will work with Lane County Behavioral Health to ensure effective coordination between levels of care and ensure engagement in outpatient and IOP programs upon step-down.
> We will engage with provider clinics to implement SBIRT as described above.
> PCPs will be sent a monthly roster that identifies of all members that are on an opioid product and the report will specifically call out those that are: high risk (120 MED+), those with multiple prescribers at multiple pharmacies, those with a back pain diagnosis that would fall under the HERC guidelines, and those with concomitant use of benzodiazepines.
> Morphine Equivalent Doses (MED) Point of Sale Edits will be utilized to alert pharmacists when prescription exceeds a 90 MED (that can be over-ridden by a pharmacist given clinical rationale), or exceeds 200 MED which requires a review by WCCCO before the prescription is filled.
> We will build on our experience in Eastern Oregon in creating an alternative to opioid use for people with chronic pain. These wellness centers host pain schools that are staffed by a multi-disciplinary team, provide group sessions that include psycho-education, movement therapy, nutrition counseling, and Behavioral Health support. Members enrolled in the program report a decrease in depression, anxiety, and pain interference, as well as an increase in self-confidence related to managing pain.
> We will continue to develop additional MAT capacity.
> We will make Naloxone available upon request and coordinate outreach and education efforts on overdose reversal.

2. **Fewer readmissions to the same or higher level of care Prioritize Access for Pregnant Women and Children Ages Birth through Five Years (recommended page limit 6 pages)**

   Applicant will prioritize access for pregnant women and children ages birth through five years to health services, developmental services, Early Intervention, targeted supportive services, and Behavioral Health treatment.

   a. **How will Applicant ensure that periodic social-emotional screening for all children birth through five years is conducted in the primary care setting? What will take place if the screening reveals concerns?**

      WCCCO will build off of Moda's experience with EOCCO. It has success meeting the developmental screening incentive measure through continued support and funding to primary care providers. EOCCO clinics that meet the incentive measure for the developmental screening measure are eligible for quality bonus payments. Each primary care clinic receives a monthly provider progress report with their improvement rate as well as an outreach roster to utilize to schedule visits for members who have not had a developmental screening in the calendar year. Moving forward, WCCCO will ensure

continued support and utilize our previously effective strategy to conduct periodic social-emotional (ASQ-SE) screening for all children 0-5 in primary care settings.

WCCCO also plans to identify early intervention/early childhood special education providers as well as behavioral health providers in the area who can evaluate social-emotional development in order to establish relationships between them and the primary care clinics. We will implement key tools and quality improvement practices to increase referrals to treatment when screenings reveal concerns. Tools include: standardized child-specific referral forms, a medical decision tree with considerations for internal behavioral health processes, and a shared decision making tool/education sheet for primary care to use with families. These tools positively impact both providers and families receiving services, advancing the discussion of behavioral health options and processes in the community. The implementation of these tools help establish and standardize a clear pathway for service providers and families if concerns are identified at screening.

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?

WCCCO will assess what tools are currently in use by local providers and support any appropriate evidence based tools that are in use. We will assist providers needing technical or material support to implement appropriate screening. Options include the Parenting Stress Index 4 Short Form (PSI4-SF), the Eyberg Early Childhood Behavioral Inventory (ECBI) and the Devereaux Early Childhood Assessment for Infant & Toddlers, DECA I/T. We will establish mechanisms for quarterly reports for data collections and evaluation processes for these tools, approved and monitored by the OHA. .

We will examine training needs, practice workflows, barriers and opportunities with regard to screening for ACEs and resiliency among primary care providers serving parents and children.

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?

WCCCO will encourage providers to utilize the PHQ-9 to screen for behavioral health needs in primary care for all pregnant members both during pregnancy and post-partum. WCCCO will also support the use of the 5 P's model to screen for substance use concerns in pregnant members. WCCCO, through Moda, intends to offer an HIE platform called Arcadia Analytics to clinics who are interested in onboarding, which allows them to see real time data on both prenatal and postpartum screening. The platform can also produce "gap in care" reports for clinics to utilize for outreach. WCCCO will also partner with local Public Health Departments and other home visiting programs to build infrastructure around providing screening and subsequent visits to every pregnant member.

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?

WCCCO will identify behavioral health resources in the community that are currently working in partnership with OBGYN services. In this discovery process we will also confirm that there is a streamlined referral process in place. We will ensure that this is a closed loop process where the behavioral health provider notifies the OB provider when the patient has been seen. WCCCO will continue to support this closed loop referral process and implement quality improvement strategies to improve this workflow when needed. WCCCO will support behavioral health integration within the primary care setting. This will help remove existing stigma associated with established mental health stand-alone sites, support the Warm Handoffs and provide in-house referral process with connection to support services.

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?

WCCCO will partner with local organizations such as the Child Center, which is able to provide rapid mobile crisis response and facilitate immediate referrals to respite services, psychiatric evaluation and linkage with other services. These immediate intensive supports allow families to weather crises and stay together while connecting with ongoing services that will ameliorate conditions that produced the crisis.

Ongoing services such as PCIT, IOSS, skills training, Child-Parent Psychotherapy and Collaborative Problem Solving will provide avenues for the necessary ongoing therapeutic work. We will assess the availability of these services and any training needs for making them more widely available and ensuring fidelity.

We will evaluate opportunities to use a Therapeutic Foster Care (TFC) program to incorporate evidence based Dyadic Treatment models, such as the Attachment and Bio-behavioral Catch-Up Intervention (ABC) model for infants 6 to 24 months and their caregivers. The TFC infrastructure currently supports foster families who foster extremely high-risk youth, putting the program in an ideal position to partner with DHS-Child Welfare serving families that will be identified through the Family First Services Prevention Act. Oregon Child Welfare reports that over 45% of children removed from their homes are under age of five. Providing supportive services and evidence based Dyadic Treatment to this age group and their parents reduces the likelihood of out of home placement, and encourages healthy parenting skills, child development, and attachment.

For children who have an autism diagnosis, we will provide Applied Behavioral Analysis in the home and other appropriate locations. ABA providers will be required to coordinate intensively with other entities serving the child including schools, pediatricians, and speech & occupational therapy. We recognize the critical importance of training parents to empower them to implement the principles of ABA to enhance the child's learning.

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)?

WCCCO will continue and expand upon programs that have enjoyed success both in Eastern Oregon and in Lane County, including:

- The Positive Parenting Program (Triple P) and Family Check-up, which in Lane County have already reached more than 25,000 families and trained at least 20 providers and reduced risks for ACEs;
- Mental Health Coaching for Home Visitors;
- CATCH Pre-K to address childhood obesity;
- Screen and Intervene, Veggie Rx and Produce Plus, which are increasing the availability of fresh produce to low income households

We will work with partners such Lane County HHS, the Lane Early Learning Alliance and the Lane Equity Coalition to identify additional needs and opportunities.

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.

Further steps will be identified in partnership with Lane County HHS in development of the Local Plan and with the wider set of stakeholders in developing the CHA and CHP. In addition, Moda will utilize the Health Complexity Data provided by OHA in partnership with the Oregon Pediatric Improvement Partnership (OPIP). The social complexity algorithm identified several ACEs into their list of 12 factors. To assist us with developing our implementation plan to meet the needs of children with high health complexity, WCCCO will use technical assistance from OPIP. Examples of TA being offered by OPIP include: using population-level findings regarding children's health complexity to engage community-level partners and facilitate community conversations, using health complexity data to develop models of best match care coordination and case management for children with various levels of health complexity, using children's health complexity information to guide efforts with front-line health care providers.

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?

WCCCO will not refer members between the ages of zero to five to residential levels of care, or partial hospitalization for day treatment. If a youth age 6 and above requires a higher level of care including day treatment, subacute, or PRTS, children and families will be automatically eligible for and offered fidelity Wraparound. Regardless of the interest in the Wraparound process, the youth is provided ICC services and supports. For any child referred to a higher level of care, continuity and coordination with existing outpatient services is of utmost importance. If a child is placed into a facility based residential treatment program, WCCCO will work with service providers to ensure the child and parent can continue treatment while in out of home placement.

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.

WCCCO through Moda has trained its clinical and customer service staff in trauma-informed principles and is evaluating how to employ TIC more systematically throughout the organization. Moda formed a work group to explore how to become a more trauma-informed organization. This work group has developed a plan for staff assessment and training and a logic model for the role of TIC within the organization.

In addition to the trainings listed below that complement the trauma informed approach, Customer Service is one of Moda Health's first departments to become Trauma Aware, Trauma Sensitive, and Trauma Responsive, delivering education and training on ACEs. The training module captures what ACEs is and what can be done from a service delivery perspective. Customer Service agents are equipped with an abusive language script that provides trauma sensitive language to use during contentious exchanges. Moda is looking to eventually expand / adapt this training, with special emphasis on all member-facing teams.

Several of Moda Health's onboarding trainings socialize new hires to trauma informed concepts – Trustworthiness and Transparency, Collaboration and Mutuality, Cultural, Historical, and Gender Issues – as early as Week 1. All staff are required to work through the following Moda University e-modules during their onboarding process and on an annual basis, thereafter, recognizing the high degree of variability of life experiences:

- Cultural Competency
  Learning Objectives:
  - Awareness of one's own cultural worldview
  - Knowledge of other cultural practices and worldviews
  - Tolerant attitudes toward cultural differences
  - Cross-cultural skills
- Implicit Bias
  Learning Objectives:
  - Understand why and how implicit bias exists
  - Identify their own implicit biases
  - Have increased awareness on how to push their bias aside while making decisions
  - Recognize the negative impact that bias can have in your team
- Working in an Inclusive Environment

Moda also offers a training on Grit and Resilience, emphasizing how the ability to bounce back from adversity and keep going when things get tough enable are two of the traits of highly successful individuals. This training explores resilience as the optimism to continue when times are tough and you've experienced some failures, and grit as the drive that keeps you on a difficult task over a sustained period of time.

In addition to internal trainings, Moda will work with provider organizations and community agencies to assess the needs and opportunities for training and technical assistance on TIC across the spectrum of care.

3. Care Coordination (recommended page limit 12 pages)

a. Describe Applicant's screening and stratification processes for Care Coordination, specifically:

(1) How will Applicant determine which enrollees receive Care Coordination services?

Children and Adolescents (Child Welfare): WCCCO will provide all children in Child Welfare and State custody with the opportunity for Care Coordination by way of the Program Eligibility Resource Codes (PERC). This weekly report will identify all youth entering Child Welfare and State custody. We will utilize our partnerships with local Child Welfare and other State agencies to facilitate engagement from legal guardians for successful Care Coordination.

Youth with SED: WCCCO will qualify for Wraparound all youth identified with a serious emotional disorder (SED) and who are involved in two or more child serving systems. If the child and family declines services through the Wraparound process, they are provided with Intensive Care Coordination (ICC). We are guided by the Wraparound principles when working with all youth at this level of care, and provides these services in a trauma informed, culturally responsive, and linguistically appropriate way.

SPMI population: Members with an SPMI diagnosis will receive Care Coordination Services at all levels. At the local level, members who carry an SPMI diagnosis that are at risk for rising to a higher level of care will be offered the Choice Model program for Care Coordination services. Intensive Care Coordinators (ICC) also provide care coordination for those who are in higher level of cares (acute/residential) and/or needing assistance with stepping down into a lower level of care. In addition, referrals for care coordination services are received from a variety of sources, including providers, members, caregivers and discharge planners; including those needing care coordination through the Multi-Disciplinary Team (MDT).

MAT services: Members seeking MAT come from a variety of referral sources including self, primary care, ED staff, SUD program staff, WCCCO staff etc. Every member screened and eligible for MAT services is served in a team based care model which includes an LMP, a Behavioral Health clinician and a care coordinator. Care coordination is considered a critical component of the model and is an essential component of the service plan. All members enrolled in MAT services will receive care coordination.

(2) How will Applicant ensure that enrollees who need Care Coordination are able to access these services?

Children and Adolescents (Child Welfare): WCCCO will ensure youth in state custody have access to care coordination services by providing access information and initiating a conversation with their legal guardian. We will generate weekly reports to identify youth in State custody and provide to contractors to initiate Care Coordination services.

Youth with SED: Youth identified with a serious emotional disorder will receive individualized outreach to assess their needs, and also offered the opportunity to participate in Wraparound services as appropriate. If the enrollee declines Wraparound services, they are provided Intensive Care Coordination to allow streamlined access to care that will meet their social, emotional, and physical needs.

MAT services: All members getting MAT services will receive care coordination as part of the basic services provided by the MAT team.

SPMI population: All members with SPMI will be offered care coordination. Members who are not yet connected with an ongoing Behavioral Health service provider will be engaged by WCCCO care coordinators with the aim of establishing an enduring treatment relationship with a contracted provider. Members in Choice Model services are engaged at least monthly by CMHP staff to assess and address care coordination needs. Needs for housing, transportation, etc. are paid for through Choice funds to ensure a member remains stable and at the lowest level of integrated care.

(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?

Children and Adolescents (Child Welfare): We will run a week utilization report using PERC codes to identify children in Child Welfare and state custody and ensure that through the CANS process, all children in Child Welfare custody are seen within their first month of care.

SPMI Population: WCCCO will to use an established coordinated process to welcome new members to the plan. All newly enrolled members receive a detailed welcome letter that explains enrollment, coverage, services and benefits. We will reach out proactively to all members whose health risk assessments indicate SPMI to ensure connection with appropriate services regardless of prior utilization.

Transition Age Youth: WCCCO will send a letter to youth transitioning to adult services three months prior to turning 18 years old, to inform of potential changes to Behavioral Health services. This letter also provides contact information for members that need assistance.

MAT services: Since care coordination is an integrated service for MAT participants, staff are immediately aware when members are not participating. The care coordinator will reach out to the member to reengage them in treatment right away. If the member declines to participate, other options will be offered.

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).

WCCCO will adhere to timeliness guidelines established in OAR 410-131-3170 for responding to referrals for ICC within one business day and completing an assessment within 30 days. Members with more urgent needs will be assessed in accordance with their medical needs. We will track timeliness of assessments and require contracted providers to adhere to the same timeliness standards.

c. Please describe Applicant's proposed process for developing, monitoring the implementation of and for updating Intensive Care Coordination plans.

Processes for developing and updating ICC plans will vary according to site-specific and population-specific factors given that ICC will happen in various settings. WCCCO will follow Moda established case management procedures for ICC. We will contractually require and monitor procedures adherent to OARs and best practices for ICC delivered by contracted providers. In all cases, ICC plans will incorporate person-centered principles reflecting the member's desires and goals. We will monitor providers' Behavioral Health care plan development, completeness and updates through provider chart audits. If a pattern of issues is identified, we will utilize performance improvement plans and progressive corrective action to work with the provider until the expected quality of care plans are achieved.

WCCCO's equity partner Moda adheres to NCQA standards in developing, monitoring and updating Intensive Care Coordination plans. The ICC plan is developed from an initial assessment which is based on on-screen prompts in the care management module of the medical management software application. Goals in the care plan are prioritized and developed based on information gained during the assessment as well as from consideration of the member or caregivers' goals and preferences. At least monthly, progress towards meeting the goals of the ICC plan are evaluated and documented in collaboration with the member. Goals, interventions and timelines are updated based on the member's needs.

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

The goal of care coordination is connecting members to resources that will improve their functioning, thereby improving quality of life and reducing costs. WCCCO will take a holistic approach to care coordination services – physical, mental health, dental and SDOH needs are all assessed and addressed. SDOH assessment includes such things as transportation needs, financial concerns, housing and social supports. Effective and cost effective coordination begins with a thorough assessment of the member's resources and needs in all these domains and identifying the individuals and systems of support already in place, and those that are needed but not yet in place. We will reduce duplication through effective identification of the member's "team," and who plays what role on the team. The ICC coordinator will ensure all team members understand the care plan and understand the roles played by others. Clear communication and collaboration will minimize team members acting at cross-purposes.

Care coordinators offer Member support through a variety of programs:

- Peer-delivered services (PDS): Peers improve the effectiveness of care plans by a number of means including providing positive role modeling, reducing stigma and isolation, ensuring the member's voice is heard, translating from clinician-ese to consumer-ese, identifying resources, and building hope and motivation for recovery.
- Money Management Program (MMP) services: MMP assists people in maintaining independence, obtaining financial security, and prevents financial abuse. The

program serves older adults, people with disabilities and veterans. Representative payees advocate for, and provide services for, individuals determined to need assistance managing their funds. Close collaboration with the Veterans Administration, the Social Security Administration, banks, landlords, family members, friends, and pension funders is required to successfully manage this program.

- Non-emergent transportation services.
- Complex care consultation for older adults through a dedicated team of specialists. This team provides written recommendations to the referral agency including clinical Behavioral Health interventions and psychiatric medication review.
- Rental assistance program: Individuals who are 18 years of age or older with Serious Mental Illness (SMI), as defined in OAR 309-032-0311(17), and who meet at least one of a set of five additional criteria may qualify for RAP. RAP Services include payments for a residential specialist position and a peer support specialist position. Staff in these positions are responsible for coordinating the program components such as application process, finding a rental unit, and payments to the landlord, and the support service components which supports Individuals in their ability to live as independently as possible in the community. RAP additionally provides coverage for move-in expenses based on the Individual's need and determined by the program. Approximately 90% of those who are in the program are also on OHP.

e. What is Applicant's policy for ensuring Applicant is operating in a way guided by person centered, Culturally Responsive and trauma informed principles?

WCCCO through its equity partner Moda recognizes that policies are easier to write than they are to follow. In addition to the training information included in our response to question E.2.i., above, our organization's commitment to operate by these principles is best embodied in the work of Moda's Diversity Council, whose mission is as follows:

> *Our mission is to build and sustain a stronger culture by nurturing new ideas and driving innovation.*
>
> *We accomplish this by embracing diversity and inclusion in background, opinion and perspectives in all aspects of our business. It helps us better connect with our members, profitably grow our business, and strengthen our community.*
>
> *We are better when we listen, understand and connect with our employees, partners, customers and community.*

Moda's Diversity Council initiatives have included, and are not limited to, the following:

- Implement a plan to improve data collection processes, including Race, Ethnicity, and Language (REaL) and other key health disparity indicators
- Increase understanding and knowledge of health care disparities and improve healthcare services based on healthcare disparity data
- Diversify panel, council, and committee membership based on healthcare disparity data

- Share best practices by hosting a biannual collaborative sessions with OHSU, EOCCO, OEBB and our other healthcare partners

Moda has been very intentionally exploring both what it means *and* what it will take to become a Trauma Informed organization. Beginning in May 2018, a small but diverse team has been meeting to assess its readiness for recognition, awareness, and foundational knowledge of trauma informed care. This same group met with Trauma Informed Oregon (recognizing the wealth of resources this team has to offer) in early February 2019.

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?

WCCCO intends to provide for continuity of existing services by supporting Lane County Behavioral Health in continuing to provide Intensive Care Coordination. This arrangement will preserve existing relationships and make use of existing expertise and infrastructure. WCCCO through Moda also has Registered Nurses who provide ICC for medical needs and they will work closely with Lane County Behavioral Health to coordinate for members with intensive medical and behavioral needs. We have extensive experience implementing and monitoring delegation agreements to comply with NCQA and CMS requirements.

Our contracts will include specific requirements for care coordination in alignment with OHA requirements. WCCCO will enforce contract requirements through regular reporting and by conducting annual reviews. Reviews include member-specific charts with attention to documentation (assessments – coordination of information to determine medical necessity, service plans – service interventions and coordination, service notes – delivery of services and coordination of care) as well as assessment of systems-level data and functions. Feedback on reviews will be given with potential for corrective action plans (CAPs), technical assistance, or additional monitoring.

g. For Fully Dual Eligibles, describe any specific Care Coordination partnerships with your Affiliated Medicare Advantage plan for Behavioral Health issues.

WCCCO will participate in MDTs to provide opportunity to coordinate care for those members who are dually eligible. All members, including those who are dually eligible, may be referred to the MDTs for care coordination needs.

Moda Health Plan, Inc. Medicare Advantage is WCCCO's Affiliated Medicare Advantage plan partner. If the provider is contracted with Moda, coordination will occur through the normal payment procedures. WCCCO's medical Case Management staff will work within the same department and in the same location as the case managers that work on the affiliate Medicare Advantage plan. When a WCCCO member is dually enrolled in both, the member will have a single medical case manager who addresses both benefit packages. For members receiving case management through Lane County Behavioral Health, the Moda Health case manager will coordinate closely with the Lane County Behavioral Health case manager.

h. What is Applicant's strategy for engaging specialized and ICC populations? What is Applicant's plan for addressing engagement barriers with ICC populations?

Children and Adolescents: WCCCO will incorporate family partners and youth partners into our delivery model to engage members in specialized populations. Many members in these populations have historically had negative experiences with Behavioral Health service providers. In an effort to engage in a culturally responsive and trauma informed way, WCCCO will use the Wraparound principles of outreach and engagement to break down barriers and address reluctance to accepting services from Behavioral Health organizations.

Services for Mother & Child: WCCCO will offer care coordination services for Mothers with babies or young children. Because Moms in recovery with babies or young children face a tremendous shift in responsibility, expectations are high to stay clean, try to get a job that overlooks the felony from drug use, and to be a mom. Offering CCM or Care Coordination for both mom and child could lessen barriers. The child may be born with developmental issues secondary to mom's substance use and need specialized supports and services. WCCCO believes that providing care coordination services for the mom and child as a unit could directly impact the health of both.

SPMI population: WCCCO will coordinate closely with mobile crisis and ACT teams to engage the SPMI ICC population. Outreach also occurs telephonically and through letters. As needed, outreach occurs in-person through CMHP staff. Offering concrete assistance can help engage an individual in care coordination. Members with SPMHI and SUD diagnoses are at particular risk when discharging from higher levels of care. Care Coordinators will try to engage the member while still confined and develop effective follow-up care plans, then follow the member after discharge to ensure engagement.

Addressing engagement barriers with the ICC population: WCCCO is committed to outreach to members, especially those who have difficulty coming to a clinic. ACT outreach services provide a mechanism to engage individuals who might not otherwise seek services. Peer Support services provide a non-threatening connection with needed care coordination services. Care coordinators will interact with members in the spirit of Motivational Interviewing to encourage an individual to engage more fully in their care. In addition, telehealth allows members to receive mental health services and access care coordination services from their home. If transportation is needed, WCCCO will provide Non-Emergent Medical Transportation (NEMT) services.

MAT Services: MAT team care coordinators will engage with outreach and engagement specialists, drug court staff, law enforcement, physical health providers, housing providers, Behavioral Health providers and social service providers in order to identify and connect with members who may have SUDs and ICC needs.

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.

Children and Adolescents: If a youth is enrolled in ICC and/or Wraparound, they and their caregivers have full participation in their plan of care. Youth and their caregivers are

the drivers of when discharge plans are implemented, and are part of the team decision making process that would determine discharge of care coordination.

SPMI population. For those members who are graduating from ICC services, a conversation between the care coordinator and member is held to ensure that the member is in agreement that goals are met. A congratulatory letter is mailed to the member as they are discharged from these services. If a member requests discharge from ICC services before achieving collaboratively developed goals, the care coordinator holds a conversation encouraging the member to continue with services. If the member continues to state that they no longer wish to participate, the care coordinator informs the member that their desire to leave the service is being honored and they are being discharged at their request. If a member is not engaging after accepting ICC services, every effort is made to re-engage the member prior to discharge. The care coordinator makes two telephonic attempts, calling on different days and different times of the day; and one attempt by mail. If the member still does not re-engage, then they are discharged from the program.

MAT services: WCCCO assumes that addiction is a chronic, relapsing brain disease, and that engagement with the member is long term with possible breaks in services if the member relapses. Teams are prepared for multiple instances of moving in and out of service. The expectation is that reengagement is part of the process. A treatment team conference will be held when it is clinically determined that a member is ready for discharge from MAT. If all agree, necessary long term supports will be put in place. Outreach for members who stop engaging prior to completion of services will follow the steps described above for the members with SPMI.

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?

Children and Adolescents (and Family): WCCCO will coordinate care when children are placed out of area or out of state, including addressing barriers related to access of physical, dental, and mental health care. Existing care coordination, ICC, and Wraparound supports continue to engage with the child and family team, incorporating any new team members necessary when a child is placed in a different level of care. In addition, the Wraparound Transfer Protocol ensures that Wraparound will transfer with them if they transfer counties or outside of WCCCO's service area. WCCCO will use the utilization management process to ensure coordination of care and appropriate discharge planning from higher levels of care. In addition, we use Pre-manage to ensure we are aware of ED visits and acute episodes. We are also able to use PreManage to provide important information to ED social workers for members at risk of repeated ED visits. WCCCO will ensure coordination with members' outpatient providers during the course of an inpatient stay.

SPMI population: WCCCO will ensure care coordination of members throughout the system at all levels of care and over multiple episodes of care, including outside the service area. Each member will have an ICC through the CMHP or directly through Moda. The ICC coordinates the care of the member, including outside the county. The ICC works with the member's providers across the health spectrum to ensure the member receives

needed services including medical, behavioral and dental care. WCCCO will monitor these members through Choice Model reports. The assignment of one care coordinator throughout episodes of care and at different levels of care will ensure continuity between different settings.

MAT services: MAT providers will be expected to provide care coordination to Members involved in the program with any other needed services. WCCCO will provide care coordination directly as needed for members accessing higher levels of care or services outside the local service area.

k. How will Applicant manage discharge planning, knowing that good discharge planning begins from the moment a Member enters services?

Children and Adolescents: Members in ICC and Wraparound participate in the development of the team mission at the initial development of the plan of care. This plan of care developed at intake addresses the planned discharge when the team mission is met and is evaluated at each child and family team meeting. As progress is made, more specifics related to discharge planning are developed by the child and family team to ensure successful transition to a lower level of Care Coordination. This transition phase is also addressed in the parent's Wraparound Guidebook, which is given to each youth and family at entrance to the program.

SPMI: Discharge planning is a major focus of utilization review from the outset of inpatient care. WCCCO care coordinators will obtain detailed discharge planning information from the facility at every review and provide assistance and resources as necessary. Once an individual is discharged the care coordinator will stay in contact with the member to ensure that a 7-day visit follow-up occurs and ongoing supports are in place.

MAT Services: Discharge discussions begin at the first team meeting and in the first conversation with the member. Identification of and planning for needed long term recovery support is part of every session. Encouragement for involvement in local support groups, educational activities and housing that is supportive of recovery goals is a major focus of the program. At the point of discharge, the team will work with the member to assure that needed follow-up is in place.

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)?

For members in higher levels of care, care coordination takes place through the utilization management process as described above.

WCCCO's strength in developing community partnerships will be key to ensuring coordination of care for members in systems such as the criminal justice system. We will work collaboratively with community entities to identify transition points, partnership opportunities, and processes for warm hand-offs. The specifics of each process will be developed collaboratively through dialogue and MOUs to formalize relationships and procedures.

m. Describe how Applicant will ensure ICC Care Coordinators will maintain the 15:1 caseload requirement.

WCCCO will develop policies, procedures and contractual requirements to ensure that all Behavioral Health care ICC Care Coordinators remain at a 15:1 caseload or lower. We will enforce contract requirements through reporting and audits of high capacity Behavioral Health providers.

n. Which outcome measure tool for Care Coordination services will Applicant use? What other general ways will Applicant use to measure for Care Coordination?

WCCCO is a strong supporter of outcome-informed Behavioral Healthcare. We believe firmly that the use of outcomes measures enhances the effectiveness of Behavioral Healthcare; and furthermore, that the provider's investment in and understanding of the outcomes measures is of critical importance in realizing the potential of outcome-informed services. We will begin by assessing for outcomes tools already in use by provider entities already engaged in care coordination within Lane County. We will support any evidence-based tool that is in use and has buy-in from the staff using it. We will also measure care coordination through member satisfaction surveys and reporting and analytics on measures such as number of members receiving services, length of time in services, and status at discharge.

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?

The sharing of information for coordination of care depends upon appreciation of its importance, provider understanding of the relevant rules and laws, and the available technology and resources. WCCCO will work collaboratively with providers to ensure accurate understanding of relevant laws including those that explicitly allow for the sharing of Protected Health Information with or without consent for specific purposes. We will educate members on the benefits of information sharing and encourage them to sign releases whenever appropriate. We will assess the state of HIE among providers and provide technical and financial assistance where feasible. Where technology is limited, we will share information the old-fashioned way, by phone and fax.

We will also assess providers' use of PreManage and encourage active use of care plans where appropriate. WCCCO will also use PreManage both to enter information and receive notifications.

4. Severe and Persistent Mental Illness (SPMI) (recommended page limit 6 pages)

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?

WCCCO through Moda will build on Moda's strong record of leadership and collaboration with other stakeholders to improve our system of care. Examples of this collaboration over the past few years include:

- Served on the OHA Behavioral Health Needs, Resource and Outcomes Technical Advisory Committee (Behavioral Health Mapping Committee) for its full duration (2015-2017)
- Served on the OHA Behavioral Health Collaborative for its full duration (2016-2018)
- Served on work group that produced the Oregon Youth Suicide Intervention Plan (2015)
- Participated actively in work group that developed HB 3090 and 3091 establishing standards for crisis assessments, disposition, coordination of care, and payers' responsibility to cover these services (2015-2017) and the Rules Advisory Committees implementing both bills
- Initiated and co-facilitated a spin-off work group from the HB 3090 and 3091 discussions, bringing commercial payers and CMHPs together to overcome barriers to CMHP services and coverage for members with commercial insurance (2016-present)
- Initiated and co-facilitated a multi-stakeholder group with goal of extending commercial coverage to OHA-funded Crisis and Transition Services (CATS) program (2018-present)
- Serves on Oregon Alliance to Prevent Suicide (2018-present)

This record of leadership is driven by belief that members are best served when the system of care is healthy, comprehensive, and robust. It is informed by an understanding that fragmentation between publicly and privately funded systems serves no-one's best interest and the conviction that competing entities can collaborate to achieve transformation when we focus on systemic improvements that will benefit all involved. We are excited about the transformative possibilities that will be opened up by administering a WCCCO together with our commercial business in in Lane County. We believe this will open up new avenues of collaboration to work toward a more integrated, responsive and equitable system of care serving the public and private markets.

Specific to serving the population with SPMI, among other efforts we will collaborate with Lane County Behavioral Health and OHA in implementing the requirements of the DOJ agreement and improving transitions from the state hospital; with local law enforcement, crisis services and Community Mental Health to improve services for individuals involved with the legal system; housing and social service providers to ensure stable housing; and advocacy and training organizations to ensure availability of peer delivered services.

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?

The cognitive and functional deficits caused by mental illness may result in the need for housing and treatment in all manner of facilities funded by the State of Oregon. Some of

these conditions are severe but temporary, while others can experience lifelong disabilities. SPMI is by definition prone to cycles of improvement and relapse and there is no set level of care an individual requires for life. WCCCO is fully cognizant of the need to allow people to get better and to move out of highly structured care settings. We will work within a continuum of residential treatment capacity that serves residents from the entire state, allowing for transitions from higher level to lower levels of care in a thoughtful and carefully coordinated manner. Strategically placed resources have helped eliminate travel barriers between the different levels of care often needed for members with SPMI.

WCCCO will coordinate with local community mental health providers to look for opportunities to invest in and partner with the development of both large and small, specialized residential treatment and adult foster home capacity that can work with certain subsets of the population who are extremely difficult to place.

Through Lane County Behavioral Health, WCCCO will manage the residential service array for mentally ill people whose needs are immediate and who may require residential services with a focus on crisis resolution, intensive short-term interventions and the preservation of existing connections to systems of support. Delay in residential placement because of waiting lists and complicated authorization procedures should not be the reason for hospitalization that is otherwise unnecessary. Some people need services requiring immediate decisions and intensive intervention. WCCCO will ensure our Utilization Management program is available to work rapidly on these situations.

WCCCO will approach the care of persons with an established residential treatment history through a focus on transition issues and by building long-term connections to natural systems of support. Coordination between Care Management, Utilization Authorization, clinical staff and community partners is critical as Members are moved through various level of care. WCCCO will provide Choice Model and Care Coordination staff with a variety of skills to work with CMHPs and community partners to assure these transitions are successful.

c. How will Applicant ensure Members with SPMI receive ICC support in finding appropriate housing and receive coordination in addressing Member's housing needs?

WCCCO will work with Lane County Behavioral Health to identify the most appropriate models for providing ICC services to members with SPMI. We will utilize Choice Model funding through agreement with OHA to support intensive care coordination for individuals who have been or are at imminent risk of civil commitment. These resources will be used, in part, for housing barrier removal and to assist individuals in locating appropriate housing. For Members involved with ACT teams, coordination occurs as part of their care. WCCCO appreciates the indispensable role of housing reflected in the maxim "housing first". We recognize that homelessness is never a safe stage for recovery to begin.

