Attachment 2 - Application Checklist

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

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

Attachment 4 - Disclosure Exemption Certificate

Sean Jessup ("Representative"), representing **Eastern Oregon 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

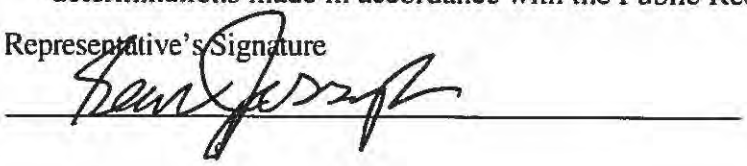


Exhibit A to Attachment 4

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 [X] **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: **1**

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

Response:

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

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

YES [ ] **NO** [X]

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** [X]

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 certificates for both Moda Health Plan and GOBHI 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: **Eastern Oregon Coordinated Care Organization**	RFA: **OHA-4690-19** Project Name: **Coordinated Care Organizations 2.0**

Signature: _____ **Title:** **President** **Date:** **4/18/2019**

(Authorized to Bind Applicant)

Certificate of Completion

The State of Oregon, iLearnOregon - Core Domain, hereby certifies that

Karen Wheeler

Has successfully completed the following:

DAS - CHRO - Overview of Pay Equity

On *3/25/2019*

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.

Eastern Oregon Coordinated Care Organization, LLC has Administrative Services Agreements with two of its members, ODS Community Health, Inc. and Greater Oregon Behavioral Health, Inc. (GOBHI). Additionally, EOCCO contracts with ODS Community Dental, the ultimate controlling parent organization of ODS Community Health, Inc., as one of its Dental Care Organizations.

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 EOCCO does not have an office within the proposed service area we have successfully demonstrated our ability to administer the program from our primary location.

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.

EOCCO's proposed service area includes 12 rural and frontier counties in Eastern Oregon. The proposed service area matches EOCCO's existing service area. Counties include: Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa and Wheeler.

EOCCO has contractual agreements in place with each of the available public health departments within the 12 county service area to provide point of contact services including but not limited to immunizations, disease treatments and family planning services. Additionally, EOCCO contracts with public health departments to provide well child care visits, school based clinic services and other services as they are available. EOCCO also has contractual agreements with each of the community mental health programs that provide services within EOCCO's 12 county service area.

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")?

Yes

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

Not Applicable

(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?

Not Applicable

(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)**

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.

GOBHI currently holds several agreements with the OHA:

- Choice Model Services - OHA #155517
- Early Assessment & Support Alliance - OHA #153236
- Older/Disabled Adult Mental Health Services - OHA #153238
- Rental Assistance Program Services - OHA #153237
- Provider Services Contract – Mental Health Organization - OHA # 132222
- Community Behavioral & Substance Use Disorder Services (Opioid Use Disorder Treatment Services) - OHA #158979
- Non-Emergent Medical Transportation (NEMT) - OHA #155736

EOCCO currently holds a contract with OHA for the Cover All Kids population under contract #156268. EOCCO intends to continue serving the Cover All Kids population as part of CCO 2.0.

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. Moda Health Plan, Inc. has offered Medicare Advantage since 2006. Our contract with CMS is current. Our PPO contract is state-wide. Our HMO contract is limited to the 12 counties in Eastern Oregon that mirror the EOCCO service area.

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

Yes, EOCCO currently has a Coordination of Benefits Agreement (COBA) and coordinates 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, EOCCO 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, EOCCO 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.

EOCCO has experience and capacity for engaging community members and health care providers to improve the health of the communities in a variety of different ways. Below are a number examples of EOCCO's work and demonstrated experiences.

EOCCO's health plan/provider joint equity structure allows for true buy in and engagement in the success of EOCCO beyond just a provider contract. Seven of the largest care delivery systems within our geography are owners in EOCCO and have a vested interest in the success of EOCCO. Additionally, regardless of ownership all 10 hospital delivery systems located within EOCCO's geography participate in EOCCO's Board meetings.

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

EOCCO provides quality measure bonus funding to primary care providers as a tool for incenting providers to continuously improve their performance.

From the community engagement standpoint EOCCO has 12 Local Community Advisory Council's (LCAC), one in each of the 12 counties. The chair of each LCAC along with a County Commissioner or County Judge services on a Regional Community Advisory Council (RCAC). The chair of the RCAC serves on the EOCCO Board.

EOCCO provides annual funding to each of our 12 LCAC's so that they can address challenges identified in each of their community health improvement plans.

EOCCO has significant data and analytics capacity and regularly provides cost/utilization reports, incentive measure performance reports and produces other ad hoc reports as needed. EOCCO's reporting gives 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 EOCCO's communities. For example, EOCCO provides 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 is then used to inform the development of the Community Health Improvement plan in each of EOCCO's 12 counties.

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

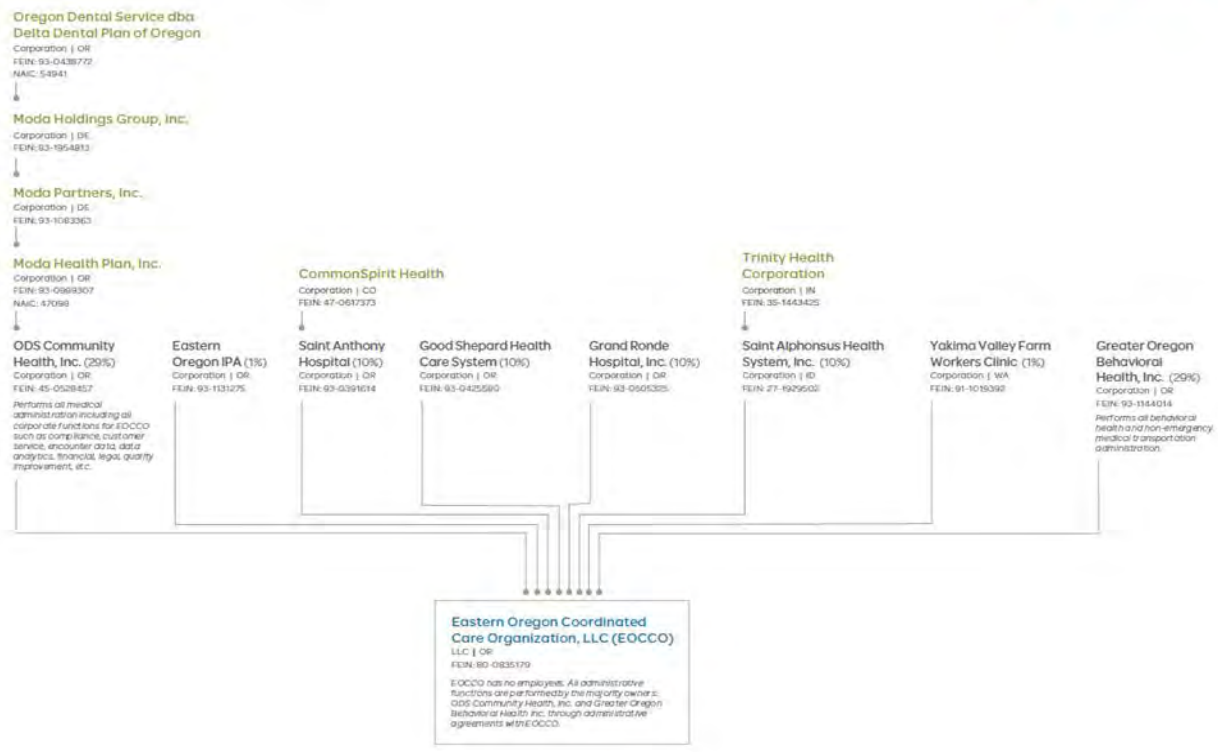
1. Questions

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 EOCCO 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.