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?

In addition to providing ICC through ACT and using the CHOICE Model for housing funding, WCCCO will engage the State of Oregon Rental Assistance Program (RAP) Services. RAP are intended to assist individuals who are 18 years of age or older with Serious Mental Illness (SMI), as defined in OAR 309-032-0311(17), and who meet at least one criteria listed in the OAR for paying for rental housing.

RAP Services include payments for a residential specialist position and a peer support specialist position. Staff in these positions are responsible for coordinating the program components such as the application process, finding a rental unit, and payments to the landlord; and the support service components including, but not limited to, financial budgeting, community navigation, and maintaining healthy relationships, which supports Individuals in their ability to live as independently as possible in the community. Both the specialist and the peer support staff visit each participant on a monthly basis to ensure compliance with the lease and assessing the need for additional support services. WCCCO will work with Lane County Behavioral Health to identify the most appropriate settings and structures for providing these services.

RAP services are coordinated with the local ICCs. The residential specialist and the ICC's work together to develop a plan to bill for Medicaid eligible services when those services are needed.

RAP additionally provides coverage for move-in expenses based on the Individual's need and determined by the program. Payments for move-in costs may include cleaning and security deposits, pet deposits, and outstanding utility bills.

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?

WCCCO will coordinate with Lane County Behavioral Health to assess capacity for fidelity ACT services within the county, develop capacity and deploy resources including training, oversight and funding to ensure that all members who are appropriate for ACT services have ready access to them.

f. How will Applicant determine (and report) whether ACT team denials are appropriate and responsible for inappropriate denials. If denial is appropriate for that particular team, but Member is still eligible for ACT, how will Applicant find or create another team to serve Member?

WCCCO will set up a process to receive information from all ACT teams regarding admission and denials. A licensed clinician will review every denial for ACT services against the admission criteria established by the team. We will determine whether the denial is appropriate or inappropriate. This will include review of the explanation for denial and recommendations for alternative intensive services to be provided. We will work with OHA and the Oregon Center of Excellence on ACT to develop more

capacity/teams. We will develop contract language with ACT providers to ensure compliance with information sharing and member admission into ACT.

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?

We will explore engagement strategies with OCEACT, consumer advocates, Lane County Behavioral Health and ACT teams to identify best practices associate with engaging this population. We will require ACT teams to conduct outreach in an attempt to engage people who have declined to participate in ACT.

h. How will Applicant provide alternative evidence-based intensive services if Member continues to decline participation in ACT, which must include Care Coordination?

We will ensure that providers develop a person-centered plan for each individual who declines ACT participation. The plan will include care coordination and appropriate level of community-based services and supports. We will ensure that providers engage Members in the following service alternatives: IPS Supported Employment, peer delivered services and other community resources including supportive housing. We will work with OCEACT and OHA to develop a set of evidence-based service alternatives to ACT.

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?

WCCCO will build on its lengthy experience managing residential benefits for adults with SUD and eating disorders and children with and youth with SUD and mental health concerns, while recognizing that adult SRTF placements present with unique characteristics. We will employ Lane County Behavioral Health's specific expertise in managing SRTF resources. We understand there is a need for increased nimbleness in assisting members in admitting to and transitioning from SRTF facilities. Our background in commercial coverage may be useful in this respect given the expectation of fluidity among levels of care according to each member's present clinical needs. While we understand this background may offer useful insights and practices, we intend to approach the problem with a healthy respect for what we don't know and for the expertise of existing staff with extensive knowledge and experience in this area.

Our experience providing utilization management for residential levels of care is founded on developing relationships with providers based on trust and collaboration. Providers develop an understanding that WCCCO's goal is the most effective and appropriate care rather than simply the shortest length of stay. Once that foundation of trust is built, providers are willing to work with UM staff to explore alternatives to continued stay when the patient is clinically ready.

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?

WCCCO will work through Lane County's established relationships with housing providers and the housing authorities (Housing and Urban Development or HUD programs within the county). We will coordinate with local experts and agencies to analyze and address housing issues in the CHA and CHP with an understanding of the essential role housing plays in recovery and the unique challenges faced by individuals with SPMI in obtaining and maintaining appropriate housing. WCCCO will work with CMHP staff to coordinate program components such as application process, finding a rental unit, and payments to the landlord; and the support service components will again include, but will not be limited to, financial budgeting, community navigation, and maintaining healthy relationships, which supports Individuals in their ability to live as independently as possible in the community. This includes having both the specialist and the peer support staff visit each participant frequently enough to assure compliance with their lease and assess the need for additional support services.

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.

WCCCO will engage Lane County Behavioral Health's Utilization Management and Care Management teams to work closely with acute psychiatric care providers to assure that Members with SPMI are receiving appropriate care in the least restrictive environment possible. We will work closely with members' care teams on discharge planning and smooth transitions between levels of care. WCCCO through Moda is actively collaborating with numerous partners to implement the requirements of HB 3090 and 3091 for coordination of care upon release from an emergency department. While the legislation and subsequent rules established the expectations for care, much work remains to be done to establish well-functioning systems to deliver that care. We are working with the Oregon Association of Hospitals and Health Systems, OHA, other carriers and peer advocates to develop systems and processes that will ensure appropriate planning and follow-up upon release from an ED.

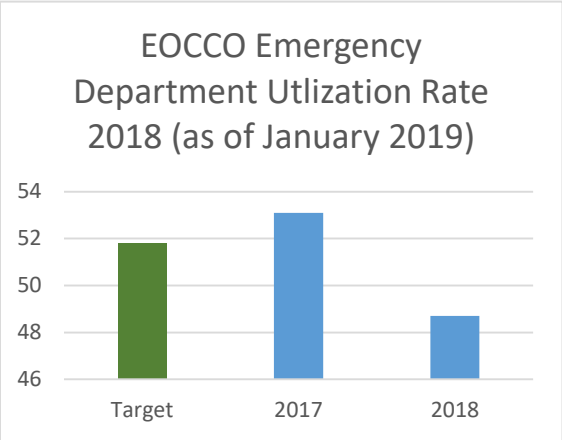
We will also use PreManage to ensure real-time notification of inpatient admissions and discharges and ED visits. This will allow us to deploy the appropriate supports immediately to assist members with rapid stabilization of Behavioral Health crises.

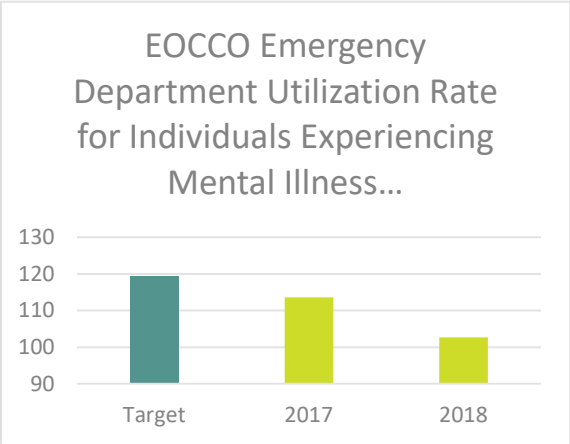
5. Emergency Department (recommended page limit 2 pages)

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.

WCCCO will build upon EOCCO's successful strategies to reduce ED admissions and readmissions. This approach includes implementation of specific measures as well as the overall approach of working with local providers to support their ground-up efforts.





- WCCCO will work with mobile crisis service providers The Child Center and White Bird Clinic to resolve crises in the community, without requiring a trip to the local Emergency Department. In addition, when The Child Center is called to the ED to provide evaluation and intervention, members are provided coaching and information on how to engage their crisis services directly without going through the ED first.

- WCCCO will evaluate the use of PreManage by Primary Care Clinics (PCPs) and mental health providers to ensure they are notified each time a member is admitted to an Emergency Department. We will assist providers as needed in establishing PreManage workflows; in addition, for providers without the ability to implement PreManage workflows, we can provide notifications directly. Effective workflows will include establishment of cohorts identifying members with repeat admissions, and the use of care plans to provide relevant information to EDs. Providers will work with members to develop person-centered crisis management plans to effectively manage crises without the need for an ED visit. ED visits will also trigger re-evaluation of the overall care plan to identify whether a change in the care plan is necessary in order to meet the member's recovery goals. Outreach will be provided to these members through Lane County Behavioral Health or WCCCO directly if they are not already established in services.

- Given that most youth are brought to the emergency room in the evening or on weekends, WCCCO will work with providers to ensure that members are aware of their options for 24/7 crisis support whether offered by the provider's office directly or by the County's contracted crisis programs. Providers will be encouraged to offer their own 24/7 support as feasible given that crisis support can be more effective

when provided by a clinician known to the person in crisis. For treatment models that include 24/7 support, Moda will monitor for this aspect of fidelity.

- WCCCO partners including PCPs, Behavioral Health providers and Lane HHS will have multidisciplinary meetings to discuss care plans for members. These meetings will identify barrier(s), determine main point of contact for members and discuss potential solutions.

6. Oregon State Hospital (recommended page limit 1 page)

a. How will Applicant coordinate with system partners as needed regarding Oregon State Hospital discharges for all adult Members with SPMI?

WCCCO will collaborate with Lane County Behavioral Health to develop the most effective workflows for OSH discharges. We will review the existing workflows and compare them with workflows in place for EOCCO, identifying any best practices that may be offered for consideration locally. Workflows in our current CCO include: Prior to OSH admission, a CCO psychiatrist reviews all LTC referrals to ensure they meet criteria for OSH admission. Once an individual is accepted for OSH admission, the ICC completes a 72hr face-to-face diversion visit. Thus, individuals who do not meet the criterion are effectively diverted from admission. However, once a member is admitted, the CCO monitors the members closely. The ICC is responsible for making an in-person visit with a member within 7 days of admission to OSH. At that time, the ICC provides additional historical information regarding the member to the OSH team and begins coordinating care toward an effective discharge plan. A CCO clinician, CCO administrative staff, and the ICC attend all IDTs held for a Member. The ICC provides an updated discharge plan at each Intra-disciplinary team meeting (IDT). In accordance with the Oregon Performance Plan (OPP), WCCCO will focus predominately on civilly committed members ensuring that they are discharged in a timely fashion. WCCCO will support the ICCs in working with system partners such as OSH SW, Kepro, residential facilities and housing supports. WCCCO will facilitate discharge to the most integrated setting appropriate to meet the member's needs with the ultimate goal of providing ACT services, with integrated community placement.

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?

WCCCO will collaborate with Lane County Behavioral Health to develop the most effective processes for these transitions. Where processes developed in our existing CCO may add value, they will be offered for consideration locally. We will build on EOCCO's current model in which we expect that the ICC will begin developing discharge plans within 7 days of OSH admission. The discharge plan will evolve and be discussed during IDT meetings with OSH. If an individual is not returning to their original service area, the ICC will work closely with the county of placement to coordinate with out-of-area providers and ensure that all out-of-service exception agreements are in place. If the member is returning to their service area, efforts are made to ensure housing is available.

This may involve maintaining an individual's housing during their OSH stay. If it is determined that the individual needs placement in a residential facility, facilities that are deemed to match the needs of the member are sent Mental Health referral packets in preparation for when the member is made Ready to Transition(RTT). The ICC schedules screenings at residential facilities as appropriate working closely with the OSH clinical team.

7. Supported Employment Services (recommended page limit 1 page)

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?

WCCCO will assess the current capacity of community mental health providers to offer Individual Placement and Support (IPS) services. If additional capacity is needed, Moda will coordinate with the Division and Lane County HHS to provide training and develop capacity. At intake and throughout the process of engagement in mental health treatment, members will be encourage to consider if they want to engage in the IPS program. Members engaged in the ACT program are also encouraged to consider employment opportunities and these teams meet on a regular basis to coordinate and assist members in meeting their treatment and employment objectives.

We will collect and review fidelity reports annually for SE programs who have passed their fidelity review with a minimum score of 100 or better. Those programs who do not pass their fidelity review are potentially subject to additional monitoring, oversight, technical assistance, and Corrective Action Plan (CAP) in order to restore care to the highest level possible. We will review a copy of any amended fidelity review in response to a non-passing score and follow-up review from the Division. WCCCO will collect a copy of SE reports sent to the Division as required by OAR 309-019-0295 as part of contractually required reporting process.

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.

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

WCCCO will use the collaborative approach that has worked well for EOCCO and Moda's commercial Behavioral Health program in supporting a robust System of Care for children and families in Lane County. We will partner with a wide range of stakeholders including Lane County Health & Human Services, Oregon Youth Authority, Child Welfare, DHS Lane County Behavioral Health, Peer & family programs such as OFSN, CASA, juvenile justice, local and statewide child-serving social service agencies, , SUD Programs, Primary Care, I/DD services, Local Lawyers and District Attorneys, SSI, Child Support Enforcement Division, Police, Parole and Probation, Lane Education Service District,, local school districts, , faith based communities, agencies representing under-served and minority populations, and local businesses. We will assess the vibrancy

of the existing SOC infrastructure and seek additional voices as needed to bring in additional perspectives and resources.

b. Please provide detail on how Applicant will utilize the practice level work group, advisory council, and executive council.

In keeping with WCCCO's collaborative and vertically integrated approach to improving systems of care, effective cross-fertilization among the practice level work group, advisory council, and executive council will be essential to ensuring that work at each of these levels supports and is informed by each other.

Practice level work groups as the "boots on the ground" are in an ideal position to identify needs and opportunities; they will be empowered to make system improvements to the extent they are resourced and capable of doing so. They will be tasked additionally with identifying systemic barriers and needs beyond their scope and sharing these issues with the advisory and executive councils. They will also share successes as a means to identify and disseminate best practices.

The Advisory council will be utilized as a support to the Practice Level Workgroup, reviewing system barriers brought to them if the Practice Level Workgroup was unsuccessful in resolving the Barrier. This group should also be able to identify and plan to resolve policy and financial barriers in recommendations to the Executive Council.

The Executive Council will be made up of Director level staff that have budget and policy decision making authority locally. This group is intended to change policy and make budgetary decisions to resolve barriers that could not be addressed at the other levels previously mentioned. This Council, if not able to address the barrier, should have the knowledge and ability to identify where the barrier exists and provide that information to the System of Care Statewide Steering Committee.

c. How does Applicant plan to track submitted, resolved, and unresolved barriers to a SOC?

WCCCO will designate a responsible point of contact to provide oversight and coordinate activities, data and needs related to SOC. The responsible individual will develop tracking and reporting mechanisms for submitted, resolved and unresolved barriers. The individual will attend to relationships with the practice work groups, advisory council and executive council in such a way as to ensure prompt and thorough reporting.

Each Local Practice Level Workgroup will complete barrier submission forms and send them to the SOC coordinator. After the next Practice Level Workgroup, the SOC coordinator updates the tracking tool, indicating it is resolved, or unresolved and escalated to the Advisory Council. The SOC coordinator will track trends and work with the various levels of governance to conduct root cause analysis and identify possible solutions.

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?

WCCCO will conduct Systems of Care and Wraparound trainings at least annually, continuing to encourage community awareness of elements of the System of Care by educating community partners. The SOC coordinator will engage local community leaders with the support of our provider network and other SOC champions. To support efforts of maintaining youth and family voice as a majority of the members on the Practice Level Workgroup, WCCCO will provide a stipend for Youth & Family representation at the Systems of Care governance boards. Included in the stipend is reimbursement for the individual's time, mileage and child care. In an effort to remove barriers for youth and family attendance, WCCCO will provide an Orientation packet for youth and family representation which includes approaches to communication, description of other members of the committee, previous meeting minutes, and other supportive documents. In addition, we will offer individual and group coaching to all youth and family support partners to help them be comfortable and effective in their roles. WCCCO will fund tuition and travel expenses for youth and family support partners to attend the 4 day Wraparound training.

9. Wraparound Services (recommended page limit 4 pages)

Applicant is required to ensure Wraparound Services are available to all children and young adults who meet criteria.

a. Provide details on how Applicant plans to ensure administration of the Wraparound Fidelity Index Short Form (WFI-EZ)?

WCCCO will establish procedures to ensure all Wraparound programs are appropriately administering and collecting the WFI-EZ at the six month mark of each Child and Family team meeting. During technical assistance meetings, Wraparound Care Coordinators will be updated on results from the WFI-EZ, and use the opportunity to collaborate on improving administration and collection efforts. Further, our provider network members will use the Wraparound Monitoring Tool to notify the provider when the WFI-EZ is due for each child and family.

b. How will Applicant communicate WFI-EZ and other applicable data to the System of Care Advisory Council?

WCCCO will work in close collaboration with our provider network, distributing WFI-EZ and other data as quickly as it is available and engaging in supportive conversations that focus on system improvements. We will compile reports regularly and share them with the Advisory Council.

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

WCCCO will establish procedures to ensure all Wraparound programs are appropriately administering and collecting the WFI-EZ at the six month mark of each Child and Family

team meeting. We will train all Wraparound Care Coordinators to conduct the WFI-EZ's during the Child and Family Team Meetings to ensure they are completed in a timely manner, and ensure that providers use the Wraparound Monitoring Tool to receive notification of when the WFI-EZ is due for each child and family. Additionally, WCCCO's SOC Coordinator will contact Wraparound Care Coordinators when the WFI-EZ due date is approaching and monitor until it is completed. We will closely watch response rates and develop additional interventions as needed to ensure sufficient response rates.

d. How will Applicant's Wraparound policy address:

(1) How Wraparound services are implemented and monitored by Providers?

WCCCO's wraparound policies will ensure appropriate provision and oversight of services by enumerating a congruent set of interlocking policies, procedures and structures as described above. Overall policy and structure will be informed by state requirements, the executive council, and fidelity to the model. Provider contracts will clearly list requirements including fidelity, fidelity monitoring and reporting, collaboration with systems partners, and access requirements. WCCCO will keep informed by playing an active role in supporting the practice level workgroups and the councils and by requiring robust reporting. WCCCO will collaborate with contracted providers to address challenges that arise in implementing the program to fidelity, and will take corrective action as necessary.

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

WCCCO will ensure that referral pathways are clear and user-friendly for system partners and members. We will monitor for children and youth who qualify on the basis of systems involvement or level of care. Referrals to wraparound services will be reviewed for appropriateness by the relevant review committee and approved or denied for services. All denials require appropriate notification including appeal rights. WCCCO will also require the review committees to report approvals and denials to WCCCO's SOC coordinator, who will monitor for decisions that may be of concern. Any denials overturned upon appeal will also be reviewed by the SOC coordinator.

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.

WCCCO's policies and procedures will make clear that wait-listing eligible children for Wraparound services is not acceptable and will establish mechanisms for ensuring children have timely access. WCCCO and its Advisory council, Practice-level workgroups, review committees and WCCCO's SOC coordinator will share responsibility for ensuring timely access with ultimate responsibility accepted by WCCCO. System partners will need to maintain clear lines of communication regarding capacity and demand, with WCCCO's coordinator monitoring in real time. We will facilitate cross-referrals within the system when capacity is unevenly distributed. We will monitor overall capacity and work with providers to add capacity as needed.

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).

WCCCO will monitor fidelity as measured by the WFI-EZ as described above as well as the Team Observation Measure (TOM). These tools establish a mechanism for program-level evaluation of fidelity as well as system-wide evaluation and will help identify training and corrective action needs. Our policies and provider contracts will require each role within the program is appropriately staffed. WCCCO will partner with contracted providers and community partners such as OFSN to ensure sufficient availability of appropriately trained professionals and family and youth peer support specialists to meet the staffing needs to provide services to fidelity.

Attachment 12 — Cost and Financial Questionnaire

A. Evaluate CCO performance to inform CCO-specific profit margin beginning in CY 2022

OHA will implement a provision of its current waiver that requires the state to vary the profit load in CCO capitation rates based on an evaluation of CCO performance. The goal of the policy is to encourage CCOs to provide financial incentives for CCOs to improve the delivery of benefits to CCO Members. This includes more efficient use of Medical Services, increased delivery of high-value services, and an increased use of Health-Related Services when appropriate. The ability to increase the profit load for high-performing CCOs is designed to alleviate concerns that CCO investments that reduce costs and use of Medical Services will lead to capitation rate reductions that threaten CCO ability to maintain access to Health-Related Services and other programs that improve value and efficiency.

1. **Does Applicant have internal measures of clinical value and efficiency that will inform delivery of services to Members? If so, please describe.**

   WCCCO will build off of the experience of its equity partner Moda, with EOCCO, and use numerous ways to track and report on clinical value and efficiency of services delivered to its members. These include retrospective risk-adjusted cost analysis; analysis of avoidable costs; analysis of delivery channels such as ED vs. primary care, inpatient vs. outpatient, hospital-based vs. clinic based; high-cost/risk member management, and others. In addition, our future value based payment models focus providers on controlling wasteful spending and improving efficiency, both through financial incentives and by sharing data on opportunities to address these areas. Some examples of these are discussed below.

   For a provider-level view of resource use, we will employ risk-adjusted cost analysis to identify areas of opportunity for efficiency improvement. A retrospective risk score will be used to provide a treatment-agnostic view of the conditions present in the population. In this way, population morbidity can be normalized and providers can be measured and compared on their efficiency of resource use in an apples-to-apples way. This is in addition to our prospective risk modeling, which is used to forecast future costs.

   We will track avoidable costs in several ways. For example, we will prepare reports on emergency department utilization, inpatient readmissions, utilization of ‘preference sensitive’ treatments (those treatments for which utilization is often guided by member or provider preference as opposed to clinical indication); and other categories. Emergency department utilization will be further broken down into ‘potentially avoidable’ vs. ‘not avoidable’ events, and frequent ED utilizers will be tracked. In evaluating readmissions, we will calculate all-cause readmissions and same-facility-only readmissions, over 30/60/90 day time periods, and also take into account transfer admissions. Examples of

preference sensitive treatments include some imaging, certain orthopedic procedures, and C-sections.

Delivery channels are an important influencer of costs, and warrant tracking and reporting. To help care delivery migrate from reactive to proactive, we will regularly monitor rates of primary care utilization, with the intent that investment there will reduce downstream ED, hospital, and specialist costs. We will identify members with chronic conditions but without primary care utilization on rosters sent to providers, and also summarized in reports to the CCO leadership. Some procedures can be done in clinical settings with very high quality and low cost, compared to hospital settings; therefore we will regularly produce reports and analysis on opportunities to shift sites of care.

High-cost/high-risk members are a big contributor of overall spending, and it is important to evaluate and manage this population. WCCCO will use predictive modeling, in combination with aggregate member-level cost reports, to identify and track these members. Output will then be fed into both provider reports as well as internal reports for the purpose of connecting members to case management, member advocate, care coordination, disease management, or other services.

WCCCO will also review drivers of trend on a regular basis, to identify services that might be contributing to cost growth. DRGs, procedure codes, and diagnosis codes that account for a higher-than-average amount of trend increase will be identified and discussed. For example, we plan to look into billing intensity of office visits and ED visits, to address the creep of RVUs over time.

We will share a comprehensive package of reporting with all of the providers in our VBP arrangements, to ensure that they have the most complete information possible on opportunities to improve quality and efficiency. For example, our member roster will include a count of ED visits in the prior year to help clinics manage high utilizers; the same report will also include a comparison of risk score to primary care utilization, to help identify mismatches (i.e. many chronic conditions but few/no primary care visits). Our pharmacy reports will identify members taking a brand name medication for which a generic is available. In the coming year we expect to roll out reports on the downstream costs of provider referral patterns. All of these activities are geared toward identifying opportunities to improve efficiency.

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 described above, WCCCO will have a robust infrastructure for analyzing and reporting on cost and utilization. This allows us to identify members, services, providers, or geographic areas needing focus from a cost or quality control perspective. This reporting feeds into collaborative workgroups of WCCCO and provider staff focused on improving quality and reducing costs.

WCCCO intends to implement an HIE tool, Arcadia Analytics, which has been extremely helpful in improving quality and coordinating care for members, by making available to providers a complete dashboard of cost and quality performance, with links to scheduling

data so that providers can plan interventions. We believe Arcadia will strongly tie to our efforts to control cost, quality, and outcomes. Similarly, PreManage gives providers the ability to coordinate and manage care for members utilizing ED and inpatient services.

Through Moda's long experience managing health plans, WCCCO will have access to a highly developed infrastructure for managing utilization of services that are high cost and/or have potential for overutilization. We will regularly review the results of prior authorization and other medical management activities to ensure that these programs are evidence based, efficient, and effective while minimizing the compliance burden on providers. For example, new high-cost technologies or procedures will be investigated for the purpose of determining whether prior authorization is warranted. In some cases, prior authorization requirements will be removed if it is determined that most procedures that are requested are appropriate, in order to minimize administrative costs. As an additional way to control hospital spending on low-value ED utilization, we intend to limit reimbursement for certain kinds of ED visits that are determined to be non-emergent based on predefined criteria.

In addition to the above, our Fraud, Waste, and Abuse team will work with internal data analytics teams to run queries on a regular basis that may trigger a focused review. The team will also initiate inquires based upon employee or external tips, as well as knowledge gained form participation in local and national Anti-Fraud groups. WCCCO partner, Moda is in the process of implementing new FWA detection software, HealthCare Fraud Shield, which will be in place by the end of 2019 and available to WCCCO. This software will monitor claims and suspicious activities through advanced post payment detection as well as provide reporting, tracking and case management tools.

Our embedded clinical editing tool will identify incorrect coding and recommends corrections or denials prior to payment. In addition to pre-payment editing, we will utilize our embedded clinical editing to 'profile' providers who may be utilizing abusive billing practices. We will use these reports to identify potential outliers and request medical records in order to document correct or incorrect billing. As a further control, a daily claim batch file will be sent post-adjudication and pre-payment to Change Healthcare, where additional provider integrity payment recommendations are returned. Medical records may be requested as well as part of this review.

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.**

WCCCO's sees Health-related services as a key lever for health system transformation. The strategy to use Health-Related Services to reduce avoidable health care services utilization and costs include:

- Evaluate and approve flex services, as part of a member's overall integrated care planning and management within or in conjunction with, their primary care team, including behavioral and oral health.
- Utilize flex services within the care coordination and case management functions within ICC and ENCC.

- Distribute Community Benefit Initiative Reinvestments (CBIRs) through the local CAC and through Grant funds that focus on reducing avoidable healthcare services utilization and costs.
- Work with our providers and communities to identify specific local community needs to improve the care delivery and overall health and well-being of the members, as improved health outcomes reduces cost and utilization.

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

WCCCO's strategy to use Health-Related Services to improve quality and efficiency in service delivery include the same strategies as reducing avoidable health care services and utilization. WCCCO believes that when Health Related Services are deployed, there is a vast impact to a member and/or community. The strategy is listed again below:

- Evaluate and approve flex services, as part of a member's overall integrated care planning and management within or in conjunction with, their primary care team, including behavioral and oral health.
- Utilize flex services within the care coordination and case management functions within ICC and ENCC.
- Distribute Community Benefit Initiative Reinvestments (CBIRs) through the local CAC and through Grant funds that focus on reducing avoidable healthcare services utilization and costs.
- Work with our providers and communities to identify specific local community needs to improve the care delivery and overall health and well-being of the members, as improved health outcomes reduces cost and utilization.

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?

WCCCO plans to fund SDOH-HE initiatives in two ways:

1) WCCCO will distribute Community Benefit Initiative Reinvestments (CBIRs) to the CAC to utilize for SDOH-HE and transformation projects that connect to their Community Health Improvement Plan (CHIPs). The CAC will be required to select appropriate interventions, evaluation metrics, and methods to measure impact which will then be reported to WCCCO on a quarterly basis.

2) WCCCO will fund SDOH-HE initiatives is through the use of Health Related Services for needs that are unique to each community. Primary care clinics and other community partners within our service area will have the opportunity to submit requests for health related service initiatives that they need funding for. This will then be approved and administered accordingly. WCCCO will track which members these services are provided to in order to evaluate the success of these investments. Many of the funded initiatives could be associated with an incentive measure which provides an additional evaluation metric.

B. Qualified Directed Payments to Providers

Beginning in 2020, OHA will develop a program of qualified directed payments (QDP) for the repayment of most provider taxes paid by Hospitals in Oregon. The specific parameters and methodology of the QDPs for fiscal year 2020 will be determined following completion of the 2019-21 Legislatively Adopted Budget and will rely on input from a variety of stakeholders. OHA will promulgate administrative rules to include a Quality and Access pool for Hospitals reimbursed by Medicare based on diagnostic-related groups (aka, DRG Hospitals).

1. **Does Applicant currently measure, track, or evaluate quality or value of Hospital services provided to its enrollees? If so, please describe.**

   WCCCO will produce a variety of analysis on hospital utilization (inpatient, outpatient, ED use, site of service, readmits, C-section rates, etc.), as described above in section A. From this we will be able to identify areas of relative efficiency or inefficiency between hospitals. As a further example, we will calculate normalized average cost per admit using DRG weights, to understand the relative price and value for hospital inpatient services. We will be introducing hospital quality metrics into our shared savings model, some of which will be based on claims data (e.g. C-section rate), and others will be based on clinical data provided by the hospitals (e.g. infection ratio).

C. Quality Pool Operation and Reporting

OHA will adjust the funding mechanism of the quality incentive pool from a bonus to a withhold of a portion of CCO capitation rates. This allows CCO expenditures of Quality Pool funds to be considered in capitation rate development and be included in the Medical Loss Ratio (MLR) requirements that apply to the CCOs. This change is intended to motivate CCOs to make timely investments in their communities and the providers and partners that enable their achievement of metrics associated with the incentive program. Including CCO spending of incentive pool earnings in capitation rate development increases the transparency of the program while retaining significant flexibility for CCOs in how they utilize their Global Budget.

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.**

   WCCCO plans to reinvest 100% of its quality pool dollars back into providers and communities. We plan to provide quality pool funding to our community advisory council to fund Community Health Improvement Plan (CHIP) activities to address the social determines of health and dedicate quality pool funds for community benefit initiative reinvestment projects that any partner in the service area can apply for. WCCCO will distribute quality pool earnings to other non-clinical partners to address local and statewide SDOH-HE priority areas as part of CCO 2.0. These partners will include but will not be limited to organizations and providers outlined in the community engagement plan tables.

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.**

   WCCCO plans to reinvest 100% of its available quality pool funds back into providers and communities. As we transition to CCO 2.0 WCCCO will make investments using quality pool and other global budget funds and surpluses to address local and statewide SDOH-HE priority areas such as housing related services and supports with partners identified in the community engagement plan tables. WCCCO will engage its Regional and Local Community Advisory Councils, our Clinical Advisory Council, the WCCCO Board and newly identified SDOH-HE partners to determine the amount of funding to distribute each year to non-clinical providers.

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?**

   WCCCO plans to reinvest 100% of its available quality pool funding back into providers and communities. Planned investments include quality bonus payments to primary care providers, enhanced Patient Centered Primary Care Home funding, quality bonus payments to Dental Care Organizations, payments to our Community Advisory Councils to invest in projects to meet quality measure targets and identified CHIP activities, Community Benefit Initiatives Reinvestments (CBIR's), technology and other initiatives such as newly identified SDOH-HE activities as identified and approved by the WCCCO Board.

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

   In collaboration with its Clinical Advisory Panel (CAP) and Community Advisory Council, WCCCO's relevant subcommittees will recommend the quality pool funding projects, initiatives and the annual allocation of funds. These recommendations will be discussed and approved by the WCCCO board annually.

5. **When will Applicant invest its Quality Pool earnings, compared with when these earning are received?**

   We expect to distribute quality pool earnings immediately after they are received. This is to ensure we know what dollars are available to reinvest. For initiatives that we intend to fund on an ongoing basis we will replenish the funds annually with quality pool funds once they are received. This ensures that there is no break in funding with respect to our various ongoing investments. As a new entity we will modify our strategy with respect to when quality pool earnings will be invested at the direction of the board.

6. **Does the Applicant have sufficient cash resources to be able to manage a withhold of a portion of its Capitation Payments?**

   Yes, we will have sufficient reserves and cash resources to be able to manage a withhold of a portion of capitation payments for the quality pool.

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.

1. **Please describe the PBM arrangements Applicant will use for its CCO Members.**

   WCCCO will use the Oregon Prescription Drug Program (OPDP) as the pharmacy benefit management solution for members. OPDP is an Oregon Health Authority (OHA)-backed innovative pharmacy program designed to meet the broad and unique pharmacy benefit needs for both public and private entities in Oregon. OPDP services are provided consistent with the objectives of the Oregon Health Policy Review Board, are delivered transparently using 100% pass-through pricing of pharmacy claims and manufacturer rebates (i.e., no spread), and are backed with robust annual market check and audit provisions to ensure market competitiveness. WCCCO partner, Moda, has administered OPDP for OHA since 2007.

   In addition to Moda's responsibility for managing all clinical support, including formulary and utilization management, as well as providing PBM operational oversight and customer service, our pharmacy program is backed by a long-standing partnership with MedImpact, the largest privately-held PBM in the U.S. MedImpact provides Moda's back-end claims processing system; contracts the OPDP pharmacy network; and serves as our primary aggregator for manufacturer rebates. This PBM platform offers tremendous flexibility to configure and manage pharmacy programs to meet the program management objectives for WCCCO.

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)**

   Yes, WCCCO's PBM relationship using OPDP requires that all pharmacy claims and manufacturer rebates administered through its PBM are 100% pass-through. WCCCO

will validate the pass-through and transparency requirements of its PBM agreement with quarterly and annual tracking of reimbursed pharmacy claims (Basis of Reimbursement Reports) and quarterly tracking and reconciliation of manufacturer rebate billing and payment.

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?**

   Yes, the OPDP program includes mandatory market checks to ensure the competitiveness of financial guarantees for all groups that participate in this program, including WCCCO. Surveys are conducted annually, with results published by July 1st each year. If survey results fall outside a predetermined point, OPDP contractually requires that Moda, as the Administrator for the OPDP program, propose updated network guarantees within 90 days of the report. Updated network rates become effective immediately upon review and acceptance.

4. **Does the Applicant plan to use the Oregon Prescription Drug Program to meet the PBM transparency requirements?**

   Yes, the OPDP program is fully transparent and includes extensive reporting and robust audit rights.

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.

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.**

   WCCCO will be utilizing a custom Medicaid PDL, which is the same PDL utilized by EOCCO, and it will be published online no later than January 1, 2020. Today, this PDL can be found at:
   https://www.eocco.com/eocco/-/media/eocco/pdfs/rx/rx_formulary_ohp.pdf

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.**

   WCCCO's coverage criteria are not currently published online; however, they will be available to providers at the point of prescribing through our electronic prior authorization platform. Through this platform, member and drug-specific criteria are presented to the prescriber upon drug selection in the tool. Additionally, we publish a list of medications that require prior authorization and/or have other utilization management edits such as step therapy or quantity limits. That list will be the same as what is in use today for EOCCO and can be found at: https://www.eocco.com/eocco/-/media/eocco/pdfs/rx/rx_priorauth_ohp.pdf

   WCCCO is committed to publishing our coverage criteria in an easily accessible location and format for prescribers, patients, pharmacies, and OHA. We have already started the process of converting our coverage criteria question algorithms into our easily readable and interpretable policy format. This process is about 10% complete, but is on track to be completed by January 1, 2020. These policies will be updated concurrently as changes to coverage criteria are made.

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**

   While there are many areas in which WCCCO's PDL will align with OHA's fee-for-service PDL, there is a key area where the PDLs differ. WCCCO's PDL does not embrace brand-over-generic strategies, so when an AB-rated generic becomes available it is added to formulary and the brand is removed.

   OBRA '90 rebates are available to OHA through its Medicaid program but are not available to CCOs. Those rebates are often large enough to make the net cost of a brand medication less than its AB-rated or therapeutic alternative generics. Supplemental rebates, which are available to CCOs, are essentially commercial rebates that some manufacturers may extend into the Managed Medicaid market. Supplemental rebates tend to be significantly smaller than OBRA '90 rebates and rarely yield a lower net cost brand compared to generic alternatives. Additionally, not all manufacturers offer supplemental Medicaid rebates on commercially rebated products.

   In therapeutic categories that are not clinically differentiated, such as TNF-alpha inhibitors for autoimmune conditions, supplemental rebates may drive selection of a preferred, lowest net-cost product. These preferred products may differ from preferred products on OHA's fee-for-service PDL.

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

   If required, WCCCO will fully align its PDL with OHA's fee-for-service PDL. However, in doing so, WCCCO may realize higher cost claims experience that would require consideration. We would welcome discussion with OHA on methods that could be applied to offset the financial risk in doing so. For example, preferring brands over alternative generics may yield a larger OBRA '90 rebate for the state, but supplemental rebates on those brands are unlikely to offset the higher cost paid by the CCO for brands relative to lower cost therapeutic alternative generic products. We would need to better understand how this issue could be offset by OHA.

F. Financial Reporting Tools and Requirements

OHA will enhance financial reporting and solvency evaluation tools by moving to the financial reporting standards used by the National Association of Insurance Commissioners (NAIC) and the associated Risk Based Capital (RBC) tool to evaluate carrier solvency, along with supplemental schedules as requested by OHA (identified in Exhibit L of the Contract). CCOs will file required NAIC reports using Statutory Accounting Principles (SAP). A financial hardship exemption will be available for Year 1 for CCOs with a demonstrated financial hardship related to converting to SAP and filing reports through NAIC. Additional reporting through the Exhibit L Financial Reporting Template will be required. OHA will promulgate administrative rules describing regulatory interventions based on RBC level.

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.**

   Yes, WCCCO is affiliated with entities that submit NAIC health filings in accordance with SAP (Oregon Dental Service and Moda Health Plan, Inc are affiliates of ODS Community Health which is an equity partner and administrator of WCCCO).

2. **Does the Applicant currently participate and file financial statements with the NAIC?**

   No, WCCCO does not file financial statements with the NAIC. As mentioned above, WCCCO has affiliates who prepare and submit all filings and statements as required by NAIC**.**

3. **Has Applicant prepared a financial statement which includes a RBC calculation? If so, please submit.**

   No, WCCCO has not prepared a RBC calculation. As mentioned above, WCCCO has affiliates who prepare and submit all filings and statements as required by NAIC.

4. **Does the Applicant currently have experience reporting in SAP either directly or through any Affiliate of Applicant?**

   Yes, WCCCO is affiliated with entities that submit NAIC health filings in accordance with SAP (Oregon Dental Service and Moda Health Plan, Inc. are affiliates of ODS Community Health which is an equity partner and administrator of WCCCO).

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.**

   Yes, WCCCO seeks an exemption from SAP and NAIC reporting for 2020 in order to allow sufficient time for hiring and training personnel. WCCCO's affiliates currently have expertise in SAP and NAIC reporting but do not have adequate coverage to complete filings without additional resources.

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**

We have included the required documentation above with our response with the exception of three years of audited financial reports. WCCCO is a newly formed entity in 2019. .

G. Accountability to Oregon's Sustainable Growth Targets

OHA seeks to improve the connection between CCO Contracts and the sustainable growth targets established in Oregon's Medicaid waiver and the legislatively enacted budget.

1. **What strategies will the Applicant employ to achieve a sustainable expenditure growth year over year?**

   We believe that our health plan/provider LLC equity model is a key strategy for engaging providers in the financial success of our CCO. When the entities that deliver care to CCO

members are at ultimate financial risk which includes risk for achieving a sustainable expenditure growth rate we have their full buy in and engagement. From there they are part of the design of strategies and initiatives along with other community partners to meet financial goals.

We also believe that significant financial investments in primary care, the implementation of VBPs such as shared risk/shared savings models, capitation and payments for meeting quality metrics, reinvestments of savings back into providers and communities and the use of traditional health workers have a cumulative effect in achieving the quadruple aim and meeting a sustainable expenditure growth rate. We also utilize OPDP to help manage pharmacy expenses. We will implement these strategies and others as they are identified to meet the sustainable expenditure growth rate goals.

2. **How will the CCO allocate and monitor expenditures across all categories of services?**

On an annual basis WCCCO's financial and actuarial teams will develop a global budget to be approved by the WCCCO Board. The global budget will be developed using a ground up approach to ensure adequate funding is available to cover all services we are required to provide to the WCCCO population. To ensure that expenditures are tracking with the budget, the WCCCO analytics team will produce a variety of reports and analysis that highlight areas for focus across service categories. This reporting infrastructure is already in place for EOCCO and Moda's other lines of business, and will be rolled out to WCCCO.

For example, regular cost and utilization reports show spending and utilization patterns by member type, service category, diagnosis, provider, and geographic region, to name a few. We intend to monitor inpatient admissions and readmissions, ED visits, outpatient surgeries, infused and specialty drugs, primary and specialty care, and many other cost categories to ensure that any trend outliers are addressed. In addition, both fee-for-service and alternative payments (e.g. capitation) will be summarized by provider to spot trends and outliers. Reports will be reviewed regularly by the WCCCO board, CAP, and Community Advisory Council, as well as operational staff such as actuarial, finance, and health care services teams.

3. **What strategies will the Applicant utilize related to Value-Based Payment arrangements to achieve a sustainable expenditure growth?**

We believe that the use of Value Based Payment (VBP) arrangements play an important role in achieving a sustainable expenditure growth rate. Building upon WCCCO affiliates experience implementing VBP arrangements with EOCCO providers we will implement foundational payments for PCPCH's, shared savings/shared risk models, payments for meeting quality targets and full risk capitation, WCCCO will work toward moving more providers and categories of service to the higher LAN category of 4A while achieving a 70% VBP target by 2024.

These VBP efforts will be supported by a robust HIT and reporting infrastructure that gives providers timely and accurate data on their assigned member populations, including risk stratification, care gaps, utilization patterns, and other opportunities for intervention. Additionally, WCCCO will put significant resources into care coordination and quality improvement, to assist clinics with acting on the data and reporting we provide.

4. **What strategies will the Applicant utilize to contain costs, while ensuring quality care is provided to Members?**

Strategies for containing costs will heavily involve implementation of VBP arrangements. We will have access to claims and clinical data and the ability and capacity to monitor the underlying utilization to make sure that all members continue to receive the appropriate level of services. We will run reports such as our cost and utilization reports to show how different sub-populations have performed from an overall utilization and quality measure perspective to ensure quality care is being provided to members.

High cost members can be a significant driver of overall spending, and so we produce spending and risk stratification reports that identify members that either have high cost now, or that we predict might have high cost in the future. We regularly review these high cost member reports to make sure the members are being managed as needed, both to ensure that members are getting the appropriate care management services, but also to ensure that resources are being utilized appropriately. Frequent ED utilizers, opiate utilizers, and members with chronic conditions are other examples of members that are important cost drivers, which receive scrutiny in our reporting.

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

WCCCO affiliate ODS Community Health, Inc. is an equity partner and administrator of EOCCO. For calendar year 2017 (For 2019 rate setting) EOCCO met the growth target of 3.4%.

H. Potential Establishment of Program-wide Reinsurance Program in Future Years

OHA seeks to establish a statewide reinsurance program to better control costs related to high-cost medical conditions, treatments, and patients.

1. **What type of reinsurance policy does the Applicant plan on holding for 2020? Please include the specifics. (e.g. attachment points, coinsurance, etc.)**

WCCCO anticipates it will have reinsurance coverage with RGA where WCCCO receives 90% coinsurance for eligible claims paid on members in excess of $350,000 for:

- Inpatient Hospital Services
- Outpatient Health Services
- Inpatient Rehabilitation WCCServices

- Physician Services
- Skilled Nursing Facility Services
- Drug Related Services

This coverage is consistent with the EOCCO.

2. **What is the Applicant's reasoning for selecting the reinsurance policy described above?**

   WCCCO will select reinsurance policy based on competitive price, coverage, risk and claims mitigation, and long term standing relationship.

3. **What aspects of its reinsurance policy are the most important to the Applicant?**

   Level of coverage and risk and claims mitigation are most important to WCCCO when assessing reinsurance policies.

4. **Does existing or previous reinsurance contract allow specific conditions or patients to be excluded, exempted, or lasered out from being covered?**

   Yes

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?**

   Not applicable. WCCCO does not have any current reinsurance arrangement. WCCCO would obtain coverage if selected as a CCO through the RFA process.

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.

1. **Please describe Applicant's past sources of capital.**

   WCCCO affiliate ODS Community Health, as an equity partner/administrator of EOCCO, has demonstrated experience and capacity for generating positive cash flow and net income after initial sources of capital are contributed by equity partners.

2. **Please describe Applicant's possible future sources of capital.**

   It is anticipated that the initial funding of the organization will be determined based on capital level requirements based on membership and stress scenarios. Equity partners will fund their proportional share of the required capital.

3. **What strategies will the Applicant use to ensure solvency thresholds are maintained?**

   WCCCO affiliate ODS Community Health, as an equity partner/administrator of EOCCO, has demonstrated experience and capacity for reporting loss ratios in excess of minimum requirements as well as the capacity to maintain sufficient capital, primarily based on its low risk investment portfolio weighted in cash and cash equivalents, in the event claims experience is unfavorable. In addition, WCCCO affiliate ODS Community Health, as an equity partner/administrator of EOCCO, has demonstrated capacity to establish value based payment models including full risk models, risk sharing models, and works closely with provider partners and case managers to manage the overall claims experience.

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.**

   In the event additional capital is needed, the partners/owners of the entities will provide additional capital to meet the required capital levels.

J. Encounter Data Validation Study

1. **Please describe Applicant's capacity to perform regular Provider audits and claims review to ensure the timeliness, correctness, and accuracy of Encounter Data.**

   WCCCO will perform annual validation of encounter data audit, in compliance with OHA requirements established in 2016. Member chart notes will be collected and evaluated for accuracy of coding and documentation, against the submitted encounter. Additional areas of validation include:

   - Documentation matches day, time duration and location submitted
   - Documentation includes the credentials of the provider
   - Provider is qualified to use the procedure code submitted
   - Documentation is specific to the encounter
   - Clinical record documentation matches the service code used

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.**

   WCCCO has a robust claims processing and clinical editing system that is programmed to flag and stop encounter claims that may require additional review. When this occurs, WCCCO will require provider chart notes prior to claims payment approval. If the chart notes do not support the encounter submission, claims payment is denied. This is an ongoing process incorporated into our workflow. WCCCO also has policies and workflows for the detection, prevention and reporting of fraud, waste and abuse, which, depending on the circumstance, may result in a chart level review of the claims data submitted.

UCAA Proforma Financial Statements

Health

UNIFORM CERTIFICATE OF AUTHORITY APPLICATION

Instructions

1. Enter the Applicant Company Name below
2. Enter the first full year of the proformas (start with 1st full year of operation).
3. Select the states to be completed for proformas by clicking the check boxes on the right and then click on the "Create Selected State Worksheets" button below.
4. Complete all sections of the proforma statements contained on each tab below.
5. Note that several tabs contain worksheets for 3 years of data. Be sure to complete all years of data.
6. Do not "Cut" and "Paste" cells in the worksheets. Use "Copy" and "Paste" instead.

Enter the Applicant Company Name:

West Central CCO

Year 1: 2020

Year 2: 2021

Year 3: 2022

☐	AK	Alaska	☐	MT	Montana	
☐	AL	Alabama	☐	NC	North Carolina	
☐	AR	Arkansas	☐	ND	North Dakota	
☐	AS	American Samoa	☐	NE	Nebraska	
☐	AZ	Arizona	☐	NH	New Hampshire	
☐	CA	California	☐	NJ	New Jersey	
☐	CO	Colorado	☐	NM	New Mexico	
☐	CT	Connecticut	☐	NV	Nevada	
☐	DC	District Of Columbia	☐	NY	New York	
☐	DE	Delaware	☐	OH	Ohio	
☐	FL	Florida	☐	OK	Oklahoma	
☐	GA	Georgia	☑	OR	Oregon	Go to OR
☐	GU	Guam	☐	PA	Pennsylvania	
☐	HI	Hawaii	☐	PR	Puerto Rico	
☐	IA	Iowa	☐	RI	Rhode Island	
☐	ID	Idaho	☐	SC	South Carolina	
☐	IL	Illinois	☐	SD	South Dakota	
☐	IN	Indiana	☐	TN	Tennessee	
☐	KS	Kansas	☐	TX	Texas	
☐	KY	Kentucky	☐	UT	Utah	
☐	LA	Louisiana	☐	VA	Virginia	
☐	MA	Massachusetts	☐	VI	U.S. Virgin Islands	
☐	MD	Maryland	☐	VT	Vermont	
☐	ME	Maine	☐	WA	Washington	
☐	MI	Michigan	☐	WI	Wisconsin	
☐	MN	Minnesota	☐	WV	West Virginia	
☐	MO	Missouri	☐	WY	Wyoming	
☐	MS	Mississippi				

If states were added to this spreadsheet in error:

1. Select the states to be deleted by clicking the check boxes on the right.
2. Click on the "Delete Selected State Worksheets" button above.

Updated: 10/07/2016

West Central CCO
(Health Company)
Pro Forma Statutory Balance Sheet (Nationwide)
(In Thousands)

	2020	2021	2022
Admitted Assets			
1. Bonds	8,015	10,232	11,609
2. Stock	4,316	5,509	6,251
3. Real Estate/Mortgage Investments			
4. Affiliated Investments			
5. Affiliated Receivables			
6. Cash/Cash Equivalents	24,490	24,203	25,044
7. Aggregate write in for assets	1,673	1,728	1,785
8. Total Assets(1+2+3+4+5+6+7)	**38,492**	**41,672**	**44,688**
Liabilities			
9. Losses (Unpaid Claims for Accident and Health Policies)	16,119	16,649	17,197
10. Unpaid claims adjustment expenses	767	792	819
11. Reserve for Accident and Health Policies			
12. Ceded Reinsurance Payable	152	160	160
13. Payable to Parents, Subsidiaries & Affiliates			
14. MLR rebates			
15. Premiums received in advanced	2,200	2,272	2,347
16. All other Liabilites	3,513	3,939	4,101
17. Total Liabilities (9+10+11+12+13+14+15+16)	**22,751**	**23,812**	**24,623**
Capital and Surplus			
18. Capital Stock			
19. Gross Paid In and Contributed Surplus	13,700	13,700	13,700
20. Surplus Notes			
21. Unassigned Surplus	2,041	4,160	6,357
22. Other Items(elaborate)			
23. Total Capital and Surplus(18+19+20+21+22)	15,741	17,860	20,057
Risk-Based Capital Analysis			
24. Authorized Control Level Risk-Based Capital	$ 8,596	$ 8,728	$ 8,769
25. Calculated Risk-Based Capital (23/24)	183.1%	204.6%	228.7%

West Central CCO
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Thousands)

	2020	2021	2022
1. Member months	528,000	528,000	528,000
2. Net Premium Income	262,126	270,713	279,590
3. Fee for Service			
4. Risk Revenue			
5. Change in unearned premium reserves			
6. Aggregate write in for other health related revenue			
7. Aggregate write in for other non-health related revenue			
8. Total (L2+L3+L4+L5+L6+L7)	**262,126**	**270,713**	**279,590**
Hospital and Medical:			
9. Hospital/Medical Benenfits	166,991	172,482	178,159
10. Other professional Services	49,829	51,468	53,162
11. Prescription Drugs	20,737	21,419	22,124
12. Aggregate write ins for other hospital/medical	-		
13. Subtotal (L9+L10+L11+L12)	**237,557**	**245,368**	**253,444**
Less:			
14. Reinsurance recoveries	1,023	1,074	1,128
15. Total hospital and Medical (L13 -L14)	236,534	244,294	252,316
16. Non health claims			
17. Claims adjustment expenses	10,690	11,042	11,405
18. General admin expenses	13,066	13,495	13,939
19. Increase in reserves for accident and health contacts			
20. Total underwriting deductions (L15+L16+L17+L18+L19)	**260,290**	**268,830**	**277,660**
21. Net underwriting gain or loss (L8 -L20)	1,836	1,882	1,930
22. Net investment income earned	206	236	268
23. Aggregate write in for other income or expenses			
24. Federal Income Taxes	-	-	-
25. Net Realized Capital Gains (Losses)			
26. Less Capital Gains Tax			
27. Net Income (L21+L22+L23-L24+L25)	**2,041**	**2,118**	**2,198**
28. Prior YE Surplus	0	15,741	17,860
29. Net Income	2,041	2,118	2,198
30. Capital Increases	13700		
31. Other Increases (Decreases)			
32. Dividends to Stockholders			
33. YE Surplus (L28+L29+L30+L31-L32)	**15,741**	**17,860**	**20,057**

***Itemize in Assumptions**

West Central CCO
(Health Company)
Pro Forma Statutory Cash Flow Statement
(In Thousands)

	2020	2021	2022
Cash From Operations			
1. Premiums Collected Net of Reinsurance	262,653	270,730	279,608
2. Benefits Paid	219,649	243,739	251,742
3. Underwriting Expenses Paid	20,090	24,103	25,174
4. Total Cash From Underwriting (L1-L2-L3)	**22,914**	**2,888**	**2,692**
5. Net Investment Income	206	236	268
6. Other Income			
7. Dividends to Policyholders			
8. Federal and Foreign Income Taxes (Paid) Recovered	-	-	-
9. Net Cash From Operations (L4+L5+L6-L7+L8)	**23,120**	**3,124**	**2,960**
Cash From Investments			
10. Net Cash from Investments	(12,330)	(3,411)	(2,118)
Cash From Financing and Misc Sources			
11. Capital and paid in Surplus	13,700		
12. Surplus Notes			
13. Borrowed Funds			
14. Dividends			
15. Other Cash Provided (Applied)			
16. Net Cash from Financing and Misc Sources (L11+L12+L13-L14+L15)	**13,700**	**-**	**-**
17. Net Change in Cash, Cash Equivalents and Short -Term Investments (L9+L10+L16)	24,490	(287)	841

Nationwide
Year 1

West Central CCO
(Health Company)
Analysis of Operations by Line of Business
(In Thousands)

	Total	Comprehensive	Medicare Supplement	Dental	Vision	Federal Employees plan	Medicare	Medicaid	Other health	Other non-health	Aggregate of All Other Lines Business
1. Net Premiums (All Business)	262,126							262,126			
2. Change in unearned premium reserve	-										
3. Fee for service	-										XXX
4. Risk revenue	-										XXX
5. Aggregate write ins for other health related revenues	-										XXX
6. Aggregate write ins for other non-health related revenues	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX
7. Total Revenue (1+2+3+4+5+6)	**262,126**	**-**	**-**	**-**	**-**	**-**	**-**	**262,126**	**-**	**-**	**-**
8. Hospital/medical benefits	166,991							166,991			
9. Other professional services	49,829							49,829			
10. Prescription Drugs	20,737							20,737			
11. Aggregatae writes for other hospital/ medical/health	-										XXX
12. Subtotal (8+9+10+11)	**237,557**	**-**	**-**	**-**	**-**	**-**	**-**	**237,557**	**-**	**-**	**-**
	-										
13. Net reinsurance recoveries								1023.053			
14. Total hospital and medical (12-13)	**236,534**	**-**	**-**	**-**	**-**	**-**	**-**	**236,534**	**-**	**-**	**-**
15. Non health claims	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
16. Claims adjustment expenses	10,690							10690.09			
17. General admin expenses	13,066							13065.66			
18. Increase in reserves for accident and health contracts	-										
19. Aggregate write in for Other Expenses	-										
20. Total underwriting deductions (14 to19)	**260,290**	**-**	**-**	**-**	**-**	**-**	**-**	**260,290**	**-**	**-**	**-**
21. Net underwriting Gain (Loss) (7-20)	**1,836**	**-**	**-**	**-**	**-**	**-**	**-**	**1,836**	**-**	**-**	**-**

Nationwide
Year 2

West Central CCO
(Health Company)
Analysis of Operations by Line of Business
(In Thousands)

	Total	Comprehensive	Medicare Supplement	Dental	Vision	Federal Employees plan	Medicare	Medicaid	Other health	Other non-health	Aggregate of All Other Lines
1. Net Premiums (All Business)	270,713							270,713			
2. Change in unearned premium reserve	-										
3. Fee for service	-										XXX
4. Risk revenue	-										XXX
5. Aggregate write ins for other health related revenues	-										XXX
6. Aggregate write ins for other non-health related revenues	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX
7. Total Revenue (1+2+3+4+5+6)	**270,713**	**-**	**-**	**-**	**-**	**-**	**-**	**270,713**	**-**	**-**	**-**
	-										
8. Hospital/medical benefits	172,482							172,482			
9. Other professional services	51,468							51,468			
10. Prescription Drugs	21,419							21,419			
11. Aggregate write ins for other hospital/ medical/health	-										XXX
12. Subtotal (8+9+10+11)	**245,368**	**-**	**-**	**-**	**-**	**-**	**-**	**245,368**	**-**	**-**	**-**
	-										
13. Net reinsurance recoveries								1074.205			
14. Total hospital and medical (12-13)	244,294	-	-	-	-	-	-	244,294	-	-	-
15. Non health claims	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
16. Claims adjustment expenses	11,042							11041.56			
17. General admin expenses	13,495							13495.23			
18. Increase in reserves for accident and health contracts	-										
19. Aggregate write in for Other Expenses	-										
20. Total underwriting deductions (14 to19)	**268,830**	**-**	**-**	**-**	**-**	**-**	**-**	**268,830**	**-**	**-**	**-**
21. Net underwriting Gain (Loss) (7-20)	**1,882**	**-**	**-**	**-**	**-**	**-**	**-**	**1,882**	**-**	**-**	**-**

Nationwide
Year 3

West Central CCO
(Health Company)
Analysis of Operations by Line of Business
(In Thousands)

	Total	Comprehensive	Medicare Supplement	Dental	Vision	Federal Employees plan	Medicare	Medicaid	Other health	Other non-health	Aggregate of All Other Lines
1. Net Premiums (All Business)	279,590							279590.2			
2. Change in unearned premium reserve	-										
3. Fee for service	-										XXX
4. Risk revenue	-										XXX
5. Aggregate write ins for other health related revenues	-										XXX
6. Aggregate write ins for other non-health related revenues	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX
7. Total Revenue (L1+L2+L3+L4+L5+L6)	**279,590**	**-**	**-**	**-**	**-**	**-**	**-**	**279,590**	**-**	**-**	**-**
	-										
8. Hospital/medical benefits	178,159							178,159			XXX
9. Other professional services	53,162							53,162			XXX
10. Prescription Drugs	22,124							22,124			XXX
11. Aggregatae writes for other hospital/ medical/health	-										XXX
12. Subtotal (L8+L9+L10+L11)	**253,444**	**-**	**-**	**-**	**-**	**-**	**-**	**253,444**	**-**	**-**	
13. Net reinsurance recoveries	1,128							1127.916			
14. Total hospital and medical (L12-L13)	252,316	-	-	-	-	-	-	252,316	-	-	-
15. Non health claims	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX
16. Claims adjustment expenses	11,405							11404.98			
17. General admin expenses	13,939							13939.41			
18. Increase in reserves for accident and health contracts	-										XXX
19. Aggregate write in for Other Expenses	-										
20. Total underwriting deductions (L14 : L19)	**277,660**	**-**	**-**	**-**	**-**	**-**	**-**	**277,660**	**-**	**-**	**-**
21. Net underwriting Gain (Loss) (L7-L20)	**1,930**	**-**	**-**	**-**	**-**	**-**	**-**	**1,930**	**-**	**-**	**-**

Nationwide
Year 1

West Central CCO
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	263,952,736		1,826,880	262,125,856
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	263,952,736	-	1,826,880	262,125,856

Nationwide
Year 2

West Central CCO
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	272,631,005		1,918,224	270,712,781
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	272,631,005	-	1,918,224	270,712,781

Nationwide
Year 3

West Central CCO
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	281,604,335		2,014,135	279,590,200
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	281,604,335	-	2,014,135	279,590,200

Nationwide
Year 1

West Central CCO
(Health Company)
Preliminary MLR
(In Thousands)

	Individual Comprehensive	Small group comprehensive	Large Group comprehensive	Individual mini-med	Small group mini-med	Large Group mini-med	Total
1. Premiums earned							-
2. Federal taxes/Federal asessments							-
3. State insurance, premium, and other taxes							-
4. Regulatory authority license and fees							-
5. Adjusted premium earned (L1-L2-L3-L4)	-	-	-	-	-	-	-
6. Incurred claims excluding prescription drugs							-
7. Prescription drugs							-
8. Pharmaceutical rebates							-
9. State stop loss, market stabilization and claim/census based assessments							-
10. Incurred medical incentive pools and bonuses							-
11. Total incurred claims (L6+L7-L8-L9+L10)	-	-	-	-	-	-	-
12. Deductible abuse detection/recovery expenses							-
13. Improved health outcomes							-
14. Activities to prevent hospital readmissions							-
15. Improve patient safety and reduce medical errors							-
16. Wellness and health promotion activities							-
17. QI Health information technology expenses							-
18. Total expenses incurred for improving health quality (L13+L14+L15+L16+L17)	-	-	-	-	-	-	-
19 Prelimary MLR (L11+L12+L18/L5)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Nationwide
Year 2

West Central CC(
(Health Company)
Preliminary MLR
(In Thousands)

	Individual Comprehensive	Small group comprehensive	Large Group comprehensive	Individual mini-med	Small group mini-med	Large Group mini-med	Total
1. Premiums earned							-
2. Federal taxes/Federal asessments							-
3. State insurance, premium, and other taxes							-
4. Regulatory authority license and fees							
5. Adjusted premium earned (L1-L2-L3-L4)	-	-	-	-	-	-	-
6. Incurred claims excluding prescription drugs							-
7. Prescription drugs							-
8. Pharmaceutical rebates							-
9. State stop loss, market stabilization and claim/census based assessments							-
10. Incurred medical incentive pools and bonuses							-
11. Total incurred claims (L6+L7-L8L-9+L10)	-	-	-	-	-	-	-
12. Deductible abuse detection/recovery expenses							-
13. Improved health outcomes							-
14. Activities to prevent hospital readmissions							-
15. Improve patient safety and reduce medical errors							-
16. Wellness and health promotion activities							-
17. QI Health information technology expenses							-
18. Total expenses incurred for improving health quality (L13+L14+L15+L16+L17)	-	-	-	-	-	-	-
19 Prelimary MLR (L11+L12+L18/L5)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Nationwide
Year 3

West Central CC(
(Health Company)
Preliminary MLR
(In Thousands)

	Individual Comprehensive	Small group comprehensive	Large Group comprehensive	Individual mini-med	Small group mini-med	Large Group mini-med	Total
1. Premiums earned							-
2. Federal taxes/Federal asessments							-
3. State insurance, premium, and other taxes							-
4. Regulatory authority license and fees							-
5. Adjusted premium earned (1-2-3-4)	**-**	**-**	**-**	**-**	**-**	**-**	**-**
6. Incurred claims excluding prescription drugs							-
7. Prescription drugs							-
8. Pharmaceutical rebates							-
9. State stop loss, market stabilization and claim/census based assessments							-
10. Incurred medical incentive pools and bonuses							-
11. Total incurred claims (6+7-8-9+10)	-	-	-	-	-	-	-
12. Deductible abuse detection/recovery expenses							**-**
13. Improved health outcomes							-
14. Activities to prevent hospital readmissions							-
15. Improve patient safety and reduce medical errors							-
16. Wellness and health promotion activities							-
17. QI Health information technology expenses							-
18. Total expenses incurred for improving health quality (L13+L14+L15+L16+L17)	**-**	**-**	**-**	**-**	**-**	**-**	**-**
19 Prelimary MLR (L11+L12+L18/L5)	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**

UCAA Proforma Financial Statements Assumptions

List all of the relevant assumptions used to create the proformas.
Note, assumptions enclosed within the Plan of Operation need not be disclosed again here.

The purpose of this proforma is to demonstrate the how the West Central CCO (WCCCO) could potentially be formed as well as to provide a forecast of the expected results over the next five year period. The underlying assumption is that a partnership will be formed with provider partners similar to the Eastern Oregon CCO (EOCCO).

ODS Community Health (Moda) intends to contribute capital to cover the estimated minimum net worth requirement which, based on the Company's projected Authorized Control Level, would also allow the Company to exceed 200% RBC by year 2.

Similar to the original formation of EOCCO, partners in the WCCCO will be welcome to come on as owners subsequent to initial CCO formation.

Region/Counties:
The geographic region that West Central CCO would serve in is Lane County.

Enrollment Levels:
The total membership for this area is estimated to be approximately 88,000. The current best estimate is that WCCCO will capture 50% of this market. It is believed that the proposed strong provider partnerships will allow it to deliver high-quality care while staying within the 3.4% annual medical trend target. It is expected that the WCCCO would be able to sucessfully manage membership levels between 40% and 105% of the total estimated enrollment and be able to stay within the 3.4% annual medical trend target while effectively managing fixed and variable administrative costs and maintaining the appropriate service and network adequacy levels.

Revenue:
The Company estimated revenues using the provided PMPM revenue amount from Attachment 12 - CCO 2.0 Procurement Rate Methodology Appendix. The company assumed the average gross rate ($483.42) excluding tax for its rating area. The gross rate was chosen because the Company intends to achieve 100% of the bonus pool. While the Company acknowledges that the performance metrics are progressively more difficult to achieve, it also believes that its structure and strong provider-partnerships and success record with administering the EOCCO through its affiliates demonstrates that this is achievable.