EXHIBIT A: Organization chart



c. Describe any licenses the corporation possesses.

EOCCO holds a current CCO contract with the OHA. EOCCO holds no other 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.

EOCCO is not a provider or recipient of services under administrative or management service agreements with unrelated third parties. EOCCO has administrative service agreements with two of its members, ODS Community Health, Inc. and Greater Oregon Behavioral 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.

EOCCO administrative functions are provided by EOCCO affiliates/equity partner's ODS Community Health, Inc. (ODSCH) and Greater Oregon Behavioral Health Inc. (GOBHI) through administrative services agreements with EOCCO.

ODSCH performs all medical administration including all corporate functions for EOCCO such as compliance, customer service, encounter data, data analytics, actuarial, financial, legal, quality improvement, etc. Under this arrangement, EOCCO paid ODSCH $19.8m and $21.6m in 2018 and 2017, respectively.

GOBHI provides all behavioral health and non-emergency medical transportation administration. Under this arrangement, EOCCO paid GOBHI $3.3m in 2018 and 2017.

Compensation for service is based on the administrative fees calculated and paid to EOCCO by OHA for the services provided by ODSCH and GOBHI respectively.

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.**

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.

EOCCO has historically met minimum financial requirements for restricted reserves and net worth. During 2018, EOCCO increased its reserves and continues to assess requirements monthly.

D. Subcontracts

1. Informational Questions

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

EOCCO will enter into an administrative services agreement with ODS Community Health, Inc. and Greater Oregon Behavioral Health, Inc. pursuant to which ODS Community Health, Inc. and Greater Oregon Behavioral Health, Inc. will provide personnel and services to allow EOCCO to fulfill its responsibilities as a coordinated care organization, including, without limitation, administrative functions, healthcare services, operations, financial services and

regulatory/compliance functions. GOBHI will provide all behavioral health and non-emergency medical transportation administration.

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)

EOCCO 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, EOCCO utilizes multiple methods to identify third party liability (TPL) information. One method is extracting the TPL data provided on the 834 enrollment files. Also, TPL information is self-reported from members and/or providers via phone, email, fax or in writing. An example of this is during a pre-authorization request where a provider sends in chart notes, faxed to EOCCO. Providers also notify EOCCO via claims submission, of member TPL information. Additionally, EOCCO utilizes a coordination of benefits data mining vendor, which match our current EOCCO 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. EOCCO has established review protocol where the subrogation department will review coordination of benefits or request additional information related to the claim. We notify providers in writing who improperly bill EOCCO before the appropriate TPL source.

EOCCO has 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, EOCCO utilizes 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.

EOCCO is a manager-managed limited liability company who's Board of Directors (Board) functions as the manager of the company. The Board is currently comprised of 16 directors. Each member listed on the organizational chart provided in response to Section B (1)(b) above appoints one Board member for a total of eight directors. An additional director is appointed collectively by the small hospitals which are not members of EOCCO but that have contracts with it which includes Morrow County Health District, Wallowa Memorial Hospital, Lake District Hospital, Blue Mountain Hospital District, and Harney District Hospital. The 12 counties which are served by EOCCO but which counties do not have a member also collectively appoint one director. The remaining five or more directors are elected by the Board as follows: two health care providers in active practice, one of whose area of practice is primary care; one mental health or chemical dependency provider; at least one person from the community advisory council, and at least two people from the community at large. The Board will elect additional directors as necessary to meet the requirements of ORS 414.625, as amended from time to time. All decisions regarding the management of EOCCO are made by the Board of Directors.

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

<u>Clinical Advisory Panel</u>

- Composition: 10 members including primary care providers, behaviorists, nurses, public health representatives, and dentists.
- Reporting relationships and responsibilities: Reports directly to the Board. Serves as a clinical matters advisory group to the EOCCO Medical Director and helps evaluate new clinical strategies directed at achieving the Triple Aim, including provision of stewardship of EOCCO delivery system transformation; monitoring implementation and performance of EOCCO risk contracts; providing monthly provider progress reports and monitoring incentive measure performance; annually proposing a Quality Bonus Payment formula to the Board; serving as a "Delivery System Review Group" (including reviewing EOCCO's Physical/Behavioral/Dental care integration progress, EOCCO claims and clinical policies, and EOCCO clinical decision tool utilization); and annually producing an Office Staff and Provider Summit.
- Oversight responsibility: Chaired by EOCCO Contract Medical Director who prepares a summary of each Panel meeting for the Board. The Board is responsible for final decisions on Panel recommendations.
- Monitoring activities: Monitored by EOCCO Medical Directors, EOCCO Clinical Consultant, EOCCO President, and the EOCCO Board.
- Other activities performed: As determined from time to time by the EOCCO Medical Director.

<u>Grant Subcommittee</u>

- Composition: Five members (Clinical consultant, GOBHI representative, and three Board members and three staff (President, two ORPRN staff).

- Reporting relationships and responsibilities: EOCCO contracts with the Oregon Rural Practice-based Research Network (ORPRN) to prepare requests for grant proposals, independently evaluate proposals, and submit funding recommendations. The Subcommittee then reviews those recommendations, amends them as appropriate, and then submits the recommendations to the Board for approval.
- Oversight responsibility: The Board is responsible for the final grant determinations. The Board is supplied a summary of each Subcommittee meeting.
- Monitoring activities: The Board is supplied a summary of each Subcommittee meeting. Grant recipients must file interim and final project reports. Yearend summaries are provided to the Board by ORPRN staff. Monitored by the EOCCO Clinical Consultant, EOCCO President, and the Board.
- Other activities performed: Each year, the Subcommittee is responsible for determining categories for proposals and for proposing new projects to the Board for approval (for example, the New Ideas fund and the Public Health Fund)

Risk Contract Surplus/Incentive Measures Settlement Distribution Subcommittee

- Composition: Seven members (five Board members, Clinical Consultant, President).
- Reporting relationships and responsibilities: Reports directly to the Board. Responsible for submitting recommendations for distribution of risk contract surpluses (within parameters of contract) and incentive measures settlement to the Board for approval.
- Oversight responsibility: The Board is responsible for final distribution decisions.
- Monitoring activities: The Board is supplied a summary of each Subcommittee meeting. Monitored by the EOCCO Clinical Consultant, EOCCO President, and the Board.
- Other activities performed: The Subcommittee has recently been involved in developing performance- and risk-based modifications to the EOCCO enhanced PCPCH payment program, the 2019 dental utilization and quality contract, and the EOCCO Public Health Fund and will soon begin discussion on performance-based hospital payments.

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

The EOCCO Board appoints a Regional Community Advisory Council (RCAC) with representation from each of the 12 Local Community Advisory Councils (LCAC). The RCAC oversees and coordinates LCAC activities including the Community Health Assessments, Community Health Improvement Plans, and preventive care activities.

The RCAC is composed of two members from each LCAC, including the Chair from each LCAC who serves as a voting member of the RCAC and a county government representative (elected, appointed, or employee). The chair of the RCAC is a voting member on the EOCCO Board.

LCACs 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. Each County Commission reviews all applications and nominates members of the LCAC, including members from county government.

The RCAC produces an annual report on EOCCO's progress with Community Health Improvement and presents the report to the EOCCO Board.

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

Subcontractor/Affiliate Name	**Tax ID #** **(SSN/FEIN)**	**Correspondence Addres** *Street Address / P.O. Box*
ODS Community Health	45-0528457	601 SW 2nd Ave.
Greater Oregon Behavioral Health Inc.	93-1144014	401 E. 3rd Street, Suite 101
ODS Community Dental	93-0438772	601 SW 2nd Ave.
Advantage Dental	93-1195386	442 SW Umatilla Ave, Ste 200

Eastern Oregon IPA	93-1131275	1100 Southgate Suite 13
EviCore Healthcare	14-1831391	400 Buckwalter Place Blvd
MedImpact Healthcare System Inc.	33-0567651	10181 Scripps Gateway Ct.
Magellan Rx Management	02-0676924	6870 Shadowridge Drive, Ste. 111

CCO Name: EOCCO

Reporting
2019 **Quarter** 1

ss				Subcontractor/Affiliate Physical Address			
City	*State*	*Zip*	*Country*	*Street Address*	*City*	*State*	*Zip*
Portland	OR	97204	USA	601 SW 2nd Ave.	Portland	OR	97204
The Dalles	OR	97058	USA	401 E. 3rd Street, Suite 101	The Dalles	OR	97058
Portland	OR	97204	USA	601 SW 2nd Ave.	Portland	OR	97204
Redmond	OR	97756	USA	442 SW Umatilla Ave, Ste 200	Redmond	OR	97756

Pendleton	OR	97801	USA	1100 Southgate Suite 13	Pendleton	OR	97801
Bluffton	SC	29910	USA	400 Buckwalter Place Blvd	Bluffton	SC	29910
San Diego	CA	92131	USA	10181 Scripps Gateway Ct.	San Diego	CA	92131
Orlando	FL	32812	USA	8621 Robert Fulton Drive	Columbia	MD	21046

Country	**Parent Company Name** *(if applicable)*	*State*	*Country*	**Service Type(s)**
USA	Moda Health	OR	USA	Medical
USA	NA	OR	USA	Behavioral Health
USA	Oregon Dental Services	OR	USA	Dental
USA	Advantage Community Holding Company, LLC	OR	USA	Dental

USA	NA	NA	NA	NA
USA	Cigna Corporation	CT	USA	High Tech Imaging
USA	NA	NA	NA	Pharmacy
USA	Magellan Pharmacy Services, Inc.	FL	USA	Dialysis

Subcontractor/Affiliate Owner(s) Business Name or Individual's Last Name	**Subcontractor/Affiliate Owner(s) Individual's First Name** *(if applicable)*	**Percent Ownership**	**Payment Methodology**
Moda Health	NA	100	100% of Admin Fee related to contracted services
Greater Oregon Behavioral Health	NA	100	100 % of Admin Fee related to contracted services
Oregon Dental Services	NA	100	PMPM
Advantage Consolidated, LLC DentaQuest, LLC	NA	20 80	PMPM

Eastern Oregon IPA	NA	100	PMPM
Cigna Corporation	NA	100	PMPM
MedImpact Healthcare System Inc.	NA	100	Flat fee per claim
Magellan Health	NA	100	PMPM

Payment Methodology: Other	Subcontract Begin Date			Subcontract End Date			Date of most recent Compliance Review
	Month	Day	Year	Month	Day	Year	
	September	1	2012	NA	NA	NA	April, 2018
	September	1	2012	NA	NA	NA	April, 2018
	September	1	2012	NA	NA	NA	April, 2018
	September	1	2012	NA	NA	NA	April, 2018

	November	1	2012	NA	NA	NA	April, 2018
	April	1	2017	NA	NA	NA	January, 2019
	September	1	2012	NA	NA	NA	December, 2018
	June	1	2013	NA	NA	NA	December, 2018

Downstream Delegation of Services	Describe the work being Subcontracted or Delegated
NA	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.
	Behavioral health claims administration, behavioral health customer service, behavioral health utilization and case management and provider network management. Non-emergent medical transportation.
NA	Oral health claims administration, customer service, provider network management and credentialing.
NA	Oral health claims administration, customer service, provider network management and credentialing.

NA	Case management, authorization and referral management for EOCCO member with EOIPA PCP's.
NA	High tech imaging utilization management.
NA	Pharmacy point of sale prescription processing.
NA	Kidney dialysis management.

CERTIFICATE

State of Oregon

OFFICE OF THE SECRETARY OF STATE
Corporation Division

I, KATE BROWN, Secretary of State of Oregon, and Custodian of the Seal of said State, do hereby certify:

That the attached copy of the
Articles of Organization
filed on
May 11, 2012
for
EASTERN OREGON COORDINATED CARE ORGANIZATION, LLC
is a true copy of the original document that has been filed with this office.

In Testimony Whereof, I have hereunto set my hand and affixed hereto the Seal of the State of Oregon.

KATE BROWN, Secretary of State

May 11, 2012

FILED

MAY 11 2012

OREGON
SECRETARY OF STATE

ARTICLES OF ORGANIZATION

OF

EASTERN OREGON COORDINATED CARE ORGANIZATION, LLC

ARTICLE 1
Name

The name of the limited liability company is Eastern Oregon Coordinated Care Organization, LLC (the "**Company**").

ARTICLE 2
Management

The Company is a manager-managed limited liability company.

ARTICLE 3

The initial members of the Company, each holding an equal interest therein, are ODS Community Health, Inc. and Greater Oregon Behavioral Health, Inc.

ARTICLE 4
Registered Office and Registered Agent

The address of the Company's initial registered office and the name of the Company's initial registered agent at that office is:

SW&W Legal Services, Inc.
Attn: Kelly T. Hagan
1211 SW Fifth Avenue, Suite 1500-2000
Portland, OR 97204

ARTICLE 5
Mailing Address for Notices

The mailing address to which notices may be mailed is:

SW&W Legal Services, Inc.
Attn: Kelly T. Hagan
1211 SW Fifth Avenue, Suite 1500-2000
Portland, OR 97204

EASTERN OREGON COORDINATED CARE

ARTICLE 6
Organizer

The name and address of the organizer is:

Kelly T. Hagan
Schwabe, Williamson, & Wyatt, PC
1211 SW Fifth Avenue, Suite 1500-2000
Portland, OR 97204

ARTICLE 7
Existence

The existence of the Company is perpetual.