Included in the revenue amount is the projected maternity payments based on the projected rate from Attachment 12 - CCO 2.0 Procurement Rate Methodology Appendix. The Company assumed the average gross rate ($11,371.75) excluding tax for its rating area and multiplied that with the projected births for the region based on the projected enrollment targets.

Total revenue for years 2021 and 2022 were increased by a growth rate of 3.4% to account for the overall global budget target.

Underwriting Expenses:
The Company estimated medical expenses at 90% of total revenues, based on the rate setting methodology and the projected non-medical load amounts. Total Pay-for-Performance amounts were also projected at 90% of total revenues.

Administrative Expenses:
The adminstrative expenses have been estimated using the rating methodology for the non-medical load administration and case management services. The 1% profit contingency has been factored into the underwriting results.

Other:
Reinsurance: Reinsurance premiums are based on the current market per member per month rate and increases 5% each year.
Reinsurance recoveries are based on a conservative 56% of premium.

Investment Income: Investment income is assumed at 1.5% of invested balances

Oregon
Year 1

West Central CCO
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	263,952,736		1,826,880	262,125,856
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	**263,952,736**	**-**	**1,826,880**	**262,125,856**

Oregon
Year 2

West Central CCO
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	272,631,005		1,918,224	270,712,781
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	**272,631,005**	**-**	**1,918,224**	**270,712,781**

Oregon
Year 3

West Central CCO
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	281,604,335		2,014,135	279,590,200
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	**281,604,335**	**-**	**2,014,135**	**279,590,200**

UCAA Proforma Financial Statements

Health

UNIFORM CERTIFICATE OF AUTHORITY APPLICATION

Instructions

1. Enter the Applicant Company Name below
2. Enter the first full year of the proformas (start with 1st full year of operation).
3. Select the states to be completed for proformas by clicking the check boxes on the right and then click on the "Create Selected State Worksheets" button below.
4. Complete all sections of the proforma statements contained on each tab below.
5. Note that several tabs contain worksheets for 3 years of data. Be sure to complete all years of data.
6. Do not "Cut" and "Paste" cells in the worksheets. Use "Copy" and "Paste" instead.

Enter the Applicant Company Name:

West Central CCO

Year 1: 2020

Year 2: 2021

Year 3: 2022

☐	AK	Alaska	☐	MT	Montana	
☐	AL	Alabama	☐	NC	North Carolina	
☐	AR	Arkansas	☐	ND	North Dakota	
☐	AS	American Samoa	☐	NE	Nebraska	
☐	AZ	Arizona	☐	NH	New Hampshire	
☐	CA	California	☐	NJ	New Jersey	
☐	CO	Colorado	☐	NM	New Mexico	
☐	CT	Connecticut	☐	NV	Nevada	
☐	DC	District Of Columbia	☐	NY	New York	
☐	DE	Delaware	☐	OH	Ohio	
☐	FL	Florida	☐	OK	Oklahoma	
☐	GA	Georgia	☑	OR	Oregon	Go to OR
☐	GU	Guam	☐	PA	Pennsylvania	
☐	HI	Hawaii	☐	PR	Puerto Rico	
☐	IA	Iowa	☐	RI	Rhode Island	
☐	ID	Idaho	☐	SC	South Carolina	
☐	IL	Illinois	☐	SD	South Dakota	
☐	IN	Indiana	☐	TN	Tennessee	
☐	KS	Kansas	☐	TX	Texas	
☐	KY	Kentucky	☐	UT	Utah	
☐	LA	Louisiana	☐	VA	Virginia	
☐	MA	Massachusetts	☐	VI	U.S. Virgin Islands	
☐	MD	Maryland	☐	VT	Vermont	
☐	ME	Maine	☐	WA	Washington	
☐	MI	Michigan	☐	WI	Wisconsin	
☐	MN	Minnesota	☐	WV	West Virginia	
☐	MO	Missouri	☐	WY	Wyoming	
☐	MS	Mississippi				

If states were added to this spreadsheet in error:

1. Select the states to be deleted by clicking the check boxes on the right.
2. Click on the "Delete Selected State Worksheets" button above.

Updated: 10/07/2016

West Central CCO
(Health Company)
Pro Forma Statutory Balance Sheet (Nationwide)
(In Thousands)

	2020	2021	2022
Admitted Assets			
1. Bonds	16,409	25,088	32,244
2. Stock	8,836	13,509	17,362
3. Real Estate/Mortgage Investments			
4. Affiliated Investments			
5. Affiliated Receivables			
6. Cash/Cash Equivalents	56,689	56,346	58,382
7. Aggregate write in for assets	3,513	3,628	3,748
8. Total Assets(1+2+3+4+5+6+7)	**85,447**	**98,572**	**111,737**
Liabilities			
9. Losses (Unpaid Claims for Accident and Health Policies)	33,849	34,962	36,113
10. Unpaid claims adjustment expenses	1,611	1,664	1,719
11. Reserve for Accident and Health Policies			
12. Ceded Reinsurance Payable	320	336	336
13. Payable to Parents, Subsidiaries & Affiliates			
14. MLR rebates			
15. Premiums received in advanced	4,619	4,771	4,928
16. All other Liabilites	6,451	7,232	7,530
17. Total Liabilities (9+10+11+12+13+14+15+16)	**46,850**	**48,965**	**50,625**
Capital and Surplus			
18. Capital Stock			
19. Gross Paid In and Contributed Surplus	28,050	28,050	28,050
20. Surplus Notes			
21. Unassigned Surplus	10,547	21,557	33,044
22. Other Items(elaborate)			
23. Total Capital and Surplus(18+19+20+21+22)	38,597	49,607	61,094
Risk-Based Capital Analysis			
24. Authorized Control Level Risk-Based Capital	$ 17,501	$ 17,746	$ 18,016
25. Calculated Risk-Based Capital (23/24)	220.5%	279.5%	339.1%

West Central CCO
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Thousands)

	2020	2021	2022
1. Member months	1,108,800	1,108,800	1,108,800
2. Net Premium Income	550,464	568,497	587,139
3. Fee for Service			
4. Risk Revenue			
5. Change in unearned premium reserves			
6. Aggregate write in for other health related revenue			
7. Aggregate write in for other non-health related revenue			
8. Total (L2+L3+L4+L5+L6+L7)	**550,464**	**568,497**	**587,139**
Hospital and Medical:			
9. Hospital/Medical Benenfits	350,682	362,211	374,133
10. Other professional Services	104,642	108,082	111,639
11. Prescription Drugs	43,547	44,979	46,460
12. Aggregate write ins for other hospital/medical	-		
13. Subtotal (L9+L10+L11+L12)	**498,871**	**515,273**	**532,232**
Less:			
14. Reinsurance recoveries	2,148	2,256	2,369
15. Total hospital and Medical (L13 -L14)	496,722	513,017	529,864
16. Non health claims			
17. Claims adjustment expenses	19,627	20,272	20,940
18. General admin expenses	23,989	24,777	25,593
19. Increase in reserves for accident and health contacts			
20. Total underwriting deductions (L15+L16+L17+L18+L19)	**540,338**	**558,066**	**576,396**
21. Net underwriting gain or loss (L8 -L20)	10,126	10,431	10,744
22. Net investment income earned	421	579	744
23. Aggregate write in for other income or expenses			
24. Federal Income Taxes	-	-	-
25. Net Realized Capital Gains (Losses)			
26. Less Capital Gains Tax			
27. Net Income (L21+L22+L23-L24+L25)	**10,547**	**11,009**	**11,488**
28. Prior YE Surplus	0	38,597	49,607
29. Net Income	10,547	11,009	11,488
30. Capital Increases	28050		
31. Other Increases (Decreases)			
32. Dividends to Stockholders			
33. YE Surplus (L28+L29+L30+L31-L32)	**38,597**	**49,607**	**61,094**

***Itemize in Assumptions**

West Central CCO
(Health Company)
Pro Forma Statutory Cash Flow Statement
(In Thousands)

	2020	2021	2022
Cash From Operations			
1. Premiums Collected Net of Reinsurance	551,571	568,533	587,177
2. Benefits Paid	461,262	511,851	528,658
3. Underwriting Expenses Paid	36,845	44,252	46,218
4. Total Cash From Underwriting (L1-L2-L3)	**53,463**	**12,430**	**12,301**
5. Net Investment Income	421	579	744
6. Other Income			
7. Dividends to Policyholders			
8. Federal and Foreign Income Taxes (Paid) Recovered	-	-	-
9. Net Cash From Operations (L4+L5+L6-L7+L8)	**53,884**	**13,009**	**13,045**
Cash From Investments			
10. Net Cash from Investments	(25,245)	(13,352)	(11,009)
Cash From Financing and Misc Sources			
11. Capital and paid in Surplus	28,050		
12. Surplus Notes			
13. Borrowed Funds			
14. Dividends			
15. Other Cash Provided (Applied)			
16. Net Cash from Financing and Misc Sources (L11+L12+L13-L14+L15)	**28,050**	**-**	**-**
17. Net Change in Cash, Cash Equivalents and Short -Term Investments (L9+L10+L16)	56,689	(343)	2,036

Nationwide
Year 1

West Central CCO
(Health Company)
Analysis of Operations by Line of Business
(In Thousands)

	Total	Comprehensive	Medicare Supplement	Dental	Vision	Federal Employees plan	Medicare	Medicaid	Other health	Other non-health	Aggregate of All Other Lines Business
1. Net Premiums (All Business)	550,464							550,464			
2. Change in unearned premium reserve	-										
3. Fee for service	-										XXX
4. Risk revenue	-										XXX
5. Aggregate write ins for other health related revenues	-										XXX
6. Aggregate write ins for other non-health related revenues	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX
7. Total Revenue (1+2+3+4+5+6)	**550,464**	**-**	**-**	**-**	**-**	**-**	**-**	**550,464**	**-**	**-**	**-**
8. Hospital/medical benefits	350,682							350,682			
9. Other professional services	104,642							104,642			
10. Prescription Drugs	43,547							43,547			
11. Aggregatae writes for other hospital/ medical/health	-										XXX
12. Subtotal (8+9+10+11)	**498,871**	**-**	**-**	**-**	**-**	**-**	**-**	**498,871**	**-**	**-**	**-**
	-										
13. Net reinsurance recoveries								2148.411			
14. Total hospital and medical (12-13)	**496,722**	**-**	**-**	**-**	**-**	**-**	**-**	**496,722**	**-**	**-**	**-**
15. Non health claims	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
16. Claims adjustment expenses	19,627							19627			
17. General admin expenses	23,989							23988.55			
18. Increase in reserves for accident and health contracts	-										
19. Aggregate write in for Other Expenses	-										
20. Total underwriting deductions (14 to19)	**540,338**	**-**	**-**	**-**	**-**	**-**	**-**	**540,338**	**-**	**-**	**-**
21. Net underwriting Gain (Loss) (7-20)	**10,126**	**-**	**-**	**-**	**-**	**-**	**-**	**10,126**	**-**	**-**	**-**

Nationwide
Year 2

West Central CCO
(Health Company)
Analysis of Operations by Line of Business
(In Thousands)

	Total	Comprehensive	Medicare Supplement	Dental	Vision	Federal Employees plan	Medicare	Medicaid	Other health	Other non-health	Aggregate of All Other Lines
1. Net Premiums (All Business)	568,497							568,497			
2. Change in unearned premium reserve	-										
3. Fee for service	-										XXX
4. Risk revenue	-										XXX
5. Aggregate write ins for other health related revenues	-										XXX
6. Aggregate write ins for other non-health related revenues	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX
7. Total Revenue (1+2+3+4+5+6)	**568,497**	**-**	**-**	**-**	**-**	**-**	**-**	**568,497**	**-**	**-**	**-**
	-										
8. Hospital/medical benefits	362,211							362,211			
9. Other professional services	108,082							108,082			
10. Prescription Drugs	44,979							44,979			
11. Aggregate write ins for other hospital/ medical/health	-										XXX
12. Subtotal (8+9+10+11)	**515,273**	**-**	**-**	**-**	**-**	**-**	**-**	**515,273**	**-**	**-**	**-**
	-										
13. Net reinsurance recoveries								2255.831			
14. Total hospital and medical (12-13)	513,017	-	-	-	-	-	-	513,017	-	-	-
15. Non health claims	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
16. Claims adjustment expenses	20,272							20272.3			
17. General admin expenses	24,777							24777.25			
18. Increase in reserves for accident and health contracts	-										
19. Aggregate write in for Other Expenses	-										
20. Total underwriting deductions (14 to19)	**558,066**	**-**	**-**	**-**	**-**	**-**	**-**	**558,066**	**-**	**-**	**-**
21. Net underwriting Gain (Loss) (7-20)	**10,431**	**-**	**-**	**-**	**-**	**-**	**-**	**10,431**	**-**	**-**	**-**

Nationwide
Year 3

West Central CCO
(Health Company)
Analysis of Operations by Line of Business
(In Thousands)

	Total	Comprehensive	Medicare Supplement	Dental	Vision	Federal Employees plan	Medicare	Medicaid	Other health	Other non-health	Aggregate of All Other Lines
1. Net Premiums (All Business)	587,139							587139.4			
2. Change in unearned premium reserve	-										
3. Fee for service	-										XXX
4. Risk revenue	-										XXX
5. Aggregate write ins for other health related revenues	-										XXX
6. Aggregate write ins for other non-health related revenues	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX
7. Total Revenue (L1+L2+L3+L4+L5+L6)	**587,139**	**-**	**-**	**-**	**-**	**-**	**-**	**587,139**	**-**	**-**	**-**
	-										
8. Hospital/medical benefits	374,133							374,133			XXX
9. Other professional services	111,639							111,639			XXX
10. Prescription Drugs	46,460							46,460			XXX
11. Aggregatae writes for other hospital/ medical/health	-										XXX
12. Subtotal (L8+L9+L10+L11)	**532,232**	**-**	**-**	**-**	**-**	**-**	**-**	**532,232**	**-**	**-**	
13. Net reinsurance recoveries	2,369							2368.623			
14. Total hospital and medical (L12-L13)	529,864	-	-	-	-	-	-	529,864	-	-	-
15. Non health claims	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX
16. Claims adjustment expenses	20,940							20939.54			
17. General admin expenses	25,593							25592.77			
18. Increase in reserves for accident and health contracts	-										XXX
19. Aggregate write in for Other Expenses	-										
20. Total underwriting deductions (L14 : L19)	**576,396**	**-**	**-**	**-**	**-**	**-**	**-**	**576,396**	**-**	**-**	**-**
21. Net underwriting Gain (Loss) (L7-L20)	**10,744**	**-**	**-**	**-**	**-**	**-**	**-**	**10,744**	**-**	**-**	**-**

Nationwide
Year 1

West Central CCO
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	554,300,745		3,836,448	550,464,297
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	554,300,745	-	3,836,448	550,464,297

Nationwide
Year 2

West Central CCO
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	572,525,110		4,028,270	568,496,840
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	572,525,110	-	4,028,270	568,496,840

Nationwide
Year 3

West Central CCO
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	591,369,103		4,229,684	587,139,420
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	591,369,103	-	4,229,684	587,139,420

Nationwide
Year 1

West Central CCO
(Health Company)
Preliminary MLR
(In Thousands)

	Individual Comprehensive	Small group comprehensive	Large Group comprehensive	Individual mini-med	Small group mini-med	Large Group mini-med	Total
1. Premiums earned							-
2. Federal taxes/Federal asessments							-
3. State insurance, premium, and other taxes							-
4. Regulatory authority license and fees							-
5. Adjusted premium earned (L1-L2-L3-L4)	-	-	-	-	-	-	-
6. Incurred claims excluding prescription drugs							-
7. Prescription drugs							-
8. Pharmaceutical rebates							-
9. State stop loss, market stabilization and claim/census based assessments							-
10. Incurred medical incentive pools and bonuses							-
11. Total incurred claims (L6+L7-L8-L9+L10)	-	-	-	-	-	-	-
12. Deductible abuse detection/recovery expenses							-
13. Improved health outcomes							-
14. Activities to prevent hospital readmissions							-
15. Improve patient safety and reduce medical errors							-
16. Wellness and health promotion activities							-
17. QI Health information technology expenses							-
18. Total expenses incurred for improving health quality (L13+L14+L15+L16+L17)	-	-	-	-	-	-	-
19 Prelimary MLR (L11+L12+L18/L5)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Nationwide
Year 2

West Central CC(
(Health Company)
Preliminary MLR
(In Thousands)

	Individual Comprehensive	Small group comprehensive	Large Group comprehensive	Individual mini-med	Small group mini-med	Large Group mini-med	Total
1. Premiums earned							-
2. Federal taxes/Federal asessments							-
3. State insurance, premium, and other taxes							-
4. Regulatory authority license and fees							
5. Adjusted premium earned (L1-L2-L3-L4)	-	-	-	-	-	-	-
6. Incurred claims excluding prescription drugs							-
7. Prescription drugs							-
8. Pharmaceutical rebates							-
9. State stop loss, market stabilization and claim/census based assessments							-
10. Incurred medical incentive pools and bonuses							-
11. Total incurred claims (L6+L7-L8L-9+L10)	-	-	-	-	-	-	-
12. Deductible abuse detection/recovery expenses							-
13. Improved health outcomes							-
14. Activities to prevent hospital readmissions							-
15. Improve patient safety and reduce medical errors							-
16. Wellness and health promotion activities							-
17. QI Health information technology expenses							-
18. Total expenses incurred for improving health quality (L13+L14+L15+L16+L17)	-	-	-	-	-	-	-
19 Prelimary MLR (L11+L12+L18/L5)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Nationwide
Year 3

West Central CC(
(Health Company)
Preliminary MLR
(In Thousands)

	Individual Comprehensive	Small group comprehensive	Large Group comprehensive	Individual mini-med	Small group mini-med	Large Group mini-med	Total
1. Premiums earned							-
2. Federal taxes/Federal asessments							-
3. State insurance, premium, and other taxes							-
4. Regulatory authority license and fees							-
5. Adjusted premium earned (1-2-3-4)	**-**	**-**	**-**	**-**	**-**	**-**	**-**
6. Incurred claims excluding prescription drugs							-
7. Prescription drugs							-
8. Pharmaceutical rebates							-
9. State stop loss, market stabilization and claim/census based assessments							-
10. Incurred medical incentive pools and bonuses							-
11. Total incurred claims (6+7-8-9+10)	-	-	-	-	-	-	-
12. Deductible abuse detection/recovery expenses							**-**
13. Improved health outcomes							-
14. Activities to prevent hospital readmissions							-
15. Improve patient safety and reduce medical errors							-
16. Wellness and health promotion activities							-
17. QI Health information technology expenses							-
18. Total expenses incurred for improving health quality (L13+L14+L15+L16+L17)	**-**	**-**	**-**	**-**	**-**	**-**	**-**
19 Prelimary MLR (L11+L12+L18/L5)	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**

UCAA Proforma Financial Statements Assumptions

List all of the relevant assumptions used to create the proformas.
Note, assumptions enclosed within the Plan of Operation need not be disclosed again here.

The purpose of this proforma is to demonstrate the how the West Central CCO (WCCCO) could potentially be formed as well as to provide a forecast of the expected results over the next five year period. The underlying assumption is that a partnership will be formed with provider partners similar to the Eastern Oregon CCO (EOCCO).

ODS Community Health (Moda) intends to contribute capital to cover the estimated minimum net worth requirement which, based on the Company's projected Authorized Control Level, would also allow the Company to exceed 200% RBC by year 2.
Similar to the original formation of EOCCO, partners in the WCCCO will be welcome to come on as owners subsequent to initial CCO formation.

Region/Counties:
The geographic region that West Central CCO would serve in is Lane County.

Enrollment Levels:
The total membership for this area is estimated to be approximately 88,000. The current best estimate is that WCCCO will capture 50% of this market. It is believed that the proposed strong provider partnerships will allow it to deliver high-quality care while staying within the 3.4% annual medical trend target. It is expected that the WCCCO would be able to sucessfully manage membership levels between 40% and 105% of the total estimated enrollment and be able to stay within the 3.4% annual medical trend target while effectively managing fixed and variable administrative costs and maintaining the appropriate service and network adequacy levels.

Revenue:
The Company estimated revenues using the provided PMPM revenue amount from Attachment 12 - CCO 2.0 Procurement Rate Methodology Appendix. The company assumed the average gross rate ($483.42) excluding tax for its rating area. The gross rate was chosen because the Company intends to achieve 100% of the bonus pool. While the Company acknowledges that the performance metrics are progressively more difficult to achieve, it also believes that its structure and strong provider-partnerships and success record with administering the EOCCO through its affiliates demonstrates that this is achievable.

Included in the revenue amount is the projected maternity payments based on the projected rate from Attachment 12 - CCO 2.0 Procurement Rate Methodology Appendix. The Company assumed the average gross rate ($11,371.75) excluding tax for its rating area and multiplied that with the projected births for the region based on the projected enrollment targets.

Total revenue for years 2021 and 2022 were increased by a growth rate of 3.4% to account for the overall global budget target.

Underwriting Expenses:
The Company estimated medical expenses at 90% of total revenues, based on the rate setting methodology and the projected non-medical load amounts. Total Pay-for-Performance amounts were also projected at 90% of total revenues.

Administrative Expenses:
The adminstrative expenses have been estimated using the rating methodology for the non-medical load administration and case management services. The 1% profit contingency has been factored into the underwriting results.

Other:
Reinsurance: Reinsurance premiums are based on the current market per member per month rate and increases 5% each year.
Reinsurance recoveries are based on a conservative 56% of premium.

Investment Income: Investment income is assumed at 1.5% of invested balances

Oregon
Year 1

West Central CCO
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	554,300,745		3,836,448	550,464,297
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	**554,300,745**	**-**	**3,836,448**	**550,464,297**

Oregon
Year 2

West Central CCO
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	572,525,110		4,028,270	568,496,840
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	**572,525,110**	**-**	**4,028,270**	**568,496,840**

Oregon
Year 3

West Central CCO
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	591,369,103		4,229,684	587,139,420
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	**591,369,103**	**-**	**4,229,684**	**587,139,420**

UCAA Proforma Financial Statements

Health

UNIFORM CERTIFICATE OF AUTHORITY APPLICATION

Instructions

1. Enter the Applicant Company Name below
2. Enter the first full year of the proformas (start with 1st full year of operation).
3. Select the states to be completed for proformas by clicking the check boxes on the right and then click on the "Create Selected State Worksheets" button below.
4. Complete all sections of the proforma statements contained on each tab below.
5. Note that several tabs contain worksheets for 3 years of data. Be sure to complete all years of data.
6. Do not "Cut" and "Paste" cells in the worksheets. Use "Copy" and "Paste" instead.

Enter the Applicant Company Name:

West Central CCO

Year 1: 2020

Year 2: 2021

Year 3: 2022

☐	AK	Alaska	☐	MT	Montana	
☐	AL	Alabama	☐	NC	North Carolina	
☐	AR	Arkansas	☐	ND	North Dakota	
☐	AS	American Samoa	☐	NE	Nebraska	
☐	AZ	Arizona	☐	NH	New Hampshire	
☐	CA	California	☐	NJ	New Jersey	
☐	CO	Colorado	☐	NM	New Mexico	
☐	CT	Connecticut	☐	NV	Nevada	
☐	DC	District Of Columbia	☐	NY	New York	
☐	DE	Delaware	☐	OH	Ohio	
☐	FL	Florida	☐	OK	Oklahoma	
☐	GA	Georgia	☑	OR	Oregon	Go to OR
☐	GU	Guam	☐	PA	Pennsylvania	
☐	HI	Hawaii	☐	PR	Puerto Rico	
☐	IA	Iowa	☐	RI	Rhode Island	
☐	ID	Idaho	☐	SC	South Carolina	
☐	IL	Illinois	☐	SD	South Dakota	
☐	IN	Indiana	☐	TN	Tennessee	
☐	KS	Kansas	☐	TX	Texas	
☐	KY	Kentucky	☐	UT	Utah	
☐	LA	Louisiana	☐	VA	Virginia	
☐	MA	Massachusetts	☐	VI	U.S. Virgin Islands	
☐	MD	Maryland	☐	VT	Vermont	
☐	ME	Maine	☐	WA	Washington	
☐	MI	Michigan	☐	WI	Wisconsin	
☐	MN	Minnesota	☐	WV	West Virginia	
☐	MO	Missouri	☐	WY	Wyoming	
☐	MS	Mississippi				

If states were added to this spreadsheet in error:

1. Select the states to be deleted by clicking the check boxes on the right.
2. Click on the "Delete Selected State Worksheets" button above.

Updated: 10/07/2016

West Central CCO
(Health Company)
Pro Forma Statutory Balance Sheet (Nationwide)
(In Thousands)

	2020	2021	2022
Admitted Assets			
1. Bonds	7,664	8,856	9,202
2. Stock	4,127	4,769	4,955
3. Real Estate/Mortgage Investments			
4. Affiliated Investments			
5. Affiliated Receivables			
6. Cash/Cash Equivalents	18,866	18,389	19,014
7. Aggregate write in for assets	1,338	1,382	1,428
8. Total Assets(1+2+3+4+5+6+7)	**31,994**	**33,396**	**34,599**
Liabilities			
9. Losses (Unpaid Claims for Accident and Health Policies)	12,895	13,319	13,757
10. Unpaid claims adjustment expenses	614	634	655
11. Reserve for Accident and Health Policies			
12. Ceded Reinsurance Payable	122	128	128
13. Payable to Parents, Subsidiaries & Affiliates			
14. MLR rebates			
15. Premiums received in advanced	1,760	1,818	1,877
16. All other Liabilites	2,979	3,340	3,478
17. Total Liabilities (9+10+11+12+13+14+15+16)	**18,370**	**19,239**	**19,895**
Capital and Surplus			
18. Capital Stock			
19. Gross Paid In and Contributed Surplus	13,100	13,100	13,100
20. Surplus Notes			
21. Unassigned Surplus	525	1,057	1,597
22. Other Items(elaborate)			
23. Total Capital and Surplus(18+19+20+21+22)	13,625	14,157	14,697
Risk-Based Capital Analysis			
24. Authorized Control Level Risk-Based Capital	$ 6,952	$ 7,058	$ 7,154
25. Calculated Risk-Based Capital (23/24)	196.0%	200.6%	205.4%

West Central CCO
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Thousands)

	2020	2021	2022
1. Member months	422,400	422,400	422,400
2. Net Premium Income	209,701	216,570	223,672
3. Fee for Service			
4. Risk Revenue			
5. Change in unearned premium reserves			
6. Aggregate write in for other health related revenue			
7. Aggregate write in for other non-health related revenue			
8. Total (L2+L3+L4+L5+L6+L7)	**209,701**	**216,570**	**223,672**
Hospital and Medical:			
9. Hospital/Medical Benenfits	133,593	137,985	142,527
10. Other professional Services	39,863	41,174	42,529
11. Prescription Drugs	16,589	17,135	17,699
12. Aggregate write ins for other hospital/medical	-		
13. Subtotal (L9+L10+L11+L12)	**190,046**	**196,294**	**202,755**
Less:			
14. Reinsurance recoveries	818	859	902
15. Total hospital and Medical (L13 -L14)	189,228	195,435	201,853
16. Non health claims			
17. Claims adjustment expenses	9,065	9,363	9,671
18. General admin expenses	11,080	11,444	11,821
19. Increase in reserves for accident and health contacts			
20. Total underwriting deductions (L15+L16+L17+L18+L19)	**209,372**	**216,242**	**223,345**
21. Net underwriting gain or loss (L8 -L20)	328	328	327
22. Net investment income earned	197	204	212
23. Aggregate write in for other income or expenses			
24. Federal Income Taxes	-	-	-
25. Net Realized Capital Gains (Losses)			
26. Less Capital Gains Tax			
27. Net Income (L21+L22+L23-L24+L25)	**525**	**532**	**540**
28. Prior YE Surplus	0	13,625	14,157
29. Net Income	525	532	540
30. Capital Increases	13100		
31. Other Increases (Decreases)			
32. Dividends to Stockholders			
33. YE Surplus (L28+L29+L30+L31-L32)	**13,625**	**14,157**	**14,697**

***Itemize in Assumptions**

West Central CCO
(Health Company)
Pro Forma Statutory Cash Flow Statement
(In Thousands)

	2020	2021	2022
Cash From Operations			
1. Premiums Collected Net of Reinsurance	210,122	216,584	223,686
2. Benefits Paid	175,719	194,991	201,394
3. Underwriting Expenses Paid	17,044	20,440	21,348
4. Total Cash From Underwriting (L1-L2-L3)	**17,360**	**1,153**	**945**
5. Net Investment Income	197	204	212
6. Other Income			
7. Dividends to Policyholders			
8. Federal and Foreign Income Taxes (Paid) Recovered	-	-	-
9. Net Cash From Operations (L4+L5+L6-L7+L8)	**17,556**	**1,358**	**1,157**
Cash From Investments			
10. Net Cash from Investments	(11,790)	(1,835)	(532)
Cash From Financing and Misc Sources			
11. Capital and paid in Surplus	13,100		
12. Surplus Notes			
13. Borrowed Funds			
14. Dividends			
15. Other Cash Provided (Applied)			
16. Net Cash from Financing and Misc Sources (L11+L12+L13-L14+L15)	**13,100**	**-**	**-**
17. Net Change in Cash, Cash Equivalents and Short -Term Investments (L9+L10+L16)	18,866	(477)	625

Nationwide
Year 1

West Central CCO
(Health Company)
Analysis of Operations by Line of Business
(In Thousands)

	Total	Comprehensive	Medicare Supplement	Dental	Vision	Federal Employees plan	Medicare	Medicaid	Other health	Other non-health	Aggregate of All Other Lines Business
1. Net Premiums (All Business)	209,701							209,701			
2. Change in unearned premium reserve	-										
3. Fee for service	-										XXX
4. Risk revenue	-										XXX
5. Aggregate write ins for other health related revenues	-										XXX
6. Aggregate write ins for other non-health related revenues	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX
7. Total Revenue (1+2+3+4+5+6)	**209,701**	**-**	**-**	**-**	**-**	**-**	**-**	**209,701**	**-**	**-**	**-**
8. Hospital/medical benefits	133,593							133,593			
9. Other professional services	39,863							39,863			
10. Prescription Drugs	16,589							16,589			
11. Aggregatae writes for other hospital/ medical/health	-										XXX
12. Subtotal (8+9+10+11)	**190,046**	**-**	**-**	**-**	**-**	**-**	**-**	**190,046**	**-**	**-**	**-**
	-										
13. Net reinsurance recoveries								818.4422			
14. Total hospital and medical (12-13)	**189,228**	**-**	**-**	**-**	**-**	**-**	**-**	**189,228**	**-**	**-**	**-**
15. Non health claims	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
16. Claims adjustment expenses	9,065							9065.193			
17. General admin expenses	11,080							11079.68			
18. Increase in reserves for accident and health contracts	-										
19. Aggregate write in for Other Expenses	-										
20. Total underwriting deductions (14 to19)	**209,372**	**-**	**-**	**-**	**-**	**-**	**-**	**209,372**	**-**	**-**	**-**
21. Net underwriting Gain (Loss) (7-20)	**328**	**-**	**-**	**-**	**-**	**-**	**-**	**328**	**-**	**-**	**-**

Nationwide
Year 2

West Central CCO
(Health Company)
Analysis of Operations by Line of Business
(In Thousands)

	Total	Comprehensive	Medicare Supplement	Dental	Vision	Federal Employees plan	Medicare	Medicaid	Other health	Other non-health	Aggregate of All Other Lines
1. Net Premiums (All Business)	216,570							216,570			
2. Change in unearned premium reserve	-										
3. Fee for service	-										XXX
4. Risk revenue	-										XXX
5. Aggregate write ins for other health related revenues	-										XXX
6. Aggregate write ins for other non-health related revenues	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX
7. Total Revenue (1+2+3+4+5+6)	**216,570**	**-**	**-**	**-**	**-**	**-**	**-**	**216,570**	**-**	**-**	**-**
	-										
8. Hospital/medical benefits	137,985							137,985			
9. Other professional services	41,174							41,174			
10. Prescription Drugs	17,135							17,135			
11. Aggregate write ins for other hospital/ medical/health	-										XXX
12. Subtotal (8+9+10+11)	**196,294**	**-**	**-**	**-**	**-**	**-**	**-**	**196,294**	**-**	**-**	**-**
	-										
13. Net reinsurance recoveries								859.3644			
14. Total hospital and medical (12-13)	195,435	-	-	-	-	-	-	195,435	-	-	-
15. Non health claims	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
16. Claims adjustment expenses	9,363							9363.239			
17. General admin expenses	11,444							11443.96			
18. Increase in reserves for accident and health contracts	-										
19. Aggregate write in for Other Expenses	-										
20. Total underwriting deductions (14 to19)	**216,242**	**-**	**-**	**-**	**-**	**-**	**-**	**216,242**	**-**	**-**	**-**
21. Net underwriting Gain (Loss) (7-20)	**328**	**-**	**-**	**-**	**-**	**-**	**-**	**328**	**-**	**-**	**-**