Dated: May 11, 2012

Organizer:

Kelly T. Hagan

Person to contact about this filing: Kelly T. Hagan
Daytime phone number: 503-222-9981

Biographical Resumes

Chief Executive Officer

Kevin Campbell, Chief Executive Officer
kevin.campbell@gobhi.net
541.298.2101

Since 2001, Kevin has been the CEO of Greater Oregon Behavioral Health, Inc. (GOBHI) a member-owned benefits management company (501(c)(3) dedicated to assuring the delivery of high quality behavioral health services in rural Oregon. GOBHI is also a licensed child placing agency and operates more than 30 therapeutic foster homes throughout rural Oregon. Kevin is also the CEO of the Eastern Oregon Coordinated Care Organization, in which GOBHI is a majority owner.

Having worked since 1995 in a leadership position of rural behavioral health, Kevin is very familiar with what the impact of the social determinants of health has on the cost of healthcare. He serves as a member of the Board of Directors of the National Council for Behavioral Health, the oldest and largest national community behavioral healthcare advocacy organization in the country.

A native Oregonian, Kevin is a University of Portland graduate, former County Judge and is the owner of a fourth generation, family owned, cattle ranch in the John Day River Valley.

President

Sean Jessup, President (EOCCO) / 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.

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

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.

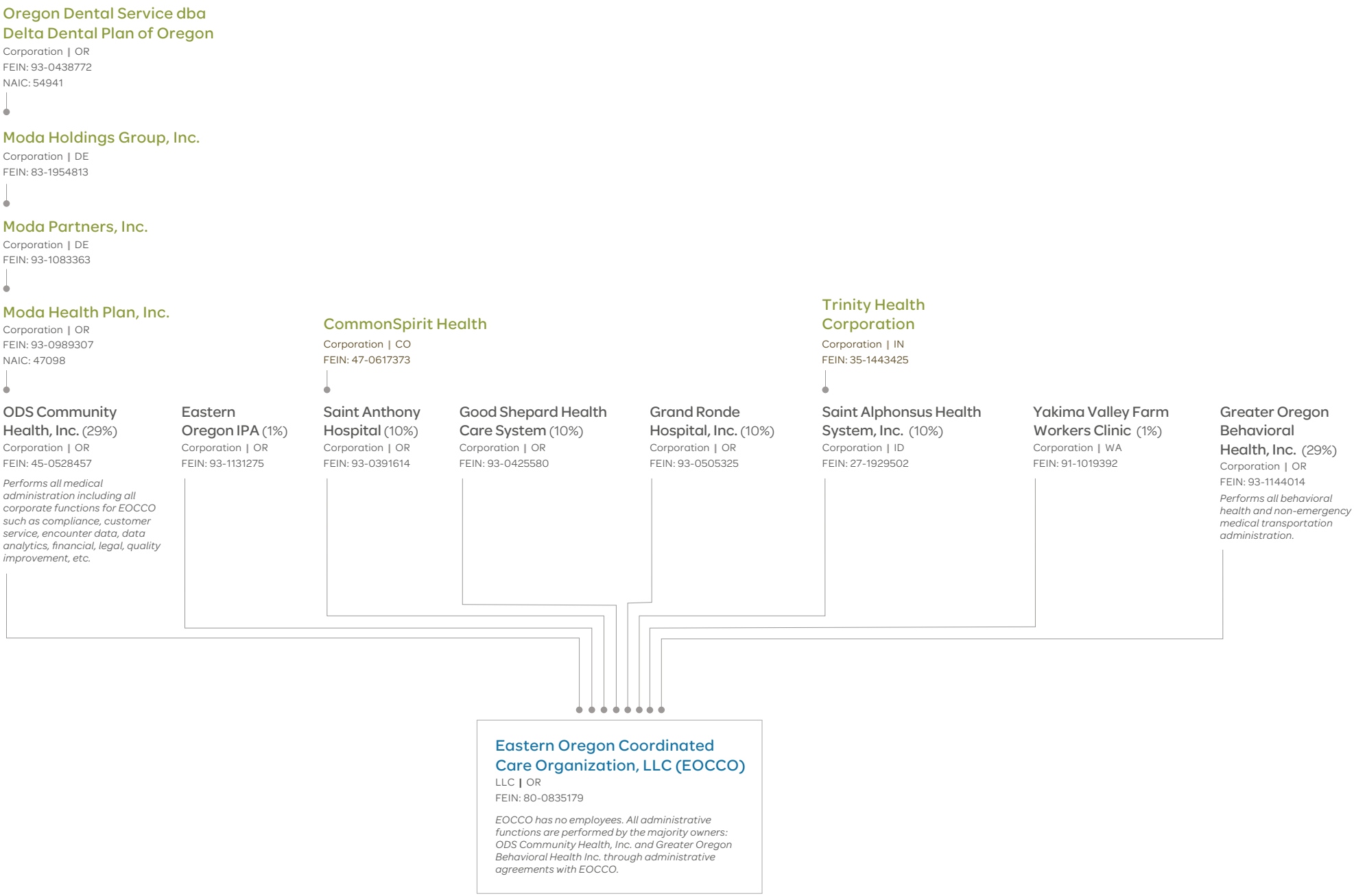
Prior to joining Moda Health in 1998, Robin served as Executive Director of the National Home Infusion Association based in Alexandria, Virginia. Prior to that he served as Vice President for Home Health Care and Institutional Services for the National Community Pharmacists Association also based in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

EXHIBIT A: Organization chart



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.

Greater Oregon Behavioral Health Inc. (GOBHI) - Behavioral health claims administration, behavioral health customer service, behavioral health utilization and case management and provider network management. Non-emergent medical transportation.

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

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

Eastern Oregon IPA - Case management, authorization and referral management for EOCCO member with EOIPA PCPs.

Evicore - High tech imaging utilization management.

MedImpact - Pharmacy point of sale prescription processing.

Magellan - Dialysis management.

The EOCCO's Compliance Officer or delegated staff will monitor and audit EOCCO'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 EOCCO. 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 EOCCO 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

Eastern Oregon 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

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.

EOCCO (Eastern Oregon Coordinated Care Organization) has a diverse ownership structure that includes a number of providers and hospital systems that deliver quality care for OHP members living in the EOCCO service area. EOCCO works with local hospitals, providers, public health, county governments and other community partners to achieve the Triple Aim for EOCCO members.

EOCCO owners include: Greater Oregon Behavioral Health, Inc. (GOBHI), ODS Community Health, Inc. (Moda Health), Good Shepherd Health Care System, Grand Ronde Hospital, Inc., Saint Alphonsus Health System, Inc., St. Anthony Hospital, Eastern Oregon IPA (Independent Physicians Association), and Yakima Valley Farm Workers Clinic.

The EOCCO Board of Directors includes each of our owners along with individuals from the community at large, including county commissioners, public health representation, physical and behavioral health provider representatives as well as a member of our Regional Community Advisory Council (RCAC).

(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.

EOCCO supports 12 LCACs and one RCAC, each representing a broad set of stakeholders including local government, public health, OHP members, and health and human service focused non-profit organizations dedicated to meeting the social, educational, and cultural needs for people of all ages and backgrounds in the region. The selection process is defined in the LCAC Charter posted on our website. There is an application form that interested parties can fill out, then the form is sent to the County Commissioner or Court for review and approval. The names are submitted annually to the EOCCO Board of Directors for final approval of CAC membership.

(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 Chairperson of the RCAC is appointed to be a member of the EOCCO Board of Directors. Recommendations from the RCAC are included in an Annual Report submitted to the EOCCO

Board. The report is presented by the RCAC Chair and items are discussed openly at a Board meeting where many of the recommendations are addressed. This method proves useful to make certain CAC ideas and suggestions are heard.

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

The EOCCO has a dedicated position on the Board of Directors for the Chair of the RCAC. This person is selected by the RCAC and represents the interests of all twelve counties. LCACs are comprised of a combination of OHP consumers and people representing various social, health and human service organizations. Members receiving DHS Medicaid-funded care are represented through the EOCCO governance structure. GOBHI, on behalf of EOCCO also facilitates a 9-member Consumer Caucus made up entirely of member receiving DHS Medicaid funds. Some of the member has been diagnosed with a severe and persistent mental illness, have spent time in LTC services, and a number have also worked as peer support specialists. One of the Consumer Caucus members also serves on the GOBHI Quality improvement Committee (QIC). Two of the Consumer Caucus members serve on the GOBHI Board of Directors. Both of these individuals are very involved, engaged, and bring the Member's voice into all QIC and Board discussions.

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.

Role: The EOCCO Clinical Advisory Panel (CAP) reports directly to the Board and serves as a clinical advisory group led by EOCCO'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 EOCCO delivery system transformation; monitoring implementation and performance of EOCCO 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 EOCCO's Physical/Behavioral/Dental care integration progress, EOCCO claims and clinical policies, and EOCCO clinical decision tool utilization); and annually producing a Clinician Summit.

Relationship to the CCO governance and organizational structure:The CAP is currently chaired by the EOCCO Contract Medical Director who prepares a summary of each CAP meeting for the Board. The Board is responsible for final decisions on CAP recommendations. It is monitored by the EOCCO Medical Director, the EOCCO Clinical Consultant, the EOCCO President, and the EOCCO Board. Additional activities are determined by the EOCCO Medical Director.

The EOCCO Board appointed an 8 member provider steering committee chaired by the EOCCO Clinical Consultant in February of 2013 and tasked it with assessing several clinical issues facing

EOCCO, including incenting PCPCH certification, possible alternative primary care payment methodologies, funding LCACs, and others. The steering committee presented its report to the board in April of 2013, which included a recommendation for EOCCO to create a Clinical Advisory Panel. EOCCO's Medical Director and Clinical Consultant developed a draft CAP Charter which was subsequently approved by the Board several months later. EOCCO provider interest was solicited, the board appointed CAP members, and the CAP met for the first time on May 28, 2014. Since that time, the CAP has met every other month and has been responsible for ensuring the healthcare transformation of EOCCO is influenced by a clinical perspective.

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

N/A

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.

EOCCO has MOUs with the DHS offices within our service area. EOCCO also has Collaborative and Multidisciplinary Teams (MDT) that are designed to meet the needs of EOCCO Members with extreme complex care coordination needs. EOCCO care management leadership meets with the APD leaders in each of the EOCCO counties. This collaboration between EOCCO and APD is outlined in the Memorandum of Understandings. Members can be referred to MDT by EOCCO employees, APD employees, or any member of the medical community such as physicians, nurses, DC planners and community health workers.

Once referred, the MDT access current documentation relating to the patient and collaborate the interventions that have already been completed for a member. The collaboration at this level reduces 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 EOCCO Collaborative and MDT have many specific goals. They include:

- Improving HIPAA related compliance by only discussing EOCCO 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

EOCCO has three MDTs based on service area:

- UMMDT = Umatilla & Morrow Counties
- East6MDT = Baker, Harney, Grant, Malheur, Union & Wallowa Counties
- West4MDT = Gilliam, Wheeler, Sherman & Lake Counties

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

N/A

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.

EOCCO has executed MOUs under CCO 1.0 with both the Local Mental Health Authorities and contractual agreements with local Community Mental Health Programs in each county served. MOUs are in place with the following CMHPs: New Directions Northwest service Baker County; Wallowa Valley Center for Wellness serving Wallowa County; Center for Human Development serving Union County; Lifeways serving Umatilla and Malheur Counties; Community Counseling Solutions serving Grant, Gilliam, Morrow and Wheeler Counties; The Center for Living serving Sherman County; and Symmetry Care serving Harney County and Lake Health District. EOCCO plans to continue these MOUs under CCO 2.0.

(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).

In order to facilitate the Behavioral Health Plan, and outline shared goals commensurate with CCO 2.0, MOUs will be reviewed and amended after initiation of the new contract. Since we have executed MOUs and contracts in place we do not anticipate difficulties amending these agreements, other than the volume (12) and timing given Board actions needed.

(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**

EOCCO works closely with community partners utilizing a number of different relationships, both formal and informal. Contracts are 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. GOBHI, on behalf of EOCCO, created the Oregon Center on Behavioral Health and Justice Integration with funding from OHA to assist jurisdictions across the state. The goal was to implement and improve systemic and programmatic efforts in the treatment of individuals with serious behavioral health needs who come into contact with the justice system, while ensuring accountability and safety. The Center provides information, training, and technical assistance to behavioral health and justice partners working closely with Local Public Safety Coordinating Councils (LPSCC).

Through our Community Benefit Initiative Reinvestments (CBIR) program, we have established long standing relationships with multiple community organizations. These organizations are able to identify projects and programs that will impact the Triple Aim. Through our funding support, they are able to 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.

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

Within the member mailing included are, 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.

EOCCO promotes the engagement and activation of Members through various channels, including the LCACs, focus groups, a consumer caucus and health fairs. For example, when developing a campaign to address colorectal cancer screening within our service area, we, along with our community partners, conducted various focus groups to determine barriers to receiving a CRC screening as well as recommendations for methods Members would be willing to participate in to complete their screening. These findings were utilized to determine a plan to address CRC screening.

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.**

EOCCO has many mechanisms, 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. EOCCO also attends health fairs to engage members and provide educational resources.
- New Member packets 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 are then used to determine if a Member is eligible for Health Coaching services. The HRAs are available in both English and Spanish.
- A variety of EOCCO specialized programs engage members during certain episodes of care. One 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, EOCCO's reinsurance partner. EOCCO

identifies 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 EOCCO informed along the way. For babies born at 34 weeks and under, EOCCO refers them to the Rosebud program's neonatal team while the baby is in the hospital and after discharge.

- Members are also 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 is extended to all Members, not just those accessing services, but in addition, we 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.
- EOCCO and providers have developed collaborative teams with the communities in the twelve county service area. These teams incorporate Traditional Health Workers, community partners and providers.
- Quality Improvement Specialists interact directly with the CAC, providing data regarding progress toward incentive measures. These conversations then provide the opportunity for ideating member engagement solutions focused on enhancing member engagement and incentive results.
- EOCCO has also offered funds through the 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.

In the EOCCO service area, there are currently 57 widely dispersed clinics and individual practices. Of the 57 clinics, 24 are Rural Health Clinics and 7 are Federally Qualified Health Centers. Today, 91% of members are assigned to a PCPCH with a tier level designation of three

or higher. Of the 57 clinics, 42 are PCPCH certified as of February 2019. EOCCO continues to provide financial incentives for providers to obtain PCPCH certification and for providers to maintain and increase their tier level of certification.