Nationwide
Year 3

West Central CCO
(Health Company)
Analysis of Operations by Line of Business
(In Thousands)

	Total	Comprehensive	Medicare Supplement	Dental	Vision	Federal Employees plan	Medicare	Medicaid	Other health	Other non-health	Aggregate of All Other Lines
1. Net Premiums (All Business)	223,672							223672.2			
2. Change in unearned premium reserve	-										
3. Fee for service	-										XXX
4. Risk revenue	-										XXX
5. Aggregate write ins for other health related revenues	-										XXX
6. Aggregate write ins for other non-health related revenues	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX
7. Total Revenue (L1+L2+L3+L4+L5+L6)	**223,672**	**-**	**-**	**-**	**-**	**-**	**-**	**223,672**	**-**	**-**	**-**
	-										
8. Hospital/medical benefits	142,527							142,527			XXX
9. Other professional services	42,529							42,529			XXX
10. Prescription Drugs	17,699							17,699			XXX
11. Aggregatae writes for other hospital/ medical/health	-										XXX
12. Subtotal (L8+L9+L10+L11)	**202,755**	**-**	**-**	**-**	**-**	**-**	**-**	**202,755**	**-**	**-**	
13. Net reinsurance recoveries	902							902.3326			
14. Total hospital and medical (L12-L13)	201,853	-	-	-	-	-	-	201,853	-	-	-
15. Non health claims	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX
16. Claims adjustment expenses	9,671							9671.419			
17. General admin expenses	11,821							11820.62			
18. Increase in reserves for accident and health contracts	-										XXX
19. Aggregate write in for Other Expenses	-										
20. Total underwriting deductions (L14 : L19)	**223,345**	**-**	**-**	**-**	**-**	**-**	**-**	**223,345**	**-**	**-**	**-**
21. Net underwriting Gain (Loss) (L7-L20)	**327**	**-**	**-**	**-**	**-**	**-**	**-**	**327**	**-**	**-**	**-**

Nationwide
Year 1

West Central CCO
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	211,162,189		1,461,504	209,700,685
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	211,162,189	-	1,461,504	209,700,685

Nationwide
Year 2

West Central CCO
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	218,104,804		1,534,579	216,570,225
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	218,104,804	-	1,534,579	216,570,225

Nationwide
Year 3

West Central CCO
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	225,283,468		1,611,308	223,672,160
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	225,283,468	-	1,611,308	223,672,160

Nationwide
Year 1

West Central CCO
(Health Company)
Preliminary MLR
(In Thousands)

	Individual Comprehensive	Small group comprehensive	Large Group comprehensive	Individual mini-med	Small group mini-med	Large Group mini-med	Total
1. Premiums earned							-
2. Federal taxes/Federal asessments							-
3. State insurance, premium, and other taxes							-
4. Regulatory authority license and fees							-
5. Adjusted premium earned (L1-L2-L3-L4)	-	-	-	-	-	-	-
6. Incurred claims excluding prescription drugs							-
7. Prescription drugs							-
8. Pharmaceutical rebates							-
9. State stop loss, market stabilization and claim/census based assessments							-
10. Incurred medical incentive pools and bonuses							-
11. Total incurred claims (L6+L7-L8-L9+L10)	-	-	-	-	-	-	-
12. Deductible abuse detection/recovery expenses							-
13. Improved health outcomes							-
14. Activities to prevent hospital readmissions							-
15. Improve patient safety and reduce medical errors							-
16. Wellness and health promotion activities							-
17. QI Health information technology expenses							-
18. Total expenses incurred for improving health quality (L13+L14+L15+L16+L17)	-	-	-	-	-	-	-
19 Prelimary MLR (L11+L12+L18/L5)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Nationwide
Year 2

West Central CC(
(Health Company)
Preliminary MLR
(In Thousands)

	Individual Comprehensive	Small group comprehensive	Large Group comprehensive	Individual mini-med	Small group mini-med	Large Group mini-med	Total
1. Premiums earned							-
2. Federal taxes/Federal asessments							-
3. State insurance, premium, and other taxes							-
4. Regulatory authority license and fees							
5. Adjusted premium earned (L1-L2-L3-L4)	-	-	-	-	-	-	-
6. Incurred claims excluding prescription drugs							-
7. Prescription drugs							-
8. Pharmaceutical rebates							-
9. State stop loss, market stabilization and claim/census based assessments							-
10. Incurred medical incentive pools and bonuses							-
11. Total incurred claims (L6+L7-L8L-9+L10)	-	-	-	-	-	-	-
12. Deductible abuse detection/recovery expenses							-
13. Improved health outcomes							-
14. Activities to prevent hospital readmissions							-
15. Improve patient safety and reduce medical errors							-
16. Wellness and health promotion activities							-
17. QI Health information technology expenses							-
18. Total expenses incurred for improving health quality (L13+L14+L15+L16+L17)	-	-	-	-	-	-	-
19 Prelimary MLR (L11+L12+L18/L5)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Nationwide
Year 3

West Central CC(
(Health Company)
Preliminary MLR
(In Thousands)

	Individual Comprehensive	Small group comprehensive	Large Group comprehensive	Individual mini-med	Small group mini-med	Large Group mini-med	Total
1. Premiums earned							-
2. Federal taxes/Federal asessments							-
3. State insurance, premium, and other taxes							-
4. Regulatory authority license and fees							-
5. Adjusted premium earned (1-2-3-4)	**-**	**-**	**-**	**-**	**-**	**-**	**-**
6. Incurred claims excluding prescription drugs							-
7. Prescription drugs							-
8. Pharmaceutical rebates							-
9. State stop loss, market stabilization and claim/census based assessments							-
10. Incurred medical incentive pools and bonuses							-
11. Total incurred claims (6+7-8-9+10)	-	-	-	-	-	-	-
12. Deductible abuse detection/recovery expenses							**-**
13. Improved health outcomes							-
14. Activities to prevent hospital readmissions							-
15. Improve patient safety and reduce medical errors							-
16. Wellness and health promotion activities							-
17. QI Health information technology expenses							-
18. Total expenses incurred for improving health quality (L13+L14+L15+L16+L17)	**-**	**-**	**-**	**-**	**-**	**-**	**-**
19 Prelimary MLR (L11+L12+L18/L5)	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**

UCAA Proforma Financial Statements Assumptions

List all of the relevant assumptions used to create the proformas.
Note, assumptions enclosed within the Plan of Operation need not be disclosed again here.

The purpose of this proforma is to demonstrate the how the West Central CCO (WCCCO) could potentially be formed as well as to provide a forecast of the expected results over the next five year period. The underlying assumption is that a partnership will be formed with provider partners similar to the Eastern Oregon CCO (EOCCO).

ODS Community Health (Moda) intends to contribute capital to cover the estimated minimum net worth requirement which, based on the Company's projected Authorized Control Level, would also allow the Company to exceed 200% RBC by year 2.

Similar to the original formation of EOCCO, partners in the WCCCO will be welcome to come on as owners subsequent to initial CCO formation.

Region/Counties:
The geographic region that West Central CCO would serve in is Lane County.

Enrollment Levels:
The total membership for this area is estimated to be approximately 88,000. The current best estimate is thatWCCCO will capture 50% of this market. It is believed that the proposed strong provider partnerships will allow it to deliver high-quality care while staying within the 3.4% annual medical trend target. It is expected that the WCCCO would be able to sucessfully manage membership levels between 40% and 105% of the total estimated enrollment and be able to stay within the 3.4% annual medical trend target while effectively managing fixed and variable administrative costs and maintaining the appropriate service and network adequacy levels.

Revenue:
The Company estimated revenues using the provided PMPM revenue amount from Attachment 12 - CCO 2.0 Procurement Rate Methodology Appendix. The company assumed the average gross rate ($483.42) excluding tax for its rating area. The gross rate was chosen because the Company intends to achieve 100% of the bonus pool. While the Company acknowledges that the performance metrics are progressively more difficult to achieve, it also believes that its structure and strong provider-partnerships and success record with administering the EOCCO through its affiliates demonstrates that this is achievable.

Included in the revenue amount is the projected maternity payments based on the projected rate from Attachment 12 - CCO 2.0 Procurement Rate Methodology Appendix. The Company assumed the average gross rate ($11,371.75) excluding tax for its rating area and multiplied that with the projected births for the region based on the projected enrollment targets.

Total revenue for years 2021 and 2022 were increased by a growth rate of 3.4% to account for the overall global budget target.

Underwriting Expenses:
The Company estimated medical expenses at 90% of total revenues, based on the rate setting methodology and the projected non-medical load amounts. Total Pay-for-Performance amounts were also projected at 90% of total revenues.

Administrative Expenses:
The adminstrative expenses have been estimated using the rating methodology for the non-medical load administration and case management services. The 1% profit contingency has been factored into the underwriting results.

Other:
Reinsurance: Reinsurance premiums are based on the current market per member per month rate and increases 5% each year.
Reinsurance recoveries are based on a conservative 56% of premium.

Investment Income: Investment income is assumed at 1.5% of invested balances

Oregon
Year 1

West Central CCO
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	211,162,189		1,461,504	209,700,685
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	**211,162,189**	**-**	**1,461,504**	**209,700,685**

Oregon
Year 2

West Central CCO
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	218,104,804		1,534,579	216,570,225
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	**218,104,804**	**-**	**1,534,579**	**216,570,225**

Oregon
Year 3

West Central CCO
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	225,283,468		1,611,308	223,672,160
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	**225,283,468**	**-**	**1,611,308**	**223,672,160**

APPLICANT NAME: **West Central CCO**

INTRODUCTION: This supplemental report is to be completed in conjunction with the NAIC UCAA Form 13H.

CALENDAR YEAR:	**2020**
CALENDAR YEAR START DATE:	**1/1/2020**
CALENDAR YEAR ENDING DATE:	**12/31/2020**

INSTRUCTIONS:

1 Prior to completing the UCAA Form 13H, first complete the "Company Assumptions" tab of this template. Identify the geographic area (Desired Locations) and the corresponding Member Months to be used in developing the Pro Formas.

2 The UCAA Balance Sheet and P and L input data comes directly from Form 13H. Three separate Form 13H templates will need to be created and submitted with the applicaion for each of the three scenarios described in the Reference Document. Copy and paste the values from Form 13H to the tabs in this template for each of the three scenarios.

3 Calculate and input the Authorized Control Level (ACL) into "UCAA Balance Sheet" Line 25 for each of the three years and each of the three scenarios (9 ACLs in total) as instructed in the Reference Document.

4 Enter your information in the yellow cells only. All other cells are calculated.

West Central CCO
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Whole Numbers)

			2020	2021	2022
1.	Desired Service Area (List Counties): Lane County				
2.	Membership totals for Desired Service Area:		88,000	88,000	88,000
3.	Best Estimate Membership Percentage:		50%	50%	50%
4.	Best Estimate Member Months	(BE MM)	528,000	528,000	528,000
5.	Estimated Minimum viable Membership Percentage:		40%	40%	40%
6.	Minimum Member Months	(MIN MM)	422,400	422,400	422,400
7.	Estimated Maximum viable Membership Percentage:		105%	105%	105%
8.	Maximum Member Months	(MAX MM)	1,108,800	1,108,800	1,108,800
	Administrative Costs:				
9.	What is the total "fixed" administrative costs for CCO Operations?		5,701,379	5,888,830	6,082,654
10.	What is the variable administrative costs for CCO Operations on a Per Member Per Month basis:		34	35	36

West Central CCO
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Whole Numbers)

Scenario Summary

	2020	2021	2022
Best Estimate MM:	528,000	528,000	528,000
Net Income	2,041,200	2,118,409	2,197,718
Net Income Claims +2%	(2,689,488)	(2,767,464)	(2,848,602)
MLR Claims +2%	92%	92%	92%
RBC Claims +2%	1.281	1.486	1.712
Net Income Claims +4%	(7,420,176)	(7,653,338)	(7,894,921)
MLR Claims +4%	94%	94%	94%
RBC Claims +4%	0.731	0.927	1.136
Minimum MM:	422,400	422,400	422,400
Net Income	524,784	532,439	539,687
Net Income Claims +2%	(3,259,766)	(3,376,260)	(3,497,369)
MLR Claims +2%	92%	92%	92%
RBC Claims +2%	1.416	1.452	1.490
Net Income Claims +4%	(7,044,317)	(7,284,959)	(7,534,425)
MLR Claims +4%	94%	94%	94%
RBC Claims +4%	0.871	0.898	0.926
Maximum MM:	1,108,800	1,108,800	1,108,800
Net Income	10,547,237	11,009,483	11,487,650
Net Income Claims +2%	612,792	749,148	890,379
MLR Claims +2%	92%	92%	92%
RBC Claims +2%	1.638	2.217	2.803
Net Income Claims +4%	(9,321,653)	(9,511,187)	(9,706,893)
MLR Claims +4%	94%	94%	94%
RBC Claims +4%	1.070	1.639	2.215

West Central CCO
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Whole Numbers)

Administrative Costs Summary

	Pro Forma Ref	2020	2021	2022
Best Estimate MM:		528,000	528,000	528,000
Fixed Administrative Costs	Assumptions Line 9	5,701,379	5,888,830	6,082,654
Variable Administrative Costs	Assumptions Line 10	18,054,367	18,647,961	19,261,737
Total Administrative Costs	calculated	23,755,746	24,536,790	25,344,390
Reported Administrative Costs	P and L Lines 17, 18	23,755,746	24,536,790	25,344,390
Difference (should be 0)	calculated	-	-	-
Minimum MM:		422,400	422,400	422,400
Fixed Administrative Costs	Assumptions Line 9	5,701,379	5,888,830	6,082,654
Variable Administrative Costs	Assumptions Line 10	14,443,494	14,918,369	15,409,389
Total Administrative Costs	calculated	20,144,873	20,807,198	21,492,043
Reported Administrative Costs	P and L Lines 17, 18	20,144,873	20,807,198	21,492,043
Difference (should be 0)	calculated	-	-	-
Maximum MM:		1,108,800	1,108,800	1,108,800
Fixed Administrative Costs	Assumptions Line 9	5,701,379	5,888,830	6,082,654
Variable Administrative Costs	Assumptions Line 10	37,914,171	39,160,718	40,449,647
Total Administrative Costs	calculated	43,615,550	45,049,547	46,532,300
Reported Administrative Costs	P and L Lines 17, 18	43,615,550	45,049,547	46,532,300
Difference (should be 0)	calculated	-	-	-

West Central CCO
(Health Company)
Pro Forma Statutory Balance Sheet (Nationwide)
(In Whole Numbers)

BASED ON BE MM IDENTIFIED IN ASSUMPTIONS

COPY VALUES OVER FROM FORM 13H (BE MM)

		12/31/2020	12/31/2021	12/31/2022
	Admitted Assets			
1.	Bonds	8,014,500	10,231,780	11,608,746
2.	Stocks (Preferred & Common)	4,315,500	5,509,420	6,250,863
3.	Real Estate/Mortgage Loans on Real Estate			
4.	Cash/Cash Equivalents/Short-Term Investments	24,489,501	24,202,552	25,043,976
5.	Other Invested Assets			
6.	Aggregate Write-Ins For Invested Assets	1,672,816	1,727,815	1,784,684
7.	All Other Assets			
8.	Total Admitted Assets (Lines 1+2+3+4+5+6+7)	**38,492,317**	**41,671,567**	**44,688,269**
	Liabilities			
9.	Losses (Unpaid Claims for Accident and Health Policies)	16,118,626	16,648,576	17,196,545
10.	Unpaid Claims Adjustment Expenses	767,247	792,472	818,556
11.	Aggregate Health Policy Reserves	-	-	-
12.	Ceded Reinsurance Premiums Payable	152,240	159,852	159,852
13.	Amounts Due To Parents, Subsidiaries & Affiliates	-	-	-
14.	MLR Rebates	-	-	-
15.	Premiums Received In Advance	2,199,606	2,271,925	2,346,703
16.	All Other Liabilites	3,513,398	3,939,132	4,101,294
17.	Total Liabilities (Lines 9+10+11+12+13+14+15+16)	**22,751,117**	**23,811,958**	**24,622,949**
	Capital and Surplus			
18.	Capital Stock			
19.	Gross Paid In And Contributed Surplus	13,700,000	13,700,000	13,700,000
20.	Surplus Notes			
21.	Unassigned Funds (Surplus)	2,041,200	4,159,610	6,357,328
22.	Aggregate Write-ins for Other-Than-Special Surplus Funds			
23.	Less Treasury Stock (Common and Preferred)			
24.	Total Capital and Surplus (Lines 18+19+20+21+22-23)	15,741,200	17,859,610	20,057,328
25.	Liabilities and Surplus (Lines 17+24)	38,492,317	41,671,567	44,680,277
	Risk-Based Capital Analysis			
25.	Authorized Control Level Risk-Based Capital	8,596,105	8,727,947	8,769,478
26.	Calculated Risk-Based Capital (Line 24 / Line 25)	183.1%	204.6%	228.7%

West Central CCO
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Whole Numbers)

BASED ON BE MM IDENTIFIED IN ASSUMPTIONS

COPY VALUES OVER FROM FORM 13H (BE MM)

	2020	2021	2022
1. Member Months	528,000	528,000	528,000
2. Net Premium Income	262,125,856	270,712,781	279,590,200
3. Fee For Service			
4. Risk Revenue			
5. Change In Unearned Premium Reserves and Reserve for Rate Credits			
6. Aggregate Write-Ins For Other Health Care Related Revenue			
7. Aggregate Write-Ins For Other Non-Health Revenue			
8. Total (Lines 2+3+4+5+6+7)	**262,125,856**	**270,712,781**	**279,590,200**
Hospital and Medical:			
9. Hospital/Medical Benefits	166,991,258	172,481,616	178,158,646
10. Other Professional Services	49,829,369	51,467,665	53,161,663
11. Prescription Drugs	20,736,836	21,418,624	22,123,593
12. Aggregate Write-Ins For Other Hospital and Medical			
13. Subtotal (Lines 9+10+11+12)	**237,557,462**	**245,367,904**	**253,443,901**
Less:			
14. Net Reinsurance Recoveries	1,023,053	1,074,205	1,127,916
15. Total Hospital and Medical (Lines 13 - 14)	236,534,409	244,293,699	252,315,986
16. Non-Health Claims (net)			
17. Claims Adjustment Expenses	10,690,086	11,041,556	11,404,976
18. General Administrative Expenses	13,065,660	13,495,235	13,939,415
19. Increase In Reserves For Life & Accident And Health Contacts			
20. Total underwriting deductions (Lines 15+16+17+18+19)	**260,290,156**	**268,830,489**	**277,660,376**
21. Net underwriting gain or loss (Lines 8 - 20)	1,835,700	1,882,291	1,929,824
22. Net investment income earned	205,500	236,118	267,894
23. Net investment gains (losses) (Lines 22 + 26)	205,500	236,118	267,894
24. Aggregate write in for other income or expenses			
25. Federal and Foreign Income Taxes Incurred	-	-	-
26. Net Realized Capital Gains (Losses)			
27. Less Capital Gains Tax			
28. Net Income (Lines 21 + 23 + 24 - 25)	**2,041,200**	**2,118,409**	**2,197,718**
29. Capital and Surplus Prior Reporting Year		15,741,200	17,859,610
30. Net Income or (Loss)	2,041,200	2,118,409	2,197,718
31. Capital Changes	13,700,000		
32. Other Increases (Decreases)			
33. Dividends to Stockholders			
34. Capital and Surplus End of Reporting Year (Lines 29 + 30 + 31 + 32 - 33)	**15,741,200**	**17,859,610**	**20,057,328**
Ratio Analysis			
35 Medical Loss Ratio (as calculated for insurers) (Line 15 / Line 2)	90%	90%	90%
36 Claim Expense Ratio (Line 17 / Line 2)	4%	4%	4%
37 Administrative Expense Ratio (Line 18 / Line 2)	5%	5%	5%
38 Combined Medical Loss and Expense Ratio (Line 35 + Line 37)	95%	95%	95%
39 Ratio of Total Revenue to Capital and Surplus (Line 8 / Line 34)	1665%	1516%	1394%
44 Authorized Control Level Risk-Based Capital	8,596,105	8,727,947	8,769,478
45 Risk Based Capital Calculation	1.831	2.046	2.287

West Central CCO
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Whole Numbers)

BASED ON BE MM IDENTIFIED IN ASSUMPTIONS

	Pro Forma Ref	2020	2021	2022
Financial Statement Data				
Total Admitted Assets	Bal Sht Line 8	38,492,317	41,671,567	44,688,269
Real Estate/Mortgage Loans on Real Estate	Bal Sht Line 3	-	-	-
Stocks (Preferred & Common)	Bal Sht Line 2	-	-	-
Restricted Reserve	calculated	9,980,600	10,303,904	10,638,166
Liquid assets	calculated	38,492,317	41,671,567	44,688,269
Aggregate Health Policy Reserves	Bal Sht Line 11	16,118,626	16,648,576	17,196,545
Ceded Reinsurance Premiums Payable	Bal Sht Line 12	767,247	792,472	818,556
Total claims reserves	calculated	16,885,873	17,441,049	18,015,100
Total liabilities	Bal Sht Line 17	22,751,117	23,811,958	24,622,949
Total capital and surplus	Bal Sht Line 24	15,741,200	17,859,610	20,057,328
Capitol stock	Bal Sht Line 18	-	-	-
Surplus	calculated	15,741,200	17,859,610	20,057,328
Net Premium Income	P and L Line 2	262,125,856	270,712,781	279,590,200
Total Hospital and Medical (net)	P and L Line 15	236,534,409	244,293,699	252,315,986
Divided by months in year	given	12	12	12
Avg claims expense	calculated	19,711,201	20,357,808	21,026,332
Ratio/Financial Analysis				
Primary Restricted Reserve	calculated	250,000	250,000	250,000
Secondary Restricted Reserve	calculated	9,730,600	10,053,904	10,388,166
Total Restricted Reserve Requirement	calculated	9,980,600	10,303,904	10,638,166
Minimum Net Worth Required	calculated	13,106,293	13,535,639	13,979,510
Working capital	given	500,000	500,000	500,000
Total Initial Required Net Worth	calculated	13,606,293	14,035,639	14,479,510
Liabilities to Liquid Assets	calculated	59%	57%	55%
Capital & Surplus/Liabilities	calculated	69%	75%	81%
Avg Mo Unpd Clms to Res & Surpl	calculated	2	2	2
Avg Mo Unpd Clms to Res & Surpl (excl minimum C&S)	calculated	1	1	1
Stress Test Results				
Combined Medical Loss and Expense Ratio	P and L Line 38	95%	95%	95%
Net underwriting gain or loss	P and L Line 21	1,835,700	1,882,291	1,929,824
Test #1 Combined Ratio plus 2 pts	calculated	97%	97%	97%
Additional underwriting expense	calculated	5,242,517	5,414,256	5,591,804
Test #2 Combined Ratio plus 4 pts	calculated	99%	99%	99%
Additional underwriting expense	calculated	10,485,034	10,828,511	11,183,608
Test #3 Combined Ratio plus 6 pts	calculated	101%	101%	101%
Additional underwriting expense	calculated	15,727,551	16,242,767	16,775,412
C&S after test #1	calculated	10,498,683	12,445,354	14,465,524
C&S after test #2	calculated	5,256,166	7,031,098	8,873,720
C&S after test #3	calculated	13,649	1,616,843	3,281,916

West Central CCO
(Health Company)
Pro Forma Statutory Balance Sheet (Nationwide)
(In Whole Numbers)

BASED ON MIN MM IDENTIFIED IN ASSUMPTIONS

COPY VALUES OVER FROM FORM 13H (MIN MM)

		12/31/2020	12/31/2021	12/31/2022
	Admitted Assets			
1.	Bonds	7,663,500	8,856,110	9,202,195
2.	Stocks (Preferred & Common)	4,126,500	4,768,675	4,955,028
3.	Real Estate/Mortgage Loans on Real Estate			
4.	Cash/Cash Equivalents/Short-Term Investments	18,866,068	18,388,831	19,013,555
5.	Other Invested Assets			
6.	Aggregate Write-Ins For Invested Assets	1,338,253	1,382,252	1,427,747
7.	All Other Assets			
8.	Total Admitted Assets (Lines 1+2+3+4+5+6+7)	**31,994,321**	**33,395,868**	**34,598,525**
	Liabilities			
9.	Losses (Unpaid Claims for Accident and Health Policies)	12,894,901	13,318,861	13,757,236
10.	Unpaid Claims Adjustment Expenses	613,797	633,978	654,844
11.	Aggregate Health Policy Reserves	-	-	-
12.	Ceded Reinsurance Premiums Payable	121,792	127,882	127,882
13.	Amounts Due To Parents, Subsidiaries & Affiliates	-	-	-
14.	MLR Rebates	-	-	-
15.	Premiums Received In Advance	1,759,685	1,817,540	1,877,362
16.	All Other Liabilites	2,979,362	3,340,384	3,477,897
17.	Total Liabilities (Lines 9+10+11+12+13+14+15+16)	**18,369,537**	**19,238,644**	**19,895,221**
	Capital and Surplus			
18.	Capital Stock			
19.	Gross Paid In And Contributed Surplus	13,100,000	13,100,000	13,100,000
20.	Surplus Notes			
21.	Unassigned Funds (Surplus)	524,784	1,057,223	1,596,910
22.	Aggregate Write-ins for Other-Than-Special Surplus Funds			
23.	Less Treasury Stock (Common and Preferred)			
24.	Total Capital and Surplus (Lines 18+19+20+21+22-23)	13,624,784	14,157,223	14,696,910
25.	Liabilities and Surplus (Lines 17+24)	31,994,321	33,395,868	34,592,131
	Risk-Based Capital Analysis			
25.	Authorized Control Level Risk-Based Capital	6,951,694	7,057,508	7,154,448
26.	Calculated Risk-Based Capital (Line 24 / Line 25)	196.0%	200.6%	205.4%

West Central CCO
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Whole Numbers)

BASED ON MIN MM IDENTIFIED IN ASSUMPTIONS

COPY VALUES OVER FROM FORM 13H (MIN MM)

	2020	2021	2022
1. Member Months	422,400	422,400	422,400
2. Net Premium Income	209,700,685	216,570,225	223,672,160
3. Fee For Service			
4. Risk Revenue			
5. Change In Unearned Premium Reserves and Reserve for Rate Credits			
6. Aggregate Write-Ins For Other Health Care Related Revenue			
7. Aggregate Write-Ins For Other Non-Health Revenue			
8. Total (Lines 2+3+4+5+6+7)	**209,700,685**	**216,570,225**	**223,672,160**
Hospital and Medical:			
9. Hospital/Medical Benefits	133,593,006	137,985,293	142,526,917
10. Other Professional Services	39,863,495	41,174,132	42,529,330
11. Prescription Drugs	16,589,468	17,134,899	17,698,874
12. Aggregate Write-Ins For Other Hospital and Medical			
13. Subtotal (Lines 9+10+11+12)	**190,045,970**	**196,294,323**	**202,755,121**
Less:			
14. Net Reinsurance Recoveries	818,442	859,364	902,333
15. Total Hospital and Medical (Lines 13 - 14)	189,227,527	195,434,959	201,852,789
16. Non-Health Claims (net)			
17. Claims Adjustment Expenses	9,065,193	9,363,239	9,671,419
18. General Administrative Expenses	11,079,680	11,443,959	11,820,624
19. Increase In Reserves For Life & Accident And Health Contacts			
20. Total underwriting deductions (Lines 15+16+17+18+19)	**209,372,400**	**216,242,157**	**223,344,831**
21. Net underwriting gain or loss (Lines 8 - 20)	328,284	328,067	327,328
22. Net investment income earned	196,500	204,372	212,358
23. Net investment gains (losses) (Lines 22 + 26)	196,500	204,372	212,358
24. Aggregate write in for other income or expenses			
25. Federal and Foreign Income Taxes Incurred	-	-	-
26. Net Realized Capital Gains (Losses)			
27. Less Capital Gains Tax			
28. Net Income (Lines 21 + 23 + 24 - 25)	**524,784**	**532,439**	**539,687**
29. Capital and Surplus Prior Reporting Year	-	13,624,784	14,157,223
30. Net Income or (Loss)	524,784	532,439	539,687
31. Capital Changes	13,100,000		
32. Other Increases (Decreases)			
33. Dividends to Stockholders			
34. Capital and Surplus End of Reporting Year (Lines 29 + 30 + 31 + 32 - 33)	**13,624,784**	**14,157,223**	**14,696,910**
Ratio Analysis			
35 Medical Loss Ratio (as calculated for insurers) (Line 15 / Line 2)	90%	90%	90%
36 Claim Expense Ratio (Line 17 / Line 2)	4%	4%	4%
37 Administrative Expense Ratio (Line 18 / Line 2)	5%	5%	5%
38 Combined Medical Loss and Expense Ratio (Line 35 + Line 37)	96%	96%	96%
39 Ratio of Total Revenue to Capital and Surplus (Line 8 / Line 34)	1539%	1530%	1522%
44 Authorized Control Level Risk-Based Capital	6,951,694	7,057,508	7,154,448
45 Risk Based Capital Calculation	1.960	2.006	2.054

West Central CCO
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Whole Numbers)

BASED ON MIN MM IDENTIFIED IN ASSUMPTIONS

	Pro Forma Ref	2020	2021	2022
Financial Statement Data				
Total Admitted Assets	Bal Sht Line 8	31,994,321	33,395,868	34,598,525
Real Estate/Mortgage Loans on Real Estate	Bal Sht Line 3	-	-	-
Stocks (Preferred & Common)	Bal Sht Line 2	-	-	-
Restricted Reserve	calculated	8,009,480	8,268,123	8,535,533
Liquid assets	calculated	31,994,321	33,395,868	34,598,525
Aggregate Health Policy Reserves	Bal Sht Line 11	12,894,901	13,318,861	13,757,236
Ceded Reinsurance Premiums Payable	Bal Sht Line 12	613,797	633,978	654,844
Total claims reserves	calculated	13,508,698	13,952,839	14,412,080
Total liabilities	Bal Sht Line 17	18,369,537	19,238,644	19,895,221
Total capital and surplus	Bal Sht Line 24	13,624,784	14,157,223	14,696,910
Capitol stock	Bal Sht Line 18	-	-	-
Surplus	calculated	13,624,784	14,157,223	14,696,910
Net Premium Income	P and L Line 2	209,700,685	216,570,225	223,672,160
Total Hospital and Medical (net)	P and L Line 15	189,227,527	195,434,959	201,852,789
Divided by months in year	given	12	12	12
Avg claims expense	calculated	15,768,961	16,286,247	16,821,066
Ratio/Financial Analysis				
Primary Restricted Reserve	calculated	250,000	250,000	250,000
Secondary Restricted Reserve	calculated	7,759,480	8,018,123	8,285,533
Total Restricted Reserve Requirement	calculated	8,009,480	8,268,123	8,535,533
Minimum Net Worth Required	calculated	10,485,034	10,828,511	11,183,608
Working capital	given	500,000	500,000	500,000
Total Initial Required Net Worth	calculated	10,985,034	11,328,511	11,683,608
Liabilities to Liquid Assets	calculated	57%	58%	58%
Capital & Surplus/Liabilities	calculated	74%	74%	74%
Avg Mo Unpd Clms to Res & Surpl	calculated	2	2	2
Avg Mo Unpd Clms to Res & Surpl (excl minimum C&S)	calculated	1	1	1
Stress Test Results				
Combined Medical Loss and Expense Ratio	P and L Line 38	96%	96%	96%
Net underwriting gain or loss	P and L Line 21	328,284	328,067	327,328
Test #1 Combined Ratio plus 2 pts	calculated	98%	98%	98%
Additional underwriting expense	calculated	4,194,014	4,331,404	4,473,443
Test #2 Combined Ratio plus 4 pts	calculated	100%	100%	100%
Additional underwriting expense	calculated	8,388,027	8,662,809	8,946,886
Test #3 Combined Ratio plus 6 pts	calculated	102%	102%	102%
Additional underwriting expense	calculated	12,582,041	12,994,213	13,420,330
C&S after test #1	calculated	9,430,771	9,825,819	10,223,467
C&S after test #2	calculated	5,236,757	5,494,414	5,750,024
C&S after test #3	calculated	1,042,743	1,163,010	1,276,580