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

EOCCO utilizes a transition of care model that ensures members are identified at admission to LTC providers. This is 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 is sent to Case Management. At that point, notification is provided to the appropriate county APD office and the regional MDT (Multidisciplinary Team). This allows 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 the rural and frontier nature of our service area, 54% of our clinics are certified FQHC, RHCs, SBHCs, migrant health clinics or safety net providers. All of the FQHC and RHCs in our services area are PCPCH certified and contracted with EOCCO. These PCPCH clinics play a crucial role in providing access to the Medicaid membership in Eastern Oregon. In some counties throughout the EOCCO service area, the only provider in the county is an FQHC, RHC, SBHC, migrant health clinic or safety net provider.

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.

EOCCO regularly performs detailed, formal assessments of the adequacy of its EOCCO network against rigorous standards that exceed regulatory requirements. Bi-annually, EOCCO assesses more than 50 specialties in every county in the service area to ensure Members have sufficient provider access. On a bi-annual basis we 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 EOCCO 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 is 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.

EOCCO and its subcontractors 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. EOCCO utilizes reports to analyze the ratio of Members to Providers. We also 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 are based on data obtained during delivery service network assessment.

EOCCO continuously communicates with Providers to ensure the appropriate Member assignment. The communication includes 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).

EOCCO continues to provide financial incentives for Providers to obtain PCPCH certification

and for Providers to maintain and increase their tier level of certification. The financial incentives include an enhanced per Member per month case management payment that increases with tier level. Additionally, EOCCO's Clinical Consultant is available to provide one-on-one training to provider practices seeking initial certification or higher levels of certification on an as needed basis.

EOCCO's primary goal moving forward is 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.

EOCCO uses 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 EOCCO’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 recredentialing of Practitioners and Facilities, EOCCO requests 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?

As defined in the Quality Improvement Work Plan, the Quality Improvement Committee periodically analyzes the following data and refers any identified access issues to the Credentialing Committee for consideration and action:

- 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.

EOCCO has placed telehealth equipment in all 12 of the EOCCO counties. The equipment was used by the county CMHPs to hold video visits with therapists, conduct telehealth visits, and provide access to specialists in other locations.

Also, EOCCO pursues 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 counties. Members are 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, EOCCO and its Provider partners allow the referral of an EOCCO Member to a non-contracted provider for needed care.

Due to the rural nature of the EOCCO service area, EOCCO also contracts with providers in Idaho and Washington and in larger communities throughout Oregon to ensure timely access to medically appropriate covered services for Members.

(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.

EOCCO uses a variety of mechanisms to monitor access and access to EOCCO 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.

- An EOCCO Provider credentialing representative conducts 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.

EOCCO notifies Providers of the primary care and behavioral health access standards in respective Provider manuals. Delegated dental plans communicate EOCCO access standards in their respective Provider manuals.

Additionally, data is collected quarterly from contracted Providers related to wait times. Templates are 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 presented to the EOCCO 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.

EOCCO has contracts with two DCO entities in Eastern Oregon. In the contract, we require Providers to notify us of any change to the Provider network. DCO capacity is monitored monthly and EOCCO sends reports to the DCO partners to ensure proper capacity and to check for any updates. Additionally, not all dental services are available locally for members who reside in rural 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, EOCCO and its provider partners allow the referral of an EOCCO member to a non-contracted Provider for needed care.

Due to the rural nature of the EOCCO service area, EOCCO also contracts with providers in Idaho and Washington and in larger communities throughout Oregon to ensure timely access to medically appropriate covered services for members.

EOCCO 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, EOCCO will request that the delegate conduct a practitioner office site survey. The delegate has the option to use EOCCO's practitioner office site survey tool.

EOCCO measures the accses 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 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, EOCCO and its provider partners allow the referral of an EOCCO Member to a non-contracted Provider for needed care.

Due to the rural nature of the EOCCO service area, EOCCO also contracts with providers in Idaho and Washington and in larger communities throughout Oregon to ensure timely access to medically appropriate covered services for members.

EOCCO previously provided funding to attempt to recruit providers to rural Oregon. Through the reimbursement of THW's, EOCCO is attempting to help with workforce however, there is still a lack and/or shortage of providers in Eastern Oregon. EOCCO is dedicated to continue to assist in the recruitment and retention of the rural workforce.

b. Requested Documents

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

Please see the CCO 2.0 EOCCO 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 EOCCO'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.

The largest number of EOCCO grievances are related to access issues. EOCCO's coverage area is located in rural and frontier counties in Eastern Oregon (Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa and Wheeler). It is a constant challenge to provide access in these counties and members may have to travel to appointments or wait to see providers. Access issues are resolved by changing the Member's PCPCH, changing the DCO, and providing Member education about their provider/CCO/DCO/NEMT options.

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

EOCCO contracts with every major hospital and clinic system in Eastern Oregon. We proactively extend contracts to any provider within 75 miles of our service area. EOCCO is also working to increase home nursing visits through the local health departments to improve access to services.

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

To provide additional solutions for these access challenges, EOCCO applied for and received 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. This new program just began implementation in November 2018, and will be monitored for enhanced access, member satisfaction and effect on NEMT service needs.

Beginning in 2019, EOCCO will begin to use a defined trigger to review situations where there are 10 or more appeals received in any service type where 40% or more of these appeals are overturned. Another trigger point will be a spike in the number of appeals for a specific service time over the last 12 months. EOCCO will assess the reason for the overturns and adjust procedures as necessary to increase efficiency.

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 are 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 EOCCO policies and procedures to determine medical necessity. Medical Necessity Criteria is 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 are made by a Physician Reviewer prior to the delivery of a Notice of Action Adverse Benefit Determination (NOABD). NOABD notification letters are formatted and pre-approved by the Oregon Health Authority to meet state, federal and NCQA guidelines. NOABD notifications are 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.

Since the inception of the CCO model, EOCCO has accepted the challenge of integrating behavioral health and addictions services with and between multiple agencies and funding streams in the EOCCO area. EOCCO is cognizant of the need to support the flow of information between all of the human service providers in our region and has made extraordinary progress in this regard. Through the Choice Model, EOCCO monitors, coordinates and informs partners, as related to all admissions and transitions between levels of care, including OSH. EOCCO communicates discharge planning from day one. Through the MDT, EOCCO meets with ADP six times each month through regional MDTs. EOCCO and its providers utilize EDIE/PreManage to track clients at all levels and each CMHP has access to EDIE/PreManage.

EOCCO has 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 and will look to expand this in CCO 2.0.

(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.

EOCCO has support staff who engage in community partnerships throughout the region. We have strong partnerships with CMHPs, 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 have invested in prevention activities in each community through the CACs. 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 have invested 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, EOCCO provides a vendor contract to all providers for translation services.

The Care Coordination program is built on the National Standards of Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. We have a strong cultural and linguistic training program for our provider network. We provide ongoing support for any questions around cultural and linguistic concerns providers may have. We are developing 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.

EOCCO 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.

We have dedicated staff who promote the use of EDIE/PreManage by providing training, technical assistance and best practice examples to our providers. All CMHP's are 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, EOCCO care managers 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, EOCCO provides 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.

EOCCO identifies 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, EOCCO assigns the Member to an ICC professional who collaborates and coordinates with the Member's care givers to assure Member's needs are addressed.

The EOCCO ICC professional acts 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 occurs through referrals, which are then followed-up to assure services were delivered and the Member's needs were met. If needed, the EOCCO 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.

Since 2014 EOCCO has implemented a fidelity based Wraparound model in all 12 counties in Eastern Oregon. Included in this model are arrangements for services for ICC youth who decline or who do not meet criteria for Wraparound. Given that our 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. Eastern Oregon's Children's System of Care is extremely fine-tuned and geared toward collaboration. PCPCH's are well informed of the ICC process and with consent from the youth and family, will be included on each individual's Child and Family Team.

In regards to Community Developmental Disabilities Programs, GOBHI, on behalf of EOCCO, merged Eastern Oregon Disabilities Program with the Applied Behavioral Analysis (ABA) program last July, which has allowed us to work closely with local Community Developmental Disabilities Programs by utilizing our Family Advocates. Family Advocates have many years of experience working in collaboration with local Community Developmental Disability Programs, as well as statewide partners in the DD system. During the ICC process, staff develop specific plans to assist parents and children with behavioral issues and other stressors on the family, with the goals of integrating all facets of treatment and decreasing emergency room visits and out-of-home placements. Family Advocates provide parents Oregon Intervention System training in Positive Behavior Support and crisis intervention approaches, provide additional parent education, in-home behavioral consultation, and provide connections to local resources as system navigators.

Through this program addition, we have the ability to train and provide in home services to youth and families experiencing both I/DD and MH, thus decreasing the bifurcated system separating DD and MH, and advancing the goal of having a single youth and family plan with shared meetings and supported interventions. The Therapeutic Foster Care program has historically and currently is serving multiple youth that qualify for DD services. Placing I/DD youth in our program provides the ability to work within systems to reduce the impact of system silos by serving youth regardless of their eligibility criteria. Additionally, we are supporting local DD foster home recruitment by including them in discussions around events and coordination of recruitment activities.

(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, are referred to the EOCCO multi-disciplinary care coordination team (MDT) and are discussed at a bi-weekly meeting until issues are resolved. For many members with SPMI, care coordination is provided by their local CMHP, and EOCCO's role is more supportive than hands-on. Documentation is 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 also 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.

EOCCO's experience in Eastern Oregon has given us 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.

EOCCO funds Traditional Health Worker capacity in the EOCCO region for the purpose of care coordination and to reach underserved populations. Traditional health workers are a valued component of multidisciplinary care teams serving EOCCO members. Behavioral health providers are contracted to provide peer support through Peer Wellness Specialists and Peer Recovery Specialists with each community mental health 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. Some provision of THW services predates Oregon's Coordinated Care movement, particularly in behavioral health; while in physical health settings, significant momentum has been gained through targeted investments by EOCCO in the last three years.

EOCCO has also supported 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.

Since 2014 EOCCO has implemented 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. Given that our 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, and to date EOCCO has seven (7) Family Peer Support Specialists – specialty code (606); and seven (7) Youth Support Specialists – specialty code (607) Peer Delivered Services Policy (300.20.60) states.

Greater Oregon Behavioral Health, Inc. (GOBHI), on behalf of EOCCO, 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.

EOCCO recently implemented 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 have been able to 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.

EOCCO sends members a new member welcome packet, including a member handbook within 14 days of member eligibility with the CCO. In the member handbook, it describes how a member should begin to seek services and select a PCP and how their PCP will help coordinate care. The welcome packet includes a PCP selection card with a self-addressed stamped envelope and other ways to notify EOCCO 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.

Frequently, a provider notifies EOCCO that one of their patients was enrolled with EOCCO through the 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.

EOCCO screens and sends an assessment to those individuals who have been identified as needing intensive care coordination (ICC). The ICC initial assessment is initiated within 30 days of the date a member is identified for ICC and completed within 60 days of that date. EOCCO assigns a care coordinator to engage each member newly identified for ICC. The care coordinator initiates telephonic contact with the member within ten business days of case assignment. The care coordinator makes 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, EOCCO network providers 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. EOCCO arranges for both telephonic and in-person interpreter services at members' medical provider appointments at no cost to the member. EOCCO Member handbooks and participating Provider manuals include instructions on how to request these services. EOCCO has developed 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. EOCCO’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. EOCCO also implemented workplace diversity and cultural competency employee trainings for all new and current staff that are member facing.

EOCCO also provides 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 use this information to assess performance and reach out to patients. EOCCO 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 includes analyzing the utilization of interpreter services and member complaints for language, ethnic, racial and cultural barriers in accessing care. We also

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.

EOCCO is notified of hospital discharges related to diagnosis with high re-admission rates or high needs via EDIE/PreManage. Outreach to these members is completed by an 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.

EOCCO meets biweekly with each county's APD office to discuss transitions of care and complex cases. This is accomplished with our MDT program, and each APD office has the direct contact information for all EOCCO supervisors and coordinators to ensure rapid communication and triaging of needs. A daily email distribution list notifies APD of their members who have transferred to LTC services, and facility contact information is provided to the DT coordinators at transfer. In addition, leadership from physical and behavioral case management and APD offices 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.

EOCCO's tracking system allows for a central location that is able to track member's transition from one care setting to another. Members enrolled in case management are noted within our systems. As members move from one care setting to another these services are also tracked and

noted within our systems, this process is completed for all members. Care Coordinators and case managers meet weekly to discuss members in an inpatient facility. Case managers would engage the member and family as appropriate. Members receive notification of all service approval 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.

The EOCCO ICMs communicate with members and their care givers to discuss enrollee's health concerns, social situations, concerns and questions the enrollee may not always think to discuss with their PCP or Behavioral Health provider. The EOCCO ICM contacts the enrollee's PCP with any concerns and informs 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 can be given to a specialist or supplier. Claims are monitored for activity, and contact with the enrollee is continued until care coordination needs are complete. Care plans are 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 are updated by the ICM and physician or Behavioral Health provider.

ICM's are 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 is then able to coordinate with the PCP or Behavioral Health provider for follow up efforts.

Individual care plans are established for all EOCCO members that are in Complex Case Management. These care plans note that the self-management plan have been discussed with the patient and the date that has been done. It also delineates 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 also includes the desired level of involvement of all parties.

EOCCO monitors 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 EOCCO ICM assists an enrollee in finding care, claims are monitored to see enrollee's visit activity. If there is a discrepancy in the care needs between the

member and the provider, the ICM reaches 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.

EOCCO utilizes 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

EOCCO meets biweekly with each county's APD office to discuss transitions of care and complex cases. This is accomplished with our MDT program, and each APD office has the direct contact information for all EOCCO supervisors and coordinators to ensure rapid communication and triaging of needs. A daily email distribution list notifies APD of their members who have transferred to LTC services, and facility contact information is provided to the MDT coordinators at transfer. In addition, leadership from physical and behavioral case management and APD offices 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.

EOCCO reassesses 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 provide opportunity to coordinate care for those members who are dually eligible. All EOCCO 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. EOCCO Case Management staff work within the same department, in the same location, as the case managers that work on the affiliated Medicare Advantage plan. When an EOCCO 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.