West Central CCO
(Health Company)
Pro Forma Statutory Balance Sheet (Nationwide)
(In Whole Numbers)

BASED ON MAX MM IDENTIFIED IN ASSUMPTIONS

COPY VALUES OVER FROM FORM 13H (MAX MM)

		12/31/2020	12/31/2021	12/31/2022
	Admitted Assets			
1.	Bonds	16,409,250	25,088,204	32,244,368
2.	Stocks (Preferred & Common)	8,835,750	13,509,033	17,362,352
3.	Real Estate/Mortgage Loans on Real Estate	-	-	-
4.	Cash/Cash Equivalents/Short-Term Investments	-	-	-
5.	Other Invested Assets	-	-	-
6.	Aggregate Write-Ins For Invested Assets	56,689,133	56,346,252	58,382,049
7.	All Other Assets	3,512,913	3,628,411	3,747,836
8.	Total Admitted Assets (Lines 1+2+3+4+5+6+7)	**85,447,046**	**98,571,901**	**111,736,606**
	Liabilities			
9.	Losses (Unpaid Claims for Accident and Health Policies)	33,849,115	34,962,010	36,112,744
10.	Unpaid Claims Adjustment Expenses	1,611,218	1,664,192	1,718,967
11.	Aggregate Health Policy Reserves	-	-	-
12.	Ceded Reinsurance Premiums Payable	319,704	335,689	335,689
13.	Amounts Due To Parents, Subsidiaries & Affiliates	-	-	-
14.	MLR Rebates	-	-	-
15.	Premiums Received In Advance	4,619,173	4,771,043	4,928,076
16.	All Other Liabilites	6,450,599	7,232,246	7,529,976
17.	Total Liabilities (Lines 9+10+11+12+13+14+15+16)	**46,849,809**	**48,965,180**	**50,625,451**
	Capital and Surplus			
18.	Capital Stock			
19.	Gross Paid In And Contributed Surplus	28,050,000	28,050,000	28,050,000
20.	Surplus Notes	-	-	-
21.	Unassigned Funds (Surplus)	10,547,237	21,556,721	33,044,371
22.	Aggregate Write-ins for Other-Than-Special Surplus Funds	-	-	-
23.	Less Treasury Stock (Common and Preferred)			
24.	Total Capital and Surplus (Lines 18+19+20+21+22-23)	38,597,237	49,606,721	61,094,371
25.	Liabilities and Surplus (Lines 17+24)	85,447,046	98,571,901	111,719,822
	Risk-Based Capital Analysis			
25.	Authorized Control Level Risk-Based Capital	17,500,586	17,745,695	18,016,024
26.	Calculated Risk-Based Capital (Line 24 / Line 25)	220.5%	279.5%	339.1%

West Central CCO
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Whole Numbers)

BASED ON MAX MM IDENTIFIED IN ASSUMPTIONS

COPY VALUES OVER FROM FORM 13H (MAX MM)

	2020	2021	2022
1. Member Months	1,108,800	1,108,800	1,108,800
2. Net Premium Income	550,464,297	568,496,840	587,139,420
3. Fee For Service	-	-	-
4. Risk Revenue	-	-	-
5. Change In Unearned Premium Reserves and Reserve for Rate Credits	-	-	-
6. Aggregate Write-Ins For Other Health Care Related Revenue	-	-	-
7. Aggregate Write-Ins For Other Non-Health Revenue	-	-	-
8. Total (Lines 2+3+4+5+6+7)	**550,464,297**	**568,496,840**	**587,139,420**
Hospital and Medical:			
9. Hospital/Medical Benefits	350,681,641	362,211,393	374,133,157
10. Other Professional Services	104,641,675	108,082,096	111,639,492
11. Prescription Drugs	43,547,355	44,979,110	46,459,545
12. Aggregate Write-Ins For Other Hospital and Medical	-		
13. Subtotal (Lines 9+10+11+12)	**498,870,670**	**515,272,599**	**532,232,193**
Less:			
14. Net Reinsurance Recoveries	2,148,411	2,255,831	2,368,623
15. Total Hospital and Medical (Lines 13 - 14)	496,722,260	513,016,768	529,863,570
16. Non-Health Claims (net)			
17. Claims Adjustment Expenses	19,626,998	20,272,296	20,939,535
18. General Administrative Expenses	23,988,553	24,777,251	25,592,765
19. Increase In Reserves For Life & Accident And Health Contacts			
20. Total underwriting deductions (Lines 15+16+17+18+19)	**540,337,810**	**558,066,315**	**576,395,870**
21. Net underwriting gain or loss (Lines 8 - 20)	10,126,487	10,430,525	10,743,549
22. Net investment income earned	420,750	578,959	744,101
23. Net investment gains (losses) (Lines 22 + 26)	420,750	578,959	744,101
24. Aggregate write in for other income or expenses			
25. Federal and Foreign Income Taxes Incurred	-	-	-
26. Net Realized Capital Gains (Losses)			
27. Less Capital Gains Tax			
28. Net Income (Lines 21 + 23 + 24 - 25)	**10,547,237**	**11,009,483**	**11,487,650**
29. Capital and Surplus Prior Reporting Year	-	38,597,237	49,606,721
30. Net Income or (Loss)	10,547,237	11,009,483	11,487,650
31. Capital Changes	28,050,000		
32. Other Increases (Decreases)			
33. Dividends to Stockholders			
34. Capital and Surplus End of Reporting Year (Lines 29 + 30 + 31 + 32 - 33)	**38,597,237**	**49,606,721**	**61,094,371**
Ratio Analysis			
35 Medical Loss Ratio (as calculated for insurers) (Line 15 / Line 2)	90%	90%	90%
36 Claim Expense Ratio (Line 17 / Line 2)	4%	4%	4%
37 Administrative Expense Ratio (Line 18 / Line 2)	4%	4%	4%
38 Combined Medical Loss and Expense Ratio (Line 35 + Line 37)	95%	95%	95%
39 Ratio of Total Revenue to Capital and Surplus (Line 8 / Line 34)	1426%	1146%	961%
44 Authorized Control Level Risk-Based Capital	17,500,586	17,745,695	18,016,024
45 Risk Based Capital Calculation	2.205	2.795	3.391

West Central CCO
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Whole Numbers)

BASED ON MAX MM IDENTIFIED IN ASSUMPTIONS

	Pro Forma Ref	2020	2021	2022
Financial Statement Data				
Total Admitted Assets	Bal Sht Line 8	85,447,046	98,571,901	111,736,606
Real Estate/Mortgage Loans on Real Estate	Bal Sht Line 3	-	-	-
Stocks (Preferred & Common)	Bal Sht Line 2	-	-	-
Restricted Reserve	calculated	20,821,761	21,500,699	22,202,649
Liquid assets	calculated	85,447,046	98,571,901	111,736,606
Aggregate Health Policy Reserves	Bal Sht Line 11	33,849,115	34,962,010	36,112,744
Ceded Reinsurance Premiums Payable	Bal Sht Line 12	1,611,218	1,664,192	1,718,967
Total claims reserves	calculated	35,460,333	36,626,202	37,831,711
Total liabilities	Bal Sht Line 17	46,849,809	48,965,180	50,625,451
Total capital and surplus	Bal Sht Line 24	38,597,237	49,606,721	61,094,371
Capitol stock	Bal Sht Line 18	-	-	-
Surplus	calculated	38,597,237	49,606,721	61,094,371
Net Premium Income	P and L Line 2	550,464,297	568,496,840	587,139,420
Total Hospital and Medical (net)	P and L Line 15	496,722,260	513,016,768	529,863,570
Divided by months in year	given	12	12	12
Avg claims expense	calculated	41,393,522	42,751,397	44,155,298
Ratio/Financial Analysis				
Primary Restricted Reserve	calculated	250,000	250,000	250,000
Secondary Restricted Reserve	calculated	20,571,761	21,250,699	21,952,649
Total Restricted Reserve Requirement	calculated	20,821,761	21,500,699	22,202,649
Minimum Net Worth Required	calculated	27,523,215	28,424,842	29,356,971
Working capital	given	500,000	500,000	500,000
Total Initial Required Net Worth	calculated	28,023,215	28,924,842	29,856,971
Liabilities to Liquid Assets	calculated	55%	50%	45%
Capital & Surplus/Liabilities	calculated	82%	101%	121%
Avg Mo Unpd Clms to Res & Surpl	calculated	2	2	2
Avg Mo Unpd Clms to Res & Surpl (excl minimum C&S)	calculated	1	1	2
Stress Test Results				
Combined Medical Loss and Expense Ratio	P and L Line 38	95%	95%	95%
Net underwriting gain or loss	P and L Line 21	10,126,487	10,430,525	10,743,549
Test #1 Combined Ratio plus 2 pts	calculated	97%	97%	97%
Additional underwriting expense	calculated	11,009,286	11,369,937	11,742,788
Test #2 Combined Ratio plus 4 pts	calculated	99%	99%	99%
Additional underwriting expense	calculated	22,018,572	22,739,874	23,485,577
Test #3 Combined Ratio plus 6 pts	calculated	101%	101%	101%
Additional underwriting expense	calculated	33,027,858	34,109,810	35,228,365
C&S after test #1	calculated	27,587,951	38,236,784	49,351,582
C&S after test #2	calculated	16,578,665	26,866,847	37,608,794
C&S after test #3	calculated	5,569,380	15,496,910	25,866,005

Please provide any text, tables, numbers, etc. that you would like to communicate but were not able to include within the

The purpose of this proforma is to demonstrate the how the Lane County CCO (LCCCO) could potentially be formed as v
underlying assumption is that a partnership will be formed with provider partners similar to the Eastern Oregon CCO (EO

ODS Community Health (Moda) intends to contribute capital to cover the estimated minimum net worth requirement whic
Company to exceed 200% RBC by year 2.

Similar to the original formation of EOCCO, partners in the LCCCO will be welcome to come on as owners subsequent to

Region/Counties:
The geographic region that Lane County CCO would serve in is Lane County.

Enrollment Levels:
The total membership for this area is estimated to be approximately 88,000. The current best estimate is that LCCCO w
will allow it to deliver high-quality care while staying within the 3.4% annual medical trend target. It is expected that the L
of the total estimated enrollment and be able to stay within the 3.4% annual medical trend target while effectively managi
network adequacy levels.

Revenue:
The Company estimated revenues using the provided PMPM revenue amount from Attachment 12 - CCO 2.0 Procureme
excluding tax for its rating area. The gross rate was chosen because the Company intends to achieve 100% of the bonus
more difficult to achieve, it also believes that its structure and strong provider-partnerships and success record with admi

Included in the revenue amount is the projected maternity payments based on the projected rate from Attachment 12 - C
gross rate ($11,371.75) excluding tax for its rating area and multiplied that with the projected births for the region based o

Total revenue for years 2021 and 2022 were increased by a growth rate of 3.4% to account for the overall global budget t

Underwriting Expenses:
The Company estimated medical expenses at 90% of total revenues, based on the rate setting methodology and the proj
at 90% of total revenues.

Administrative Expenses:
The adminstrative expenses have been estimated using the rating methodology for the non-medical load administration a
underwriting results.

Other:
Reinsurance: Reinsurance premiums are based on the current market per member per month rate and increases 5% ea
Reinsurance recoveries are based on a conservative 56% of premium.

Investment Income: Investment income is assumed at 1.5% of invested balances

Investment Income - Investment income is assumed at 1.5% of invested capital.

preceding reports.

well as to provide a forecast of the expected results over the next five year period. The
CCO).

:h, based on the Company's projected Authorized Control Level, would also allow the

› initial CCO formation.

ill capture 50% of this market. It is believed that the proposed strong provider partnerships
.CCCO would be able to sucessfully manage membership levels between 40% and 105%
ng fixed and variable administrative costs and maintaining the appropriate service and

ent Rate Methodology Appendix. The company assumed the average gross rate ($483.42)
s pool. While the Company acknowledges that the performance metrics are progressively
nistering the EOCCO through its affiliates demonstrates that this is achievable.

CO 2.0 Procurement Rate Methodology Appendix. The Company assumed the average
›n the projected enrollment targets.

target.

jected non-medical load amounts. Total Pay-for-Performance amounts were also projected

and case management services. The 1% profit contingency has been factored into the

ach year.

West Central Coordinated Care Organization (WCCCO) NAIC Biographical Affidavits

moda HEALTH

Attachment 13 — Attestations

Applicant Name: West Central Coordinated Care Organization

Authorizing Signature: _____

Printed Name: Robin Richardson

Instructions: For each attestation, Applicant will check "yes," or "no." A "yes" answer is normal, and an explanation will be furnished if Applicant's response is "no". Applicant must respond to all attestations. If an attestation has more than one question and Applicant's answer is "no" to any question, check "no" and provide an explanation.

These attestations must be signed by a representative of Applicant.

Unless a particular item is expressly effective at the time of Application, each attestation is effective starting at the time of Readiness Review and continuing throughout the term of the Contract. Each section of attestations refers to a questionnaire in an Attachment, which may furnish background and related questions.

A. General Questions Attestations (Attachment 6)

1. Contract

a. Is Applicant willing to enter into a Contract for 2020 in the form of Appendix B?

☒ Yes ☐ No

If "no" please provide explanation: _____

b. Is Applicant willing to satisfy Readiness Review standards by September 30, 2019?

☒ Yes ☐ No

If "no" please provide explanation: _____

2. Subcontracts

a. Is Applicant willing to hold written agreements with Subcontractors that clearly describe the scope of work?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to provide to OHA an inventory of all work described in this Contract that is delegated or subcontracted and identify the entity performing the work?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to provide to OHA unredacted copies of written agreements with Subcontractors?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

3. Third Party Liability and Personal Injury Lien

a. Is Applicant willing to identify and require its Subcontractors and Providers to identify and promptly report the presence of a Member's Third Party Liability?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to document all efforts to pursue financial recoveries from third party insurers?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to report and require its Subcontractors to report all financial recoveries from third party insurers?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to provide and require its Affiliated entities and Subcontractors to provide to OHA all information related to TPL eligibility to assist in the pursuit of financial recovery?

☒Yes ☐No

If "no" please provide explanation: _____

_____

4. Oversight and Governance

a. Is Applicant willing to provide its organizational structure, identifying any relationships with subsidiaries and entities with an ownership or Control stake?

☒Yes ☐No

If "no" please provide explanation: _____

_____

B. Provider Participation and Operations Attestations (Attachment 7)

1. General Questions

a. Will Applicant have an individual accountable for each of the operational functions described below?

- Contract administration
- Outcomes and evaluation
- Performance measurement
- Health management and Care Coordination activities
- System coordination and shared accountability between DHS Medicaid-funded LTC system and CCO
- Behavioral Health (mental health and addictions) coordination and system management
- Communications management to Providers and Members
- Provider relations and network management, including credentialing
- Health information technology and medical records
- Privacy officer
- Compliance officer
- Quality Performance Improvement
- Leadership contact for single point of accountability for the development and implementation of the Health Equity Plan
- Traditional Health Workers Liaison

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Will Applicant participate in the Learning Collaboratives required by ORS 442.210?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Will Applicant collect, maintain and analyze race, ethnicity, and preferred spoken and written languages data for all Members on an ongoing basis in accordance with standards jointly established by OHA and DHS in order to identify and track the elimination of health inequities?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Will Applicant (i) authorize the provision of a drug requested by the Primary Care Physician (PCP) or Referral Provider, if the approved prescriber certifies medical necessity for the drug such as: the formulary's equivalent has been ineffective in the treatment or the formulary's drug causes or is reasonably expected to cause adverse or harmful reactions to the Member and (ii) reimburse Providers for dispensing a 72-hour supply of a drug that requires Prior Authorization?

☒Yes ☐No

If "no" please provide explanation: _____

_____

e. Will Applicant comply with all applicable Provider requirements of Medicaid law under 42 CFR Part 438, including Provider certification requirements, anti-discrimination requirements, Provider participation and consultation requirements, the prohibition on interference with Provider advice, limits on Provider indemnification, rules governing payments to Providers, and limits on physician incentive plans?

☒Yes ☐No

If "no" please provide explanation: _____

_____

f. Will Applicant ensure that all Provider, facility, and supplier contracts or agreements contain the required contract provisions that are described in the Contract?

☒Yes ☐No

If "no" please provide explanation: _____

_____

g. Will Applicant have executed Provider, facility, and supplier contracts in place to demonstrate adequate access and availability of Covered Services throughout the requested Service Area?

☒Yes ☐No

If "no" please provide explanation: _____

_____

h. Will Applicant have all Provider contracts or agreements available to OHA in unredacted form?

☒Yes ☐No

If "no" please provide explanation: _____

_____

i. Will Applicant's contracts for administrative and management services contain the OHA required Contract provisions?

☒Yes ☐No

If "no" please provide explanation: _____

_____

j. Will Applicant establish, maintain, and monitor the performance of a comprehensive network of Providers to ensure sufficient access to Medicaid Covered Services, including comprehensive behavioral and oral health services, as well as supplemental services offered by the CCO in accordance with written policies, procedures, and standards for participation established by the CCO? Participation status will be revalidated at appropriate intervals as required by OHA regulations and guidelines.

☒Yes ☐No

If "no" please provide explanation: _____

_____

k. Will Applicant have executed written agreements with Providers (first tier, downstream, or related entity instruments) structured in compliance with OHA regulations and guidelines?

☒Yes No

If "no" please ☐provide explanation: _____

_____

l. Will Applicant have executed written agreements with Local Mental Health Authorities throughout its Service Area, structured in compliance with OHA regulations and guidelines?

☒Yes ☐No

If "no" please provide explanation: _____

_____

m. Will Applicant develop a comprehensive Behavioral Health plan in collaboration with the Local Mental Health Authority and other Community partners?

☒Yes ☐No

If "no" please provide explanation: _____

_____

n. Will Applicant coordinate and collaborate on the development of the Community health improvement plan (CHP) under ORS 414.627 with the Local Mental Health Authority's comprehensive local plan for the delivery of mental health services (ORS 430.630)?

☒Yes ☐No

If "no" please provide explanation: _____

_____

o. Will Applicant, through its contracted Participating Provider Network, along with other specialists outside the network, Community resources or social services within the CCO's Service Area, provide ongoing primary care, Behavioral Health care, oral health care, and specialty care as needed and will guarantee the continuity of care and the integration of services as described below?

- Prompt, convenient, and appropriate access to Covered Services by Members 24 hours a day, 7 days a week;
- The coordination of the individual care needs of Members in accordance with policies and procedures as established by the Applicant;
- Member involvement in decisions regarding treatment, proper education on treatment options, and the coordination of follow-up care;
- Effectively addressing and overcoming barriers to Member compliance with prescribed treatments and regimens; and
- Addressing diverse patient populations in a linguistically diverse and culturally competent manner.

☒Yes ☐No

If "no" please provide explanation: _____

_____

p. Will Applicant establish policies, procedures, and standards that:

- Ensure and facilitate the availability, convenient, and timely access to all Medicaid Covered Services as well as any supplemental services offered by the CCO;
- Ensure access to medically necessary care and the development of medically necessary individualized care plans for Members;
- Promptly and efficiently coordinate and facilitate access to clinical information by all Providers involved in delivering the individualized care plan of the Member while following Timely Access to Services standards;
- Communicate and enforce compliance by Providers with medical necessity determinations; and
- Do not discriminate against Medicaid Members, including providing services to individuals with disabilities in the most integrated Community setting appropriate to the needs of those individuals.

☒Yes ☐No

If "no" please provide explanation: _____

_____

q. Will Applicant have verified that contracted Providers included in the CCO Facility Table are Medicaid certified and the Applicant certifies that it will only contract with Medicaid certified Providers in the future?

☒Yes ☐No

If "no" please provide explanation: _____

_____

r. Will Applicant provide all services covered by Medicaid and comply with OHA coverage determinations?

☒Yes ☐No

If "no" please provide explanation: _____

_____

s. Will Applicant have an Medicare plan to serve Fully Dual Eligibles either through contractual arrangement or owned by Applicant or Applicant parent company to create integrated Medicare-Medicaid opportunities during the contract period? [Plan can be a Dual Special Needs Plan or MA plan that offers low premiums and integrated Part D medications options].

☒Yes ☐No

If "no" please provide explanation:

t. Will Applicant, Applicant staff and its Affiliated companies, subsidiaries or Subcontractors (first tier, downstream, and related entities), and Subcontractor staff be bound by 2 CFR 376 and attest that they are not excluded by the Department of Health and Human Services Office of the Inspector General or by the General Services Administration? Please note that this attestation includes any member of the board of directors, key management or executive staff or major stockholder of the Applicant and its Affiliated companies, subsidiaries or Subcontractors (first tier, downstream, and related entities).

☒Yes ☐No

If "no" please provide explanation: _____

_____

u. Is it true that neither the state nor federal government has brought any past or pending investigations, legal actions, administrative actions, or matters subject to arbitration involving the Applicant (and Applicant's parent corporation, subsidiaries, or entities with an ownership stake, if applicable) or its Subcontractors, including key management or executive staff, or major shareholders over the past three years on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services?

☒Yes ☐No

If "no" please provide explanation: _____

_____

2. Network Adequacy

a. Is Applicant willing to monitor and evaluate the adequacy of its Provider Network?

☒ Yes ☐No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to remedy any deficiencies in its Provider Network within a specified timeframe when deficiencies are identified?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to report on its Provider Network in a format and frequency specified by OHA?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to collect data to validate that its Members are able to access care within time and distance requirements?

☒Yes ☐No

If "no" please provide explanation: _____

_____

e. Is Applicant willing to collect data to validate that its Members are able to make appointments within the required timeframes?

☒Yes ☐No

If "no" please provide explanation: _____

_____

f. Is Applicant willing to collect data to validate that its Members are able to access care within the required timeframes?

☒Yes ☐No

g. Is Applicant willing to arrange for Covered Services to be provided by Non-Participating Providers if the services are not timely available within Applicant's Provider Network?

☒Yes ☐No

3. Fraud, Waste and Abuse Compliance

a. Is Applicant willing to designate a Compliance Officer to oversee activities related to the prevention and detection of Fraud, Waste and Abuse?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to send two representatives, including the Applicant's designated Compliance Officer and another member of the senior executive team to attend a mandatory Compliance Conference on May 30, 2019?

☒Yes ☐No

If "no" please provide explanation: _____

_____

C. Value-Based Payment (VBP) Attestations (Attachment 8)

1. Have you reviewed the VBP Policy Requirements set forth in the VBP Questionnaire?

☒ Yes ☐No

If "no" please provide explanation: _____

_____

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

☒ Yes ☐No

If "no" please provide explanation: _____

_____

3. Can you implement and report on VBP as defined by VBP Questionnaire and the Health Care Payment Learning and Action Network's (LAN's) "Alternative Payment Model Framework White Paper Refreshed 2017" (https://hcp-lan.org/apm-refresh-white-paper/) and the OHA Value-Based Payment Roadmap Categorization Guidance for Coordinated Care Organizations?

☒Yes ☐No

If "no" please provide explanation: _____

_____

4. Will you begin CCO 2.0 – January 2020 – with at least 20% of your projected annual payments to your Providers under contracts that include a Value-Based Payment component as defined by the Health Care Payment Learning and Action Network's (LAN's) "Alternative Payment Model Framework White Paper Refreshed 2017" (https://hcp-lan.org/apm-refresh-white-paper/), Pay for Performance category 2C or higher and the OHA Value-Based Payment Roadmap Categorization Guidance for Coordinated Care Organizations?

☒Yes ☐No

If "no" please provide explanation: _____

_____

5. Do you permit OHA to publish your VBP data such as the actual VBP percent of spending that is LAN category 2C or higher and spending that is LAN category 3B or higher, as well as data pertaining to your care delivery areas, Patient-Centered Primary Care Home (PCPCH) payments, and other information about VBPs required by this RFA? (OHA does not intend to publish specific payments amounts from an Applicant to a specific rovider.)

☒Yes ☐No

If "no" please provide explanation: _____

_____

6. Do you agree to develop mitigation plans for adverse effects VBPs may have on health inequities, health disparities, or any adverse health-related outcomes for any specific population (including racial, ethnic and culturally-based communities; LGBTQ people; persons with disabilities; people with limited English proficiency; and immigrants or refugees and Members with complex health care needs, as well as populations at the intersections of these groups) and to report on these plans to OHA annually?

☒Yes ☐No

If "no" please provide explanation: _____

_____

7. Do you agree to the requirements for VBP targets, care delivery areas and PCPCH clinics for years 2020 through 2024, as set forth in the VBP Questionnaire?

☒Yes ☐No

If "no" please provide explanation: _____

_____

8. Do you agree to the requirements for VBP data reporting for years 2020 through 2024, as set forth in the VBP Questionnaire?

☒Yes ☐No

If "no" please provide explanation: _____

_____

9. Should OHA contract with one or more other CCOs serving Members in the same geographical area, will you participate in OHA-facilitated discussions to select performance measures to be incorporated into each CCO's VBP Provider contracts for common Provider types and specialties?

☒Yes ☐No

If "no" please provide explanation: _____

_____

10. If, after the discussion described in the previous question, OHA informs you of the Provider types and specialties for which the performance measures apply, will you incorporate all selected measures into applicable Provider contracts?

☒Yes ☐No

If "no" please provide explanation: _____

_____

D. Health Information Technology (HIT) Attestations (Attachment 9)

1. HIT Roadmap

a. Does Applicant agree to participate in an interview/demonstration and deliver an HIT Roadmap with any refinements/adjustments agreed to with OHA during Readiness Review, for OHA approval?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Does Applicant agree to provide an annual HIT Roadmap update for OHA approval to include status/progress on CCO-identified milestones, and any adjustments to the HIT Roadmap; as well as participate in an annual interview with OHA?

☒Yes ☐No

If "no" please provide explanation: _____

_____

2. HIT Partnership

a. Does Applicant agree to participate in the HIT Commons beginning 2020, including agreeing to do all of the following:

- Maintaining an active, signed HIT Commons MOU and adhering to its terms,
- Paying annual HIT Commons assessments, and
- Serving, if elected, on the HIT Commons Governance Board or one of its committees?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Does Applicant agree to participate in OHA's HIT Advisory Group, (HITAG), at least once annually?

☒Yes ☐No

If "no" please provide explanation: _____

_____

3. Support for EHR Adoption

a. Will Applicant support EHR adoption for its contracted physical health Providers?

☒ Yes ☐No

If "no" please provide explanation: _____

_____

b. Will Applicant support EHR adoption for its contracted Behavioral Health Providers?

☒ Yes ☐No

If "no" please provide explanation: _____

_____

c. Will Applicant support EHR adoption for its contracted oral health Providers?

☒ Yes ☐No

If "no" please provide explanation: _____

_____

d. During Year 1, will Applicant report on the baseline of EHR adoption among its contracted physical health Providers, set Improvement Targets, and provide supporting detail about its implementation approach?

☒Yes ☐No

If "no" please provide explanation: _____

_____

e. During Year 1, will Applicant report on the baseline of EHR adoption among its contracted Behavioral Health Providers, set Improvement Targets, and provide supporting detail about its implementation approach?

☒Yes ☐No

If "no" please provide explanation: _____

_____

f. During Year 1, will Applicant report on the baseline of EHR adoption among its contracted oral health Providers, set Improvement Targets, and provide supporting detail about its implementation approach?

☒Yes ☐No

If "no" please provide explanation: _____

_____

g. Will Applicant report to the state annually on which EHR(s) each of its contracted physical health Providers is using, by means of definitions and data sources agreed upon during Readiness Review? Will reports include product and vendor name, version, and, if applicable, certification year the ONC Certification (CHPL) number for Certified EHR Technology? See https://chpl.healthit.gov/ and https://www.healthit.gov/topic/certification-ehrs/2015-edition for more information about Certified EHR Technology.

☒Yes ☐No

If "no" please provide explanation: _____

_____

h. Will Applicant report to the state annually on which EHR(s) each of its contracted Behavioral Health Providers are using, by means of definitions and data sources agreed upon during Readiness Review? Will reports include product and vendor name, version, and, if applicable, certification year the ONC Certification (CHPL) number for Certified EHR Technology? See https://chpl.healthit.gov/ and https://www.healthit.gov/topic/certification-ehrs/2015-edition for more information about Certified EHR Technology.

☒Yes ☐No

If "no" please provide explanation: _____

_____

i. Will Applicant report to the state annually on which EHR(s) each of its contracted oral health Providers is using, by means of definitions and data sources agreed upon during Readiness Review? Will reports include product and vendor name, version, and, if applicable, certification year the ONC Certification (CHPL) number for Certified EHR Technology? See https://chpl.healthit.gov/ and https://www.healthit.gov/topic/certification-ehrs/2015-edition for more information about Certified EHR Technology.

☒Yes ☐No

If "no" please provide explanation: _____

_____

4. Support for HIE

a. Will Applicant ensure access to timely Hospital event notifications for its contracted physical health Providers? If there are costs associated with ensuring access to timely Hospital event notifications for contracted Providers, will the Applicant be responsible for those costs?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Will Applicant ensure access to timely Hospital event notifications for its contracted Behavioral Health Providers? If there are costs associated with ensuring access to timely Hospital event notifications for contracted Providers, will the Applicant will be responsible for those costs?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Will Applicant ensure access to timely Hospital event notifications for its contracted oral health Providers? If there are costs associated with ensuring access to timely Hospital event notifications for contracted Providers, will the Applicant will be responsible for those costs.

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Will Applicant use Hospital event notifications within the CCO, for example to support Care Coordination and/or population health efforts?

☒Yes ☐No

If "no" please provide explanation: _____

_____

e. Will Applicant support access to health information exchange that enables sharing patient information for Care Coordination for its contracted physical health Providers?

☒Yes ☐No

If "no" please provide explanation: _____

_____

f. Will Applicant support access to health information exchange that enables sharing patient information for Care Coordination for its contracted Behavioral Health Providers?

☒Yes ☐No

If "no" please provide explanation: _____

_____

g. Will Applicant support access to health information exchange that enables sharing patient information for Care Coordination for its contracted oral health Providers?

☒Yes ☐No

If "no" please provide explanation: _____

_____

h. During Year 1, will Applicant report on the baseline of HIE access and use among its contracted physical health Providers (inclusive of Hospital event notifications and HIE for Care Coordination), set Improvement Targets, and provide supporting detail about its implementation approach?

☒Yes ☐No

If "no" please provide explanation: _____

_____

i. During Year 1, will Applicant report on the baseline of HIE access and use among its contracted Behavioral Health Providers (inclusive of Hospital event notifications and HIE for Care Coordination), set Improvement Targets, and provide supporting detail about its implementation approach?

☒Yes ☐No

If "no" please provide explanation: _____

_____

j. During Year 1, will Applicant report on the baseline of HIE access and use among its contracted oral health Providers (inclusive of Hospital event notifications and HIE for Care Coordination), set Improvement Targets, and provide supporting detail about its implementation approach?

☒Yes ☐No

If "no" please provide explanation: _____

_____

k. Will Applicant report to the state annually on which HIE tool(s) each of its contracted physical health Providers is using, using definitions and data sources agreed upon during Readiness Review?

☒Yes ☐No

If "no" please provide explanation: _____

_____

l. Will Applicant report to the state annually on which HIE tool(s) each of its contracted Behavioral Health Providers is using, using definitions and data sources agreed upon during Readiness Review?

☒Yes ☐No

If "no" please provide explanation: _____

_____

m. Will Applicant report to the state annually on which HIE tool(s) each of its contracted oral health Providers is using, using definitions and data sources agreed upon during Readiness Review?

☒Yes ☐No

If "no" please provide explanation: _____

_____

5. Health IT for VBP and Population Management.

a. For the initial VBP arrangements, will Applicant have by the start of Year 1 the HIT needed to administer the arrangements (as described in its supporting detail)?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. For the planned VBP arrangements for Years 2 through 5, does Applicant have a roadmap to obtain the HIT needed to administer the arrangements (as described in its supporting detail)?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. By the start of Year 1, will the Applicant provide contracted Providers with VBP arrangements with timely (e.g., at least quarterly) information on measures used in the VBP arrangement(s) applicable to the Providers?

☒Yes ☐No

If "no" please provide explanation: _____

d. By the start of Year 1, will the Applicant provide contracted Providers with VBP arrangements with accurate and consistent information on patient attribution?

☒Yes ☐No

If "no" please provide explanation: _____

e. By the start of Year 1, will the Applicant identify for contracted Providers with VBP arrangements specific patients who need intervention through the year, so they can take action before the year end?

☒Yes ☐No

If "no" please provide explanation: _____

f. By the start of Year 1, will the Applicant have the capability to risk stratify and identify and report upon Member characteristics, including but not limited to past diagnoses and services, that can inform the targeting of interventions to improve outcomes?

☒Yes ☐No

If "no" please provide explanation: _____

g. By the start of each subsequent year for Years 2 through 5, will the Applicant CCO provide risk stratification and Member characteristics to your contracted Providers with VBP arrangements for the population(s) included in the arrangement(s) in place for each year?

☒Yes ☐No

If "no" please provide explanation: _____

E. Social Determinants of Health and Health Equity (SDOH-HE) Attestations (Attachment 10)

1. Social Determinants of Health and Health Equity Spending, Priorities, and Partnership

a. Is Applicant willing to direct a portion of its annual net income or reserves, as required by Oregon State Statute and defined by OHA in rule, to addressing health disparities and SDOH-HE?

☒Yes ☐No

If "no" please provide explanation: _____

b. Is Applicant willing to enter into written agreements with SDOH-HE partners that describe the following: any relationship or financial interest that may exist between the SDOH-HE partner and the CCO, how funds will be distributed, the scope of work including the domain of SDOH-HE addressed and the targeted population, whether CCO will refer Members to the SDOH-HE partner, the geographic area to be covered, how outcomes will be evaluated and measured, and how the CCO will collect and report data related to outcomes?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. When identifying priorities for required SDOH-HE spending, is Applicant willing to designate, define and document a role for the CAC in directing, tracking and reviewing spending?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to align its SDOH-HE spending priorities with the priorities identified in the Community Health Improvement Plan and its Transformation and Quality Strategy, and to include at least one statewide priority (e.g. housing-related services and supports, including Supported Housing) in addition to its Community priorities?

☒Yes ☐No

If "no" please provide explanation: _____

_____

2. Health-related Services

a. Is Applicant willing to align HRS Community benefit initiatives with Community priorities from the CCO's Community Health Improvement Plan?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to align HRS Community benefit initiatives with a designated statewide priority should OHA require it?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to designate, define and document a role for the CAC when determining how Health-Related Services Community benefit initiatives decisions are made?

☒Yes ☐No

If "no" please provide explanation: _____

_____

3. Community Advisory Council membership and role

a. Is the Applicant willing to provide to OHA an organizational chart that includes the Community Advisory Council, and notes relationships between entities, including the CAC and the Board, how information flows between the bodies, the CAC and Board connection to various committees, and CAC representation on the board?

☒Yes ☐No

If "no" please provide explanation: _____

_____

4. Health Equity Assessment and Health Equity Plan

a. Is Applicant willing to develop and implement a Health Equity Plan according to OHA guidance, which includes a plan to provide cultural responsiveness and implicit bias education and training across the Applicant's organization and Provider Network? See Sample Contract and Cultural Responsiveness Training Plan Guidance Document.

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to include in its Health Equity Plan at least one initiative using HIT to support patient engagement?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to adopt potential health equity plan changes, including requirements, focus areas and components, based on OHA plan review feedback and, when applicable, based on guidance provided by the Oregon Health Policy Board's Health Equity Committee?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to designate a single point of accountability within the organization, who has budgetary decision-making authority and health equity expertise, for the development and implementation of the Health Equity Plan?

☒Yes ☐No

If "no" please provide explanation: _____

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

☒ Yes ☐No

If "no" please provide explanation: _____

f. Is Applicant willing to a) ask vendors for cultural and linguistic accessibility when discussing bringing on new HIT tools for patient engagement and b) when possible, seek out HIT tools for patient engagement that are culturally and linguistically accessible?

☒Yes ☐No

If "no" please provide explanation: _____

5. Traditional Health Workers (THW) Utilization and Integration

a. Is Applicant willing to develop and fully implement a Traditional Health Workers Integration and Utilization Plan?

☒Yes ☐No

If "no" please provide explanation: _____

b. Is Applicant willing to work in collaboration with the THW Commission to implement the Commission's best practices for THW integration and utilization?

☒Yes ☐No

If "no" please provide explanation: _____

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

☒Yes ☐No

If "no" please provide explanation: _____

d. Is Applicant willing to develop and implement a payment strategy for THWs that is informed by the recommendations from the Payment Model Committee of the THW Commission?

☒Yes ☐No

If "no" please provide explanation: _____

e. Is Applicant willing to designate an individual within the organization as a THW Liaison as of the Effective Date of the Contract?

☒Yes ☐No

If "no" please provide explanation: _____

_____

f. Is Applicant willing to engage THWs during the development of the CHA and CHP?

☒ Yes ☐No

If "no" please provide explanation: _____

_____

g. For services that are not captured on encounter claims, is Applicant willing to track and document Member interactions with THWs?

☒Yes ☐No

If "no" please provide explanation: _____

_____

6. Community Health Assessment and Community Health Improvement Plan

a. Is Applicant willing to partner with local public health authorities, non-profit Hospitals, any CCO that shares a portion of its Service Area, and any Tribes that are developing a CHA/CHP to develop shared CHA and CHP priorities?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to align CHP priorities with at least two State Health Improvement Plan (SHIP) priorities and implement statewide SHIP strategies based on local need?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to submit its Community Health Assessment and Community Health Improvement Plan to OHA?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to develop and fully implement a community engagement plan?

☒ Yes ☐No

If "no" please provide explanation:

F. Behavioral Health Attestations (Attachment 11)

1. Behavioral Health Benefit

a. Will Applicant report performance measures and implement Evidence-Based outcome measures, as developed by the OHA Metrics and Scoring Committee, and as specified in the Contract?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Will Applicant work collaboratively with OHA and its partners to implement all of the requirements in Exhibit M of the Contract?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Will Applicant be fully responsible for the Behavioral Health benefit for Members beginning in CY 2020?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Will Applicant manage the Global Budget (as defined in ORS 414.025) in a fully integrated manner? Fully integrated manner means that Applicant will not sub-capitate any Provider or entity for Behavioral Health services separately from physical health services nor will Applicant enter into any Value-Based Payment arrangements under which Behavioral Health spending is tracked separately from physical health services.

☒Yes ☐No

If "no" please provide explanation: _____

_____

e. Will Applicant report on the information and data specified in the Performance Expectations section as specified in the Contract and submit an annual report to OAH for review and approval?

☒Yes ☐No

If "no" please provide explanation: _____

_____

f. Will Applicant have sufficient resources, including technological, financial, Provider and workforce, to integrate the Behavioral Health benefit with oral and physical health care benefits?

☒Yes ☐No

If "no" please provide explanation: _____

_____

g. Will Applicant ensure the provision of cost-effective, comprehensive, person-centered, Culturally Responsive, and integrated Community-based Behavioral Health services for Members?

☒Yes ☐No

If "no" please provide explanation: _____

_____

h. Will Applicant provide oversight, Care Coordination, transition planning and management of the Behavioral Health needs of Members to ensure Culturally Responsive and linguistically appropriate Behavioral Health services are provided in a way that Members are served in a most natural and integrated environment possible and that minimizes the use of institutional care?

☒Yes ☐No

If "no" please provide explanation: _____

_____

i. Will Applicant follow Intensive Care Coordination standards as identified in OAR 410-141-3160/70?

☒Yes ☐No

If "no" please provide explanation: _____

_____

j. Will Applicant ensure Members have access to Referral and screening at multiple health system or health care entry points?

☒Yes ☐No

If "no" please provide explanation: _____

_____

k. Will Applicant use a standardized Assessment tool, to adapt the intensity and frequency of Behavioral Health services to the Behavioral Health needs of the Member?

☒Yes ☐No

If "no" please provide explanation: _____

_____

l. Will Applicant work collaboratively to improve services for adult Members with SPMI as a priority population? Will Applicant make significant commitments and undertake significant efforts to continue to improve treatment and services so that adults with SPMI can live and prosper in integrated Community settings?

☒Yes ☐No

If "no" please provide explanation: _____

_____

m. Will Applicant ensure Members have timely access to all services under the Behavioral Health benefit in accordance with access to service standards as developed in Appendix C, the Administrative Rules Concept Document, under OHPB #17?

☒Yes ☐No

If "no" please provide explanation: _____

_____

n. Will Applicant have an adequate Provider Network to ensure Members have timely access to Behavioral Health services and effective treatment in accordance with the Delivery System and Provider Capacity section of the Contract?

☒Yes ☐No

If "no" please provide explanation: _____

_____

o. Will Applicant establish written policies and procedures for Prior Authorizations, in compliance with the Mental Health Parity and Addiction Equity Act of 2008, and be responsible for any inquiries or concerns and not delegate responsibility to Providers?

☒Yes ☐No

If "no" please provide explanation: _____

_____

p. Will Applicant establish written policies and procedures for the Behavioral Health benefit and provide the written policies and procedures to OHA by the beginning of CY 2020?

☒Yes ☐No

If "no" please provide explanation: _____

_____

q. Will Applicant require mental health and substance use disorder programs be licensed or certified by OHA to enter the Provider Network?

☒Yes ☐No

If "no" please provide explanation: _____

_____

r. Will Applicant require Providers to screen Members for adequacy of supports for the Family in the home (e.g., housing adequacy, nutrition/food, diaper needs, transportation needs, safety needs and home visiting)?

☒Yes ☐No

If "no" please provide explanation: _____

_____

n. Will Applicant ensure Applicant's staff and Providers are trained in recovery principles, motivational interviewing, integration, and Foundations of Trauma Informed Care (https://traumainformedoregon.org/tic-intro-training-modules/)?

☒Yes ☐No

If "no" please provide explanation: _____

_____

t. Will Applicant ensure Providers are trained in Trauma Informed approaches and provide regular periodic oversight and technical assistance to Providers?

☒Yes ☐No

If "no" please provide explanation: _____

_____

u. Will Applicant require Providers, in developing Individual Service and Support Plans for Members, to assess for Adverse Childhood Experiences (ACEs) and trauma in a Culturally Responsive and Trauma Informed framework and approach?

☒Yes ☐No

If "no" please provide explanation: _____

_____

v. Will Applicant ensure Behavioral Health services are Culturally Responsive and Trauma Informed?

☒Yes ☐No

If "no" please provide explanation: _____

_____

w. Will Applicant assume responsibility for the entire Behavioral Health residential benefit by the beginning of CY 2022?

☒Yes ☐No

If "no" please provide explanation: _____

_____

x. Will Applicant include OHA approved Behavioral Health homes (BHHs) in Applicant's network as the BHHs qualify in Applicant's Region?

☒Yes ☐No

If "no" please provide explanation: _____

_____

y. Will Applicant assist Behavioral Health organizations within the delivery system to establish BHHs?

☒Yes ☐No

If "no" please provide explanation: _____

_____

z. Will Applicant utilize BHHs in their network for Members to the greatest extent possible?

☒Yes ☐No

If "no" please provide explanation: _____

_____

aa. Will Applicant provide a full psychological evaluation and child psychiatric consultation for children being referred to the highest levels of care (day treatment, subacute or PRTS)?

☒Yes ☐No

If "no" please provide explanation: _____

_____

2. MOU with Community Mental Health Program (CMHP)

a. Will Applicant enter into a written memorandum of understanding (MOU) with the local Community Mental Health Program (CMHP) in Applicant's Region by beginning of CY 2020, in accordance with ORS 414.153?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Will Applicant develop a comprehensive Behavioral Health plan for Applicant's Region in collaboration with the Local Mental Health Authority and other Community partners (e.g., education/schools, Hospitals, corrections, police, first responders, Child Welfare, DHS, public health, Peers, families, housing authorities, housing Providers, courts)?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Will Applicant coordinate and collaborate on the development of the Community health improvement plan (CHP) under ORS 414.627 with the local Community Mental Health Program (CMHP) for the delivery of mental health services under ORS 430.630

☒Yes ☐No

If "no" please provide explanation: _____

_____

3. Provisions of Covered Services – Behavioral Health

a. Will Applicant provide services as necessary to achieve compliance with the mental health parity requirements of 42 CFR§ 438, subpart K and ensure that any quantitative treatment limitations (QTLs), or non-quantitative treatment limitations (NQTLs) placed on Medically Necessary Covered Services are no more restrictive than those applied to fee-for-service medically necessary covered benefits, as described in 42 CFR 438.210(a)(5)(i)?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Will Applicant assume accountability for Members that are civilly committed and are referred to and enter Oregon State Hospital; be financially responsible for the services for Members on waitlist for Oregon State Hospital after the second year of the Vontract, with timeline to be determined by OHA; and be financially responsible for services for Members admitted to Oregon State Hospital after the second year of the Vontract, with timeline to be determined by OHA?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Will Applicant reimburse for covered Behavioral Health services rendered in a primary care setting by a qualified Behavioral Health Provider, and reimburse for covered physical health services in Behavioral Health care settings, by a qualified medical Provider?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Will Applicant ensure Members receive services from Non-Participating Providers for Behavioral Health services if those services are not available from Participating Providers or if a Member is not able to access services within the timely access to care standards? Will Applicant remain responsible for coordinating Behavioral Health services with Non-Participating Providers and reimbursing for services?

☒Yes ☐No

If "no" please provide explanation: _____

_____

e. Will Applicant ensure continuity of care throughout episodes of care and provide Intensive Care Coordination and general Care Coordination as specified in the Contract?

☒Yes ☐No

If "no" please provide explanation: _____

_____

4. Covered Services Component – Behavioral Health

a. Will Applicant establish written policies and procedures for an emergency response system, including post-stabilization care services and Urgent Services for all Members on a 24-hour, 7-day-a-week basis consistent with OAR 410-141-3140 and 42 CFR 438.114? Will the emergency response system provide an immediate, initial or limited duration response for emergency situations or potential Behavioral Health emergency situations that may include Behavioral Health conditions?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Will Applicant ensure access to Mobile Crisis Services for all Members in accordance with OAR 309-019-0105, OAR 309-019-0150, 309-019-0242, and 309-019-0300 to 309-019-0320 to promote stabilization in a Community setting rather than arrest, presentation to an Emergency Department, or admission to an Acute psychiatric care facility?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Will Applicant establish written policies and procedures for a Quality Improvement plan for the emergency response system?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Will Applicant collaboratively work with OHA and CMHPs to develop and implement plans to better meet the needs of Members in Community integrated settings and to reduce recidivism to Emergency Departments for Behavioral Health reasons?

☒Yes ☐No

If "no" please provide explanation: _____

_____

e. Will Applicant work with Hospitals to provide data on Emergency Department (ED) utilization for Behavioral Health reasons and length of time in the ED? Will Applicant develop remediation plans with EDs with significant numbers of ED stays longer than 23 hour?

☒Yes ☐No

If "no" please provide explanation: _____

_____

f. Will Applicant establish a policy and procedure for developing a management plan for contacting and offering services to each Member who has two or more readmissions to an ED in a six-month period?

☒Yes ☐No

If "no" please provide explanation: _____

g. Will Applicant make a reasonable effort to provide Covered Services on a voluntary basis and consistent with current Declaration for Mental Health Treatment as provided at: http://www.oregon.gov/oha/amh/forms/declaration.pdf in lieu of involuntary treatment?

☒Yes ☐No

If "no" please provide explanation: _____

h. Will Applicant establish written policies and procedures describing the appropriate use of Emergency Psychiatric Holds consistent with ORS 426 and alternatives to involuntary psychiatric care when a less restrictive voluntary service will not meet the Medically Appropriate needs of the Member and the behavior of the Member meets legal standards for the use of an Emergency Psychiatric Hold?

☒Yes ☐No

If "no" please provide explanation: _____

i. Will Applicant assure that any involuntary treatment provided under the Contract is provided in accordance with administrative rule and statute, and coordinate with the CMHP Director in assuring that all statutory requirements are met? Will Applicant also work with the CMHP Director in assigning a civilly committed Member to any placement and participate in circuit court hearings related to planned placements, if applicable?

☒Yes ☐No

If "no" please provide explanation: _____

j. If Applicant identifies a Member, over age 18 with no significant nursing care needs due to a general medical condition, Acute medical condition or physical disorder, is appropriate for Long Term Psychiatric Care (State Facility level of care), will Applicant request a LTPC determination from the OHA LTPC reviewer?

☒Yes ☐No

If "no" please provide explanation: _____

k. If Applicant identifies a Member, age 18 to age 64, with no significant nursing care needs due to a general medical condition, Acute medical condition or physical disorder of an enduring nature, is appropriate for LTPC, will Applicant request a LTPC determination from the applicable HSD Adult Mental Health Services Unit, as described in Procedure for LTPC Determinations for Members 18 to 64, available on the Contract Reports Web Site?

☒Yes ☐No

If "no" please provide explanation: _____

_____

l. If Applicant identifies a Member, age 65 and over, or age 18 to age 64 with significant nursing care needs due to a general medical condition, Acute medical condition or physical disorder of an enduring nature, is appropriate for LTPC, will Applicant request a LTPC determination from the State hospital-NTS, Outreach and Consultation Service (OCS) Team as described in Procedure for LTPC Determinations for Member Requiring Neuropsychiatric Treatment, available on the Contract Reports Web Site?

☒Yes ☐No

If "no" please provide explanation: _____

_____

m. For the Member age 18 and over, will Applicant work with the Member to assure timely discharge and transition from LTPC to the most appropriate, independent and integrated Community-based setting possible consistent with Member choice?

☒Yes ☐No

If "no" please provide explanation: _____

_____

n. Will Applicant authorize and reimburse Care Coordination services, in particular for Members who receive ICC, that are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are provided to Members receiving care through licensed Community treatment programs? Will Applicant authorize and reimburse for ICC services, in accordance with standards identified in OAR 410-141-3160-70?

☒Yes ☐No

If "no" please provide explanation: _____

_____

o. Will Applicant ensure that any involuntary treatment provided under the Contract is provided in accordance with administrative rule and statute and coordinate with the CMHP Director in assuring that all statutory requirements are met? Will Applicant work with the CMHP Director in assigning a civilly committed Member to any placement and participate in circuit court hearings related to planned placements, if applicable?

☒Yes ☐No

If "no" please provide explanation: _____

_____

p. Will Applicant provide Acute Inpatient Hospital Psychiatric Care for Members who do not meet the criteria for LTPC?

☒Yes ☐No

If "no" please provide explanation: _____

_____

q. Will Applicant ensure that all Members discharged from Acute Care Psychiatric Hospitals are provided a Warm Handoff to a Community case manager, Peer bridger, or other Community provider prior to discharge, and that all such Warm Handoffs are documented?

☒Yes ☐No

If "no" please provide explanation: _____

_____

r. Will Applicant ensure that all Members discharged from Acute Care Psychiatric Hospitals have linkages to timely, appropriate behavioral and primary health care in the Community prior to discharge and that all such linkages are documented, in accordance with OAR provisions 309-032-0850 through 309-032-0870?

☒Yes ☐No

If "no" please provide explanation: _____

_____

s. Will Applicant ensure all adult Members receive a follow-up visit with a Community Behavioral Health Provider within seven (7) days of their discharge from an Acute Care Psychiatric Hospital?

☒Yes ☐No

If "no" please provide explanation: _____

_____

t. Will Applicant reduce readmissions of adult Members with SPMI to Acute Care Psychiatric Hospitals?

☒Yes ☐No

If "no" please provide explanation: _____

_____

u. Will Applicant coordinate with system Community partners to ensure Members who are homeless and who have had two or more readmissions to an Acute Care Psychiatric Hospital in a six-month period are connected to a housing agency or mental health agency to ensure these Members are linked to housing in an integrated Community setting, Supported Housing to the extent possible, consistent with the individual's treatment goals, clinical needs and the individual's informed choice?

☒Yes ☐No

If "no" please provide explanation: _____

_____

v. Will Applicant ensure coordination and appropriate Referral to Intensive Care Coordination to ensure that Member's rights are met and there is post-discharge support? If Member is connected to ICC coordinator, will Applicant ensure coordination with this person as directed in OAR 410-141-3160-3170?

☒Yes ☐No

If "no" please provide explanation: _____

_____

w. Will Applicant work with OHA and the CMHPs to ensure that Members who are discharged from Acute Care Psychiatric Hospitals are discharged to housing that meets the individuals' immediate need for housing and work with Acute Care Psychiatric Hospitals in the development of each individual's housing assessment?

☒Yes ☐No

If "no" please provide explanation: _____

_____

x. Will Applicant establish a policy and procedure for developing a management plan for contacting and offering services to each Member who has two (2) or more readmissions to an Acute Care Psychiatric Hospital in a six-month period?

☒Yes ☐No

If "no" please provide explanation: _____

_____

y. Will Applicant work with OHA, other state agencies, and other state funded or operated entities to identify areas where treatment and services for adult Members with SPMI can be improved?

☒Yes ☐No

If "no" please provide explanation: _____

_____

z. Will Applicant coordinate services for each adult Member with SPMI who needs assistance with Covered or Non-covered Services?

☒Yes ☐No

If "no" please provide explanation: _____

_____

aa. Will Applicant provide oversight, Care Coordination, transition planning and management for Members receiving Behavioral Health services, including Mental Health Rehabilitative Services and Personal Care Services, in licensed and non-licensed home and Community-based settings, ensuring that individuals who no longer need placement in such settings are transitioned to a Community placement in the most integrated Community setting appropriate for that person?

☒Yes ☐No

If "no" please provide explanation: _____

_____

bb. Will Applicant provide Utilization Review and utilization management, for Members receiving Behavioral Health Services, including Mental Health Rehabilitative Services and Personal Care Services, in licensed and non-licensed home and Community-based settings, ensuring that individuals who no longer need placement in such setting transition to the most integrated Community setting, Supported Housing to the extent possible, consistent with the individual's treatment goals, clinical needs, and the individual's informed choice?

☒Yes ☐No

If "no" please provide explanation: _____

_____

cc. Will Applicant encourage utilization of Peer-Delivered Services (PDS) and ensure that Members are informed of their benefit to access and receive PDS from a Peer Support Specialist, Peer Wellness Specialist, Family Support Specialist, or Youth Support Specialist as applicable to the Member's diagnosis and needs?

☒Yes ☐No

If "no" please provide explanation: _____

_____

dd. Will Applicant ensure that Members with SPMI receive Intensive Care Coordination (ICC) support in finding appropriate housing and receive coordination in addressing Member's housing needs?

☒Yes ☐No

If "no" please provide explanation: _____

_____

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

☒Yes ☐No

If "no" please provide explanation: _____

_____

ff. Will Applicant ensure ACT services are provided for all adult Members with SPMI who are referred to and eligible for ACT services in accordance with OAR 309-019-0105 and 309-019-0225 through 309-019-0255?

☒Yes ☐No

If "no" please provide explanation: _____

_____

gg. Will Applicant ensure additional ACT capacity is created to serve adult Members with SPMI as services are needed?

☒Yes ☐No

If "no" please provide explanation: _____

_____

hh. Will Applicant, when ten (10) or more of Applicant's adult Members with SPMI in Applicant's Service Area are on a waitlist to receive ACT for more than thirty (30) days, without limiting other Applicant solutions, create additional capacity by either increasing existing ACT team capacity to a size that is still consistent with Fidelity standards or by adding additional ACT teams?

☒Yes ☐No

If "no" please provide explanation: _____

_____

If Applicant lacks qualified Providers to provide ACT services, will Applicant consult with OHA and develop a plan to develop additional qualified Providers? Will lack of capacity not be a reason to allow individuals who are determined to be eligible for ACT to remain on the waitlist? Will no individual on a waitlist for ACT services be without such services for more than 30 days?

☒Yes ☐No

If "no" please provide explanation: _____

_____

ii. Will Applicant ensure all denials of ACT services for all adult Members with SPMI are: based on established, evidence-based medical necessity criteria; reviewed, recorded and compiled in a manner that allows denials to be accurately reported out as appropriate or inappropriate; and follow the Notice of Adverse Benefit Determination process for all denials as described in the Contract?

☒Yes ☐No

If "no" please provide explanation: _____

_____

jj. Will Applicant be responsible for finding or creating a team to serve Members who have appropriately received a denial for a particular ACT team but who meet ACT eligibility standards?

☒Yes ☐No

If "no" please provide explanation: _____

_____

kk. Will Applicant be responsible for engaging with all eligible Members who decline to participate in ACT in an attempt to identify and overcome barriers to the Member's participation?

☒Yes ☐No

If "no" please provide explanation: _____

_____

ll. Will Applicant require that a Provider or care coordinator meets with the Member to discuss ACT services and provide information to support the Member in making an informed decision regarding participation? Will this include a description of ACT services and how to access them, an explanation of the role of the ACT team and how supports can be individualized based on the Member's self-identified needs, and ways that ACT can enhance a Member's care and support independent Community living?

☒Yes ☐No

If "no" please provide explanation: _____

_____

mm. Will Applicant provide alternative evidence-based intensive services if Member continues to decline participation in ACT, which must include coordination with an ICC?

☒Yes ☐No

If "no" please provide explanation: _____

_____

nn. Will Applicant report the number of individuals referred to ACT, number of individuals admitted to ACT programs, number of denials for the ACT benefit, number of denials to ACT programs, and number of individuals on waitlist by month?

☒Yes ☐No

If "no" please provide explanation: _____

_____

oo. Will Applicant ensure a Member discharged from OSH who is appropriate for ACT shall receive ACT or an evidence-based alternative?

☒Yes ☐No

If "no" please provide explanation: _____

_____

pp. Will Applicant document efforts to provide ACT to individuals who initially refuse ACT services, and document all efforts to accommodate their concerns?

☒Yes ☐No

If "no" please provide explanation: _____

_____

qq. Will Applicant offer alternative evidence-based intensive services for individuals discharged from OSH who refuse ACT services?

☒Yes ☐No

If "no" please provide explanation: _____

_____

rr. Will Applicant ensure a Member discharged from OSH who is determined not to meet the level of care for ACT shall be discharged with services appropriate to meet their needs?

☒Yes ☐No

If "no" please provide explanation: _____

_____

ss. Will Applicant coordinate with system partners as needed regarding Oregon State Hospital discharges for all adult Members with SPMI in accordance with OAR 309-091-0000 through 0050?

☒Yes ☐No

If "no" please provide explanation: _____

_____

tt. Will Applicant ensure access to Supported Employment Services for all adult Members eligible for these services, in accordance with OAR 309-019-0275 through 309-019-0295? ("Supported Employment Services" means the same as "Individual Placement and Support (IPS) Supported Employment Services" as defined in OAR 309-019-0225.)

☒Yes ☐No

If "no" please provide explanation: _____

_____

uu. Will Applicant work with local law enforcement and jail staff to develop strategies to reduce contacts between Members and law enforcement due to Behavioral Health reasons, including reduction in arrests, jail admissions, lengths of stay in jails and recidivism?

☒Yes ☐No

If "no" please provide explanation: _____

_____

vv. Will Applicant work with SRTFs to expeditiously move civilly committed adult Members with SPMI who no longer need placement in an SRTF to a Community placement in the most integrated setting, Supported Housing to the extent possible, consistent with the individual's treatment goals, clinical needs, and the individual's informed choice?

☒Yes ☐No

If "no" please provide explanation: _____

_____

ww. Will Applicant provide Substance Use Disorder (SUD) services to Members, which include outpatient, intensive outpatient, medication assisted treatment including Opiate Substitution Services, residential and detoxification treatment services consistent with OAR Chapter 309, Divisions 18, 19 and 22, and OAR Chapter 415 Divisions 20, and 50?

☒Yes ☐No

If "no" please provide explanation: _____

_____

xx. Will Applicant comply with Substance Use Disorder (SUD) waiver program designed to improve access to high quality, clinically appropriate treatment for opioid use disorder and other SUDs, upon approval by Centers for Medicare and Medicaid Services (CMS)?

☒Yes ☐No

If "no" please provide explanation: _____

_____

yy. Will Applicant inform all Members using Culturally Responsive and linguistically appropriate means that Substance Use Disorder outpatient, intensive outpatient, residential, detoxification and medication assisted treatment services, including opiate substitution treatment, are Covered Services consistent with OAR 410-141-3300?

☒Yes ☐No

If "no" please provide explanation: _____

_____

zz. Will Applicant participate with OHA in a review of OHA provided data about the impact of these criteria on service quality, cost, outcome, and access?

☒Yes ☐No

If "no" please provide explanation: _____

_____

5. Children and Youth

a. Will Applicant develop and implement cost-effective comprehensive, person-centered, individualized, and integrated Community-based Child and Youth Behavioral Health services for Members, using System of Care (SOC) principles?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Will Applicant utilize evidence-based Behavioral Health interventions for the needs of children 0-5, and their caregivers, with indications of Adverse Childhood Experiences (ACEs) and high complexity?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Will Applicant provide Intensive Care Coordination (ICC) that is Family and youth-driven, strengths based and Culturally Responsive and linguistically appropriate and abide by ICC standards as set forth in Appendix C, Administrative Rules Concept under OHPB #24 and in accordance with the ICC section in the Contract? Will Applicant abide by ICC standards as forth in Appendix C, Administrative Rules Concept, under OHPB #24, and in accordance with the ICC section in the Contract?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Will Applicant provide services to children, young adults and families of sufficient frequency, duration, location, and type that are convenient to the youth and Family? Will Services alleviate crisis while allowing for the development of natural supports, skill development, normative activities and therapeutic resolution to Behavioral Health disorders and environmental conditions that may impact the remediation of a Behavioral Health disorder?

☒Yes ☐No

If "no" please provide explanation: _____

_____

e. Will Applicant adopt policies and guidelines for admission into Psychiatric Residential Treatment Services (PRTS), Psychiatric Day Treatment Services (PDTS) and/or Intensive Outpatient Services and Supports?

☒Yes ☐No

If "no" please provide explanation: _____

_____

f. Will Applicant ensure the availability of service, supports or alternatives 24 hours a day/7 days a week to remediate a Behavioral Health crisis in a non-emergency department setting?

☒Yes ☐No

If "no" please provide explanation: _____

_____

g. Will Applicant encourage utilization of Peer-Delivered Services (PDS) and ensure that Members are informed of their benefit to access and receive PDS from a Peer Support Specialist, Peer Wellness Specialist, Family Support Specialist, or Youth Support Specialist as applicable to the Member's diagnosis and needs?

☒Yes ☐No

If "no" please provide explanation: _____

_____

h. If Applicant identifies a Member is appropriate for LTPC Referral, will Applicant request a LTPC determination from the applicable HSD Child and Adolescent Mental Health Specialist, as described in Procedure for LTPC Determinations for Members 17 and Under, available on the Contract Reports Web Site?

☒Yes ☐No

If "no" please provide explanation: _____

_____

i. Will Applicant arrange for the provision of non-health related services, supports and activities that can be expected to improve a Behavioral Health condition?

☒Yes ☐No

If "no" please provide explanation: _____

_____

j. Will Applicant coordinate admissions to and discharges from Acute Inpatient Hospital Psychiatric Care and Sub-Acute Care for Members 17 and under, including Members in the care and custody of DHS Child Welfare or OYA? For a Member 17 and under, placed by DHS Child Welfare through a Voluntary Placement Agreement (CF 0499), will Applicant also coordinate with such Member's parent or legal guardian?

☒Yes ☐No

If "no" please provide explanation: _____

_____

k. Will Applicant ensure a CANS Oregon is administered to a Member who is a child or youth and the data is entered into OHA approved data system according to the eligibility and timeline criteria in the Contract?

☒Yes ☐No

If "no" please provide explanation: _____

_____

l. Will Applicant have funding and resources to implement, to fidelity, Wraparound Services?

☒Yes ☐No

If "no" please provide explanation: _____

_____

m. Will Applicant enroll all eligible youth in Wraparound and place no youth on a waitlist?

☒ Yes ☐No

If "no" please provide explanation: _____

_____

n. Will Applicant screen all eligible youth with a Wraparound Review Committee in accordance with Wraparound Services as described in the OHA System of Care Wraparound Initiative (SOCWI) guidance document found at the link below and in Wraparound Service OARs? http://www.oregon.gov/oha/hsd/amh/pages/index.aspx.

☒Yes ☐No

If "no" please provide explanation: _____

_____

o. Will Applicant establish and maintain a functional System of Care in its Service Area in accordance with the Best Practice Guide located at https://www.pdx.edu/ccf/best-practice-guide including a Practice Level Workgroup, Advisory Committee and Executive Council with a goal of youth and Family voice representation to be 51 percent?

☒Yes ☐No

If "no" please provide explanation: _____

_____

p. Will Applicant have a functional SOC governance structure by the beginning of CY 2020 that consists of a practice level work group, advisory council, and executive council?

☒Yes ☐No

If "no" please provide explanation: _____

_____

q. By end of CY 2020, will Applicant have written Charters and new Member handbooks for Practice Level Work group, Advisory Council and Executive Council?

☒Yes ☐No

If "no" please provide explanation: _____

_____

G. Cost and Financial Attestations (Attachment 12)

1. Rates

Does Applicant accept the CY 2020 Rate Methodology appended to Attachment 12?

☒Yes ☐No

If "no" please provide explanation: _____

_____

2. Evaluate CCO performance to inform CCO-specific profit margin

a. Does Applicant agree to performance and efficiency evaluation being used to set profit margins in CCO capitation rates?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Does Applicant agree to accept the CCO 2.0 capitation rate methodology as described in the Oregon CY20 Procurement Rate Methodology document and also accept the performance evaluation methodology and its use in setting CCO-specific profit margins?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Does Applicant agree to report additional data as needed to inform the performance evaluation process, including data on utilization of Health-Related Services?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to have OHA use efficiency analysis to support managed care efficiency adjustments that may result in adjustments to the base data used in capitation rate development to further incentivize reductions in Waste in the system?

☒Yes ☐No

If "no" please provide explanation: _____

_____

3. Qualified Directed Payments to Providers

a. Is Applicant willing to make OHA-directed payments to certain Hospitals within five Business Days after receipt of a monthly report prepared and distributed by OHA?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to report to OHA promptly if it determines payments to Hospitals will be significantly delayed?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to exclude the portion of OHA-directed payments for provider tax repayment when negotiating alternative or Value-Based Payment reimbursement arrangements?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to provide input and feedback to OHA on the selection of measures of quality and value for OHA-directed payments to Providers?

☒Yes ☐No

If "no" please provide explanation: _____

_____

4. Quality Pool Operations and Reporting

a. Does Applicant agree to having a portion of capitation withheld from monthly Capitation Payment and awarded to the Applicant based on performance on metrics based on the Quality Incentive Pool program?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Does Applicant agree to report to OHA separately on expenditures incurred based on Quality Pool revenue earned?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Does Applicant agree to report on the methodology it uses to distribute Quality Pool earnings to Providers, including SDOH-HE partners and public health partners?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Does Applicant have a plan to evaluate contributions made by SDOH-HE and public health partners toward the achievement of Quality Pool metrics?

☒Yes ☐No

If "no" please provide explanation: _____

_____

5. Transparency in Pharmacy Benefit Management Contracts

a. Will Applicant select and contract with the Oregon Prescription Drug Program to provide Pharmacy Benefit Management services? If yes, please skip to section 5. If not, please answer parts b-f of this question.

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Will Applicant use a pharmacy benefit manager that will provide pharmacy cost passthrough at 100% and pass back 100% of rebates received to Applicant?

☐Yes ☐No

If "no" please provide explanation: _____

_____

c. Will Applicant separately report to OHA any and all administrative fees paid to its PBM?

☐ Yes ☐No

If "no" please provide explanation: _____

_____

d. Will Applicant require reporting from PBM that provides paid amounts for pharmacy costs at a claim level?

☐Yes ☐No

If "no" please provide explanation: _____

_____

e. Will Applicant obtain market check and audits of their PBMs by a third party on an annual basis, and share the results of the market check with the OHA?

☐Yes ☐No

If "no" please provide explanation: _____

_____

f. Will Applicant require its PBM to remain competitive with enforceable contract terms and conditions driven by the findings of the annual market check and report auditing?

☐Yes ☐No

If "no" please provide explanation: _____

_____

6. Alignment Preferred Drug Lists (PDLs) and Prior Authorization Criteria

a. Will Applicant partner with OHA on the goal of increasing the alignment of CCO preferred drug lists (PDL) with the Fee-For-Service PDL set every year by OHA?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Will Applicant align its PDL in any and all categories of drugs as recommended by the P&T committee and as required by OHA?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Will Applicant post online in a publicly accessible manner the Applicant's specific PDL with coverage and Prior Authorization criteria in a format designated by OHA and update the posting concurrently or before any changes to the PDL or coverage/PA criteria become effective?

☐Yes ☒No

If "no" please provide explanation: WCCCO will post its PDL coverage and prior authorization in a self prescribed format.

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: WCCCO commits to achieving sustainable growth in expenditures each calendar year equal or below target of 3.4% as long as uncontrollable costs are taken into consideration.

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: WCCCO will participate in a fair and equitable program-wide reinsurance program after 2020.

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: WCCCO agrees in concept. A complete understanding of the program including funding and coverage would need to be better understood.

10. CCO Solvency Standards and OHA Tools to Regulate and Mitigate Insolvency Risk

a. Is Applicant willing to have its financial solvency risk measured by Risk Based Capital (RBC) starting in 2021?

☒Yes ☐No

If "no" please provide explanation: _____

b. Is Applicant willing to achieve a calculated RBC threshold of 200% by end of Q3 of 2021 and thereafter to maintain a minimum RBC threshold of 200%?

☒Yes ☐No

If "no" please provide explanation: _____

c. Is Applicant willing to report to OHA promptly if it determines that its calculated RBC value is or is expected to be below 200%?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to report to OHA promptly if it determines that its actual financial performance departs materially from the pro forma financial statements submitted with this Application?

☒Yes ☐No

If "no" please provide explanation: _____

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

☒ Yes ☐No

If "no" please provide explanation: _____

11. Encounter Data Validation Study

a. Is Applicant willing to perform regular chart reviews and audits of its encounter claims to ensure the Encounter Data accurately reflects the services provided?

☒Yes ☐No

If "no" please provide explanation: _____

_____

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

☒Yes ☐No

If "no" please provide explanation: _____

_____

H. Member Transition Plan (Attachment 16)

1. Is Applicant willing to faithfully execute its Member Transition Plan as described in Attachment 16?

☒Yes ☐No

If "no" please provide explanation: _____

_____

Attachment 14 — Assurances

Applicant Name: West Central Coordinated Care Organization

Authorizing Signature: _____

Printed Name: Robin Richardson

Instructions: Assurances focus on the Applicant's compliance with federal Medicaid law and related Oregon rules. For each assurance, Applicant will check "yes," or "no." A "yes" answer is normal, and an explanation will be furnished if Applicant's response is "no". Applicant must respond to all assurances. If an assurance has more than one question and Applicant's answer is "no" to any question, check "no" and provide an explanation.

These assurances must be signed by a representative of Applicant.

Each assurance is effective starting at the time of Readiness Review and continuing throughout the term of the Contract.

1. **Emergency and Urgent Care Services.** Will Applicant have written policies and procedures, and oversight and monitoring systems to ensure that emergency and urgent services are available for all Members on a 24-hour, 7-days-a-week basis? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? (See 42 CFR 438.114 and OAR 410-141-3140]

   ☒Yes ☐No

   If "no" please provide explanation: _____

2. **Continuity of Care.** Will Applicant implement written policies and procedures that ensure a system for the coordination of care and the arrangement, tracking and documentation of all Referrals and Prior Authorizations to other Providers? Will Applicant follow Intensive Care Coordination (ICC)/ENCC standards and Care Coordination standards, including transition meetings, as directed in OAR 410-141-3170? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.208 and OAR 410-141-3160]

   ☒Yes ☐No

   If "no" please provide explanation: _____

3. Will Applicant implement written policies and procedures that ensure maintenance of a record keeping system that includes maintaining the privacy and security of records as required by the Health Insurance Portability and Accountability Act (HIPAA), 42 USC § 1320-d et seq., and the federal regulations implementing the Act, and complete Clinical Records that document the care received by Members from the Applicant's Primary Care and Referral Providers? Will Applicants communicate these policies and procedures to Participating Providers, regularly monitor Participating Providers' compliance with these policies and procedures and take any Corrective Action necessary to ensure Participating Provider compliance? Will Applicants document all monitoring and Corrective Action activities? Will such policies and procedures will ensure that records are secured, safeguarded and stored in accordance with applicable Law? [See 45 CFR Parts 160 – 164, 42 CFR 438.242, ORS 414.679 and OAR 410-141-3180]

   ☒Yes ☐No

   If "no" please provide explanation: _____

4. Will Applicant have an ongoing quality performance improvement program for the services it furnishes to its Members? Will the program include an internal Quality Improvement program based on written policies, standards and procedures that are designed to achieve through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas and that are expected to have a favorable effect on health outcomes and Member satisfaction? The improvement program will track outcomes by race, ethnicity and language. The Applicant will communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance. [See OAR 410-141-0200]

☒Yes ☐No

If "no" please provide explanation: _____

_____

5. Will Applicant make Coordinated Care Services accessible to enrolled Members? Will Applicant not discriminate between Members and non-Members as it relates to benefits to which they are both entitled including reassessment or additional screening as needed to identify exceptional needs in accordance with OAR 410-141-3160 through 410-141-3170? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.206 to 438.210; and OAR 410-141-3220]

☒Yes ☐No

If "no" please provide explanation: _____

_____

6. Will Applicant have written procedures approved in writing by OHA for accepting, processing, and responding to all complaints and Appeals from Members or their Representatives that are consistent with Exhibit I of the Appendix B "Sample Contract"? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.228, 438.400 – 438.424]

☒Yes ☐No

If "no" please provide explanation: _____

_____

7. Will Applicant develop and distribute OHA-approved informational materials to Potential Members that meet the language and alternative format requirements of Potential Members? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.10; OAR 410-141-3280]

☒Yes ☐No

If "no" please provide explanation: _____

_____

8. Will Applicant have an on-going process of Member education and information sharing that includes appropriate orientation to the Applicant provided in the Member handbook or via health education, about the availability of intensive Care Coordination Care Coordination for Members who are aged, blind and/or disabled, or are part of a prioritized population, and appropriate use of emergency facilities and urgent care? Will Applicant will communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.10; and OAR 410-141-3300]

☒Yes ☐No

If "no" please provide explanation: _____

_____

9. Will Applicant have written policies and procedures to ensure Members are treated with the same dignity and respect as other patients who receive services from the Applicant that are consistent with Appendix B, Core Contract? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.100, ORS 414.635 and OAR 410-141-3320]

☒Yes ☐No

If "no" please provide explanation: _____

_____

10. Will Applicant provide Intensive Care Coordination (otherwise known as Exceptional Needs Care Coordination or ENCC) to Members who are Aged, Blind or Disabled; Members with high health needs or multiple chronic conditions; Members receiving Medicaid-funded long-term care or long-term services and supports or receiving Home and Community-Based Services (HCBS) under the state's 1915(i), 1915(j), or 1915(k) State Plan Amendments or the 1915(c) HCBS waivers, or Behavioral Health priority populations in accordance with OAR 410-141-3170? Will Applicant ensure that Prioritized Populations, who sometimes have difficulty with engagement, are fully informed of the benefits of Care Coordination? Will Applicant ensure that their organization will be Trauma Informed by January 1, 2020? Will Applicant utilize evidence-based outcome measures? Will Applicant ensure that Members who meet criteria for ENCC receive contact and service delivery as required in OAR 410-141-3170? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.208]

☒Yes ☐No

If "no" please provide explanation: _____

_____

11. Will Applicant maintain an efficient and accurate billing and payment process based on written policies, standards, and procedures that are in accordance with accepted professional standards, OHP Administrative Rules and OHA Provider Guides? Will Applicant and its Providers or Subcontractors will not hold Members responsible for debt incurred by the Applicant or by Providers if the entity becomes insolvent? Will Applicant have monitoring systems in operation and review the operations of these systems on a regular basis. The Applicant will communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 447.46]

☒Yes ☐No

If "no" please provide explanation: _____

_____

12. Will Applicant participate as a trading partner of the OHA in order to timely and accurately conduct electronic transactions in accordance with the HIPAA electronic transactions and security standards? Has Applicant executed necessary trading partner agreements and conducted business-to-business testing that are in accordance with accepted professional standards, OHP Administrative Rules and OHA Provider Guides? Will Applicant have monitoring systems in operation and review the operations of these systems on a regular basis? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 45 CFR Part 162; OAR 943-120-0100 to 943-120-0200]

☒Yes ☐No

If "no" please provide explanation: _____

_____

13. Will Applicant maintain an efficient and accurate system for capturing Encounter Data, timely reporting the Encounter Data to OHA, and regularly validating the accuracy, truthfulness and completeness of that Encounter Data based on written policies, standards, and procedures that are in accordance with accepted professional standards, CCO and OHP Administrative Rules and OHA Provider Guides? Will Applicant have monitoring systems in operation and review the operations of these systems on a regular basis? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.242; and the Contract]

☒Yes ☐No

If "no" please provide explanation: _____

_____

14. Will Applicant maintain an efficient and accurate process that can be used to validate Member Enrollment and Disenrollment based on written policies, standards, and procedures that are in accordance with accepted professional standards, OHP Administrative Rules and OHA Provider Guides? Will Applicant have monitoring systems in operation and review the operations of these systems on a regular basis? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.242 and 438.604; and Contract]

☒Yes ☐No

If "no" please provide explanation: _____

_____

15. Assurances of Compliance with Medicaid Regulations

Item 15 of this Attachment 14 has ten assurances of Compliance with Medicaid Regulations. These Assurances address specific Medicaid regulatory requirements that must be met in order for the Applicant to be eligible to contract as a CCO. For purposes of this section and the federal Medicaid regulations in 42 CFR Part 438, a CCO falls within the definition of a "managed care organization" in 42 CFR 438.2. This section asks the Applicant to provide a brief narrative of how the Applicant meets each applicable Assurance. The Applicant must provide supporting materials available to the OHA upon request.

Please describe in a brief narrative how Applicant meets the standards and complies with the Medicaid requirements cited in the Medicaid Assurances in Item 15:

a. Medicaid Assurance #1 – 42 CFR § 438.206 Availability of services.

b. Medicaid Assurance #2 – 42 CFR § 438.207 Assurances of adequate capacity and services.

c. Medicaid Assurance #3 – 42 CFR § 438.208 Coordination and continuity of care.

d. Medicaid Assurance #4 – 42 CFR § 438.210 Coverage and authorization of services.

e. Medicaid Assurance #5 – 42 CFR § 438.214 Provider selection.

f. Medicaid Assurance #6 – 42 CFR § 438.224 Confidentiality.

g. Medicaid Assurance #7 – 42 CFR § 438.228 Grievance and Appeal systems.

h. Medicaid Assurance #8 – 42 CFR § 438.230 Subcontractual relationships and delegation.

i. Medicaid Assurance #9 – 42 CFR § 438.236 Practice guidelines.

j. Medicaid Assurance #10 – 42 CFR § 438.242 Health information systems.

We have provided a separate document titled "Assurances of Compliance with Medicaid Regulations" per instructions in Addendum 5 with our response.

Assurances of Compliance with Medicaid Regulations

A. Medicaid Assurance #1 – 42 CFR § 438.206 Availability of services.

WCCCO ensures that all members have access to services in a timely manner consistent with the appropriateness of their health need. WCCCO establishes culturally competent access-to-care standards, allowing appropriate choice for members, including diverse communities and underserved populations, access to second opinions and monitoring to ensure compliance with our standards. WCCCO provides services for primary care, women's healthcare, specialty care, behavioral health services, dental health, pharmacy, hospital, vision and ancillary services. If subcontractor is unable to provide necessary services, subcontractor has processes in place to cover and coordinate services out of network.

B. Medicaid Assurance #2 – 42 CFR § 438.207 Assurances of adequate capacity and services.

WCCCO and its provider partners ensure that the capacity of providers is sufficient in numbers to meet the healthcare needs of WCCCO's membership. WCCCO has access standards in place and will provide documentation of network adequacy through the Delivery Services Network Report on an annual basis or any time there is a significant change in the network.

C. Medicaid Assurance #3 – 42 CFR § 438.208 Coordination and continuity of care.

WCCCO has policies and procedures that ensure it coordinates the care its members receive. WCCCO utilizes a Multidisciplinary Team and Health Risk assessment process to identity and coordinate member health concerns in a timely manner. Once concerns are identified WCCCO assures that care is coordinated among the member's care team and primary care physician. Additionally, WCCCO has procedures to ensure transition in cases of members moving to or from a new coordinated care organization.

D. Medicaid Assurance #4 – 42 CFR § 438.210 Coverage and authorization of services.

WCCCO and its delegated entities follow consistent guidelines for processing requests for referrals and service authorizations to or from participating providers, including alternative care settings and house doctors of residential facilities. All requested services are subject to the rules and limitations of the appropriate Oregon Health Plan (OHP) administrative rules and provider guides. Standard authorization decisions are made as expeditiously as the enrollee requires and will not exceed 14 days. For expedited preauthorization or referral requests in which the provider indicates that following the standard timeframe could

seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, decisions are made as expeditiously as the member's health condition requires and no later than 72 hours after the receipt of the request for service. Preauthorization for prescription drugs will be made within 24 hours of receipt of a request. If preauthorization for a prescription cannot be completed within 24 hours, WCCCO provides for dispensing of at least a 72-hour supply of the medication if the medical need for the medication is immediate.

E. Medicaid Assurance #5 – 42 CFR § 438.214 Provider selection.

WCCCO requires the completion of the initial credentialing process by a new practitioner or facility and recredentialing at least every three years for continued participation in the WCCCO's provider network. Practitioners and facilities must complete the credentialing process prior to providing services to members and will not be discriminated against for serving high risk populations or specialize in conditions that require costly treatment.

WCCCO credentials and recredentials independent physical medicine and behavioral health practitioners, licensed behavioral health providers who are affiliated with Community Mental Health Programs (CMHP) and/or Patient-Centered Primary Care Homes (PCPCH) and organizational providers (facilities) according to the National Committee for Quality Assurance (NCQA), Centers for Medicare and Medicaid Services (CMS) and Oregon Health Authority standards and rules. WCCCO will not employ or contract with providers that are excluded from participation in Federal health care programs.

F. Medicaid Assurance #6 – 42 CFR § 438.224 Confidentiality.

WCCCO will safeguard confidential information about individuals. We will inform individuals about our privacy practices and will respect individual privacy rights. WCCCOs staff shall maintain the confidentiality of information whether oral, written or electronically recorded in any form or medium, without limitation. Discussion, transmission or disclosure of Protected Health Information (PHI) without authorization shall occur only for the purpose of payment, treatment and healthcare operations or as required or permitted by federal or state law. For all other disclosures, proper authorization will be obtained. WCCCO staff will limit the disclosure of PHI to the minimum necessary to accomplish a given business purpose. Access to systems will be aligned with the work functions necessary to perform required duties. Only those individuals performing those work functions will be granted system access.

G. Medicaid Assurance #7 – 42 CFR § 438.228 Grievance and Appeal systems.

WCCCO will provide an internal procedure for members or their representatives to voice or submit and obtain timely resolution of their complaints and appeals. Member Grievances will be resolved within 5 five business days of receipt or will be notified in the same timeframe if a delay is required to resolve the Grievance. Standard Appeals are resolved within 16 days of receipt. Expedited Appeals will be resolved as expeditiously as the enrollee's health

condition requires, not to exceed 72 hours of receipt. WCCCO is the final adjudicator of all appeals and will not discourage, encourage withdrawal, retaliate, or take punitive actions against any member or provider that uses any aspect of the grievance system, including the expedited appeal process.

H. Medicaid Assurance #8 – 42 CFR § 438.230 Subcontractual relationships and delegation.

WCCCO may delegate functions to third parties related to its Medicaid Plans. Medicaid program requirements apply to subcontractors who contract with WCCCO to provide certain administrative or health care services for enrollees on behalf of WCCCO. WCCCO shall require all subcontractors to comply with all applicable State and Federal requirements. WCCCO will monitor and audit subcontractor to ensure they are compliance with applicable laws, regulations and obligations with respect to its delegated responsibilities. Areas of non-compliance will result in corrective action and review. Continued non-compliance will result in further corrective action up to and including termination of the contract with Contractor.

I. Medicaid Assurance #9 – 42 CFR § 438.236 Practice guidelines.

WCCCO's staff use clinical support tools based on evidence-based guidelines and written policies to apply criteria based on individual needs and complete an assessment of the local delivery system to support clinical interventions and access to current healthcare resources for assistance in providing services to members. WCCCO clinical practice guidelines are reviewed and approved by the WCCCO's Quality Improvement Committee to ensure guidelines are being applied consistently. Clinical practice guidelines are posted on WCCCO's website for provider and member education and access. Clinical guideline information is also published in the provider administrative manuals.

J. Medicaid Assurance #10 – 42 CFR § 438.242 Health information systems.

WCCCO has policies and procedures in place and maintains a health information system that provides information related to utilization, claims, grievances and appeals, and member eligibility. WCCCO utilizes systems that accurately collect, report and process member, claims and provider data in a timely and accurate fashion. Additionally, WCCCO collects data in standardized, compliant formats and submits encounter data regularly, as required by the State contract, which provides an accurate and complete representation of services provided to members.

Attachment 15 — Representations

Applicant Name: West Central Coordinated Care Organization

Authorizing Signature: _____

Printed Name: Robin Richardson

Instructions: For each representation, Applicant will check "yes," or "no,". On representations, no particular answer is normal, and an explanation will be furnished in all cases. Applicant must respond to all representations.

These representations must be signed by a representative of Applicant.

Each representation is effective starting at the time of Readiness Review and continuing throughout the term of the Contract.

1. Will Applicant have an administrative or management contract with a contractor to manage/handle all staffing needs with regards to the operation of all or a portion of the CCO program?

☒ Yes ☐ No

Explanation: Yes, we will have administrative agreements with one or more affiliates to manage staffing and operations for all CCO program functions.

2. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the systems or information technology to operate the CCO program for Applicant?

☒ Yes ☐ No

Explanation: Yes, we will have an administrative agreement with our affiliate to manage system and information technology to operate the CCO program.

3. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the claims administration, processing and/or adjudication functions?

☒ Yes ☐ No

Explanation: Yes, we will have administrative agreements with one or more affiliates to perform all claims administration, processing and adjudication functions.

4. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the Enrollment, Disenrollment and membership functions?

☒ Yes ☐ No

Explanation: Yes, we will have an administrative agreement with our affiliate to perform all enrollment, disenrollment and membership functions.

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: Yes, we will have administrative agreements with one or more affiliates to perform all credentialing functions.

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: Yes, we will have administrative agreements with one or more affiliates to perform all utilization operations management.

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: Yes, we will have an administrative agreement with our affiliate to perform all Quality Improvement operations.

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: Yes, we will have an administrative agreement with our affiliate to perform all call center operations.

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: Yes, we will have an administrative agreement with our affiliate to perform all financial services.

10. Will Applicant have an administrative or management contract with a contractor to delegate all or a portion of other services that are not listed?

☒Yes ☐ No

Explanation: WCCCO administrative functions will be provided by WCCCO affiliate/equity partner ODS Community Health, Inc. (ODSCH) through an administrative services agreement with WCCCO.

ODSCH will perform all administration including all corporate functions for WCCCO such as staffing, information technology, claims, enrollment, credentialing, utilization management, quality improvement, compliance, customer service, encounter data, data analytics, actuarial, financial, legal, etc.

11. Will Applicant will have contracts with related entities, contractors and Subcontractors to perform, implement or operate any aspect of the CCO operations for the CCO Contract, other than as disclosed in response to representation 1-10 above?

☒Yes ☐ No

Explanation: Yes, WCCCO intends to subcontract with entities to perform Dental administration, Pharmacy/PBM administration, NEMT administration, high tech imaging utilization management and dialysis utilization management.

12. Other then VBP arrangements with Providers, will Applicant sub-capitate any portion of its Capitation Payments to a risk-accepting entity (RAE) or to another health plan of any kind?

☐Yes ☒ No

Explanation: WCCCO does not intend to sub-capitate any portion of its capitation payment to a risk-accepting entity (RAE) or to another health plan of any kind.

13. Does Applicant have a 2019 CCO contract? Is Applicant a risk-accepting entity or Affiliate of a 2019 CCO? Does Applicant a management services agreement with a 2019 CCO? Is Applicant under common management with a 2019 CCO?

☒Yes ☐ No

Explanation: WCCCO affiliate ODS Community Health, Inc. is an equity partner and administrator of EOCCO which currently holds a 2019 CCO contract with OHA.

ATTACHMENT 16 — MEMBER TRANSITION PLAN

1. Background and Supporting Sources

As described in Section 5.8 Member Enrollment, OHA will hold an Open Enrollment period for Members in Choice Areas of the state. Members in these areas may move from their current plan to another plan during the Open Enrollment period. For purposes of its Application, Applicant should assume that all of its service areas will be Choice Areas.

The Member Transition Plan should describe the process for the safe and orderly transfer of Members to another CCO and receiving Members from another CCO during the Open Enrollment period. and how the plan will maximize and maintain continuity of care for Members. This includes, but is not limited to, continuity of care with primary and specialty care Providers, primary care and Behavioral Health homes, plans of care, Prior Authorizations, prescription medications, medical Case Management Services, and Transportation.

The Member Transition Plan should include specific processes for Members who may suffer serious detriment to their physical and mental health or who are at-risk of hospitalization or institutionalization, if any breakdown in service provisions or access to care were to occur, including services provided by Practitioners that may not be contracted with the new CCO. OHA considers these populations to include, but not limited to:

- **Prioritized Populations;**
- **Medically fragile children;**
- **Breast and Cervical Cancer Treatment program Members;**
- **Members receiving CareAssist assistance due to HIV/AIDS;**
- **Members receiving services for end stage renal disease, prenatal or postpartum care, transplant services, radiation, or chemotherapy services;**
- **Members discharged from the Oregon State Hospital or Medicaid funded residential Behavioral Health programs in the last 12 calendar months; and**
- **Members participating in Oregon's CMS approved 1915 (k) and 1915 (c) programs for individuals who have met institutional level of care requirements in order to access Home and Community- Based Services (HCBS) under these federal authorities. These individuals are at risk of institutionalization or would require services in an institution within 30 days. Institution is defined as Hospital, Nursing Facility or intermediate care facility for individuals with intellectual disabilities.**

A successful Member Transition Plan will result in a seamless transition experience for Members changing CCOs during the Open Enrollment period, with minimal and ideally no disruptions of care.

OHA will inform Applicants, in connection with RFA awards, which of its service areas are likely to be Choice Areas. In light of that information, Applicants are expected to submit an complete Member Transition Plan (not subject to the page limits of this RFA), gain OHA approval of its Plan, and update the Plan as part of negotiation activities, contracting, and Open Enrollment period processes.

2. Plan Contents

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.

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.

WCCCO currently does not have any membership in 2019 to transfer data to another CCO for 1/1/2020. However, WCCCO is dedicated to ensuring a smooth transition for all members by providing continued access to care while a member is transitioning from/to WCCCO to/from another CCO at any point after 1/1/2020. WCCCO will provide medically necessary covered services and care coordination, without delay, during a member's transition. This includes prioritized populations and all members transferring to and from one CCO to another. WCCCO is also dedicated to providing input, followed by compliance with Oregon Health Authority (OHA) ruling on the Transition of Care, determined through the collaboration of the CCO Operations Collaborative Meeting, associated workgroups and ultimately, the final rule from OHA.

(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).

From a data sharing perspective, WCCCO is flexible and has a robust analytics team and software that has the ability to provide reporting to a receiving CCO. As required, through collaboration with the receiving CCO, WCCCO will execute required written and/or legal agreements necessary to transfer data. This is to ensure the protection and safe transmission of Protected Health Information (PHI).

WCCCO is able to pull customized reports and provide historical data for all services provided to WCCCO members. As proposed by OHA to the CCOs in November 2018, as a result of the OHA Transition of Care Survey to CCO, WCCCO is able to provide the requirements outlined below. This would be a starting point in the discussion with the receiving CCO and WCCCO may be able to be adjusted to suit the needs of the receiving CCO. WCCCO will comply with all request from the receiving CCO for complete historical utilization data within 21 calendar days of the member's effective date with the receiving CCO.

Member ID
Member Name
DOB
Address
Phone
ALL diagnosis codes
CPT codes
PCP and treating provider
Claim status (paid/denied CARC code)
Rendering Provider NPI and name
Referring Provider NPI and name
Date of Service
Place of Service
ICD-10 Code
Service code (CPT,HCPC,REV)
Service code description
ED utilization
Hospitalizations
Utilization of behavioral or mental health services
Pharmacy claims data—both via pharmacy claims and PADs
Medical claims—especially for these receiving services for ESRD, transplant services, radiation, chemotherapy services, prenatal or postpartum care
Members receiving CareAssist services and associated covered medications
Recent Dental claims
Existing Authorizations—both physical and pharmacy with the duration of the existing PA, specialist services
Any current authorizations in place by previous CCO
Psychological Trauma History

In addition to the requirements outlined above, WCCCO is able to provide data on non-emergent medical transportation rides and information on members accessing case management services.

WCCCO is able to format the data in other formats, as discussed and agreed upon with the receiving CCO. Some examples are ASCII text file formatted in pipe delimited format, SQL, or Excel.

Transmission of the agreed upon data can be passed to the receiving CCO through an upload to an SFTP server, through secure email or other channels identified by the receiving CCO.

Staffing will be allocated based on the size of the transfer population. However, on all transfer requests, the Medicaid Services Supervisor and Medicaid Services Provider Relations Rep for WCCCO will be direct points of contact for the receiving CCO. Collaborative meetings will include these two participants and other staff, as necessary and defined by the scope of the receiving CCO requests. This includes technical assistance with file transfers or data validation.

(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).

WCCCO will provide the PCP and treating provider information, which will include Behavioral Health home Providers, as outlined in the table in the data sharing section. As desired by the receiving CCO, WCCCO can provide the PCP assignment history as well.

(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).

WCCCO is dedicated to support the continuity of care. Through providing the information outlined in the table the data sharing section, establishing single points of contact and by collaborating on the specific needs of the receiving CCO, WCCCO will support the continuity of care of outgoing members.

(4) 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.

WCCCO's care coordinators, care managers and staff will support outgoing Members and their Providers and will conduct Warn Handoff activities for high-

need Members and priority populations. This member population will be discussed with the receiving CCO, through the collaborative meetings. Meetings will be scheduled on a regular interval to address any concerns or to address any issues prior, during and after the transition.

c. Receiving CCOs with Incoming Members

(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, and distribution.**

WCCCO will request collaborative meetings with the transferring CCO to identify the data capabilities, formats, timelines for transfer and set a meeting schedule that spans beyond the transition period.

WCCCO has a robust analytics team and software that has the ability to load incoming data and transforms it via an automated process to match the file format, naming convention and business logic used in the Analytics Data Warehouse (ADW).

WCCCO has secure processes and IT staff that will securely store data files, perform front-end validation and automatically load the data into our system and ADW. WCCCO has pre-established methods of sharing data with some partners. This transfer would follow current processes and file formats established partners.

(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 be enrolled with the Provider from the Transferring CCO.

WCCCO would request data from the transferring CCO that our analytics team would be able to identify the Member's primary care provider, Behavioral Health Home and any specialty providers. WCCCO would assign members to their current PCP and Behavioral Health home to promote continuity of care.

WCCCO would allow services without referral and authorization for the first 30 days of enrollment for physical and oral health, sixty days for behavioral health or until the enrollee's new provider review's the member's treatment plan, whichever comes first. There will be a 90 days allowance for members who are Medicare and Medicaid Dual Eligible Members.

If a Member is unable to be enrolled with the provider from the transferring CCO, member outreach will be conducted to assist member's selecting a new provider. These members will be identified through analytics reporting.

(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.

WCCCO is dedicated to support Member continuity of care. As outlined in OAR 410-141-3061, WCCCO will waive referral and authorization requests systemically, for the necessary timeframes, based on service type. This will assist in ensuring access to all medically necessary services for members at risk of serious detriment. Additionally, through the data request from the transferring CCO, our analytics team would be able to auto load referral and prior authorization, including prescription medications, for members.

Priority populations will be identified by requesting data on members that are in case management from the transferring CCO. Additionally, our analytics team will identify members in the priority populations and WCCCO care coordinators, case managers, member health advocates and/or health coaches will contact priority population members, based on diagnosis drivers. These calls will assist in identifying the specific member needs and providing for the appropriate care plans to be established, if not already sent by the transferring CCO.

Through the collaboration meeting with the transferring CCO, a request for an in-person or call with the case management team to discuss critical cases would be requested. This meeting would be to discuss specific details of a case that are not in the data or that simply needs to be done with a voice, from one case manager to another that can be lost in an email or in data.

(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.

WCCCO's care coordinators, care managers, member health advocates and/or health coaches will support incoming Members and their Providers and will conduct Warm Handoff activities, in collaboration with the transferring CCO, for high-need Members and priority populations. This member population will be discussed with the transferring CCO, through the collaborative meetings.

Meetings will be scheduled on a regular interval to address any concerns or to address any issues prior, during and after the transition.

The care coordinators, care managers, member health advocates, and/or health coaches will work directly with Members and their Providers to assist in explaining benefits and coverage, assist in provider network navigation and also support for social services and community resources available based on the member's health condition and psychosocial factors.

WCCCO CCO 2.0 DSN Report

This report has been redacted per ORS 192.355(2)