(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 EOCCO 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, EOCCO or family/caregiver referrals.

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

EOCCO Case Manager 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.

EOCCO Case Manager 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.

EOCCO evaluates 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 are 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

EOCCO ensures 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 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 are regularly engaged by various teams in the referral process for coordination needs as well as how to submit PA requests. Member specific discussions are 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, EOCCO makes the process of sharing records efficient to providers and ensures timely communication between clinics/facilities/EOCCO.

(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.

EOCCO provides 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;

EOCCO meets biweekly with each county's APD office to discuss transitions of care and complex cases. This is accomplished with our MDT program, and each APD office has the direct contact information for all EOCCO supervisors and coordinators to ensure rapid communication and triaging of needs. A daily email distribution list notifies APD of their members who have transferred to LTC services, and facility contact information is provided to the DT coordinators

at transfer. In addition, leadership from physical and behavioral case management and APD offices 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;

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

EOCCO is piloting a project that places a local community mental health provider (CMHP) social worker in a PCPCH via tele-health for warm handoffs. This allows the PCPCH staff to immediately connect the Member with the LCSW. The Member, LCSW and PCPCH staff then determine the best next steps to meet the Member's needs. This also provides a natural connection between the CMHP and PCPCH.

EOCCO meets biweekly with each county's APD office to discuss transitions of care and complex cases.

(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.

EOCCO meets biweekly with each county's APD office to discuss transitions of care and complex cases. This is accomplished with our MDT program, and each APD office has the direct contact information for all EOCCO supervisors and coordinators to ensure rapid communication and triaging of needs. A daily email distribution list notifies APD of their members who have transferred to LTC services, and facility contact information is provided to the DT coordinators at transfer. In addition, leadership from physical and behavioral case management and APD offices 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) 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)

EOCCO meets biweekly with each county's APD office to discuss transitions of care and complex cases. This is accomplished with our MDT program, and each APD office has the direct contact information for all EOCCO supervisors and coordinators to ensure rapid communication and triaging of needs. A daily email distribution list notifies APD of their members who have transferred to LTC services, and facility contact information is provided to the DT coordinators at transfer. In addition, leadership from physical and behavioral case management and APD offices 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) 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.

EOCCO is partnering with local public health departments to implement a universal screening and nurse home visiting program for providing in home services for infant and maternal health. EOCCO is also utilizing tele-behavioral health to provide services to Members in their homes or alternative care settings.

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

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

EOCCO and its delegated entities have structured review mechanisms in place to detect and address over-and under-utilization of services. These mechanisms 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 EOCCO 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 discharge
- Monthly 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 EOCCO 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 EOCCO QIC provides oversight to transformation, quality assessment and performance improvement activities to ensure that EOCCO Members receive high quality physical, behavioral and dental services. The committee is 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 EOCCO populations, and to reduce the cost of healthcare. To track the quality measure performance across the CCO, we 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 is available to multiple clinic systems within our service area as well as our CMHPs. Moving forward we plan to continue to

support this HIE as well as increase the number of those who are connected to the platform. This systems allows 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)?

EOCCO equity partners Moda and GOHBI are both NCQA accredited. 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.

GOBHI is an NCQA accredited Managed Behavioral Healthcare Organization (MBHO) and is re-surveyed every 3 years to assure they are meeting national standards. NCQA reviews include a strong focus on Members Rights and Responsibilities, Utilization Management, Complex Case Management, Credentialing and Quality Improvement. GOBHI has continued to achieve high scores within these categories as well as overall.

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

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

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

EOCCO providers are 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 EOCCO Quality Improvement Committee provides 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 EOCCO members and meeting our objectives in the delivery and evaluation of the quality and safety of the care and services provided to EOCCO members.

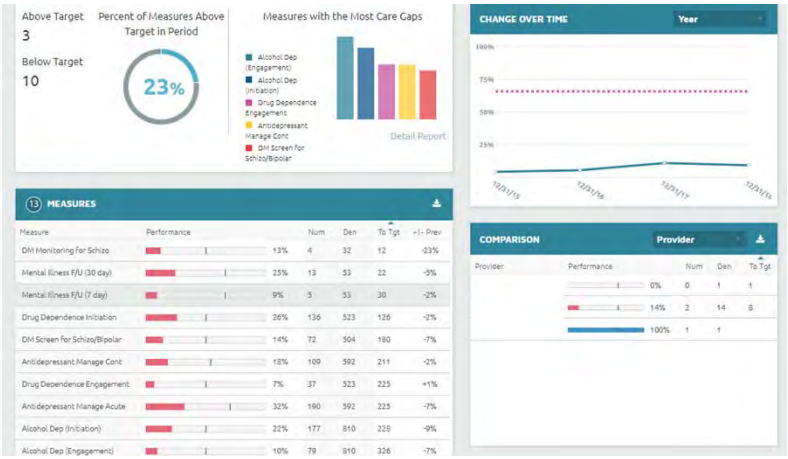
The program encompasses transformation and quality assessment and quality improvement activities for EOCCO. This includes monitoring and evaluating the quality and safety of care and services provided in ambulatory settings, hospitals, residential treatment and skilled nursing facilities; through home 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 EOCCO QIC Committee 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 EOCCO 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 EOCCO and our partners
- Support EOCCO practitioners and providers to improve the quality and safety of care and service delivered in their respective settings

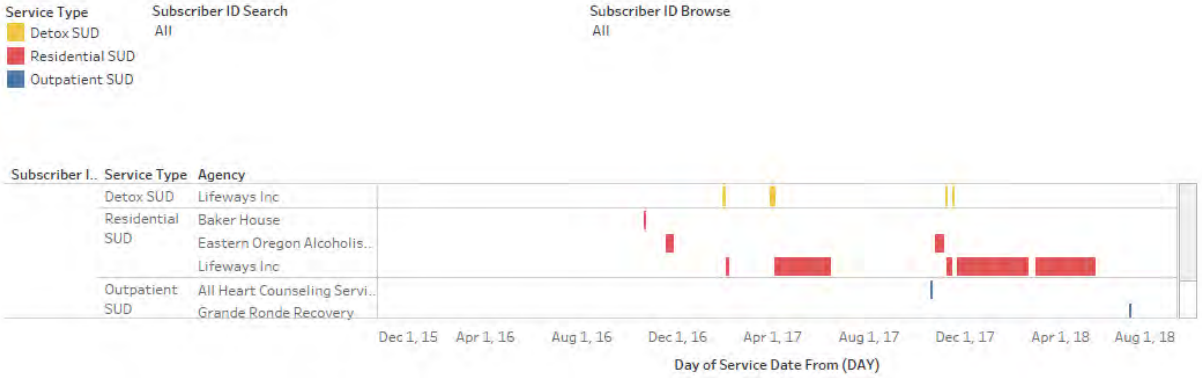
d. Describe the mechanisms that the Applicant has for sharing performance information with Providers and contractors for Quality Improvement.

EOCCO shares 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, Regional Community Advisory Council, and annually through GOBHI's Spring Conference and EOCCO's Clinician 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, EOCCO 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 was shared with the care team so they could 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.

EOCCO maintains the following activities and controls within various departments 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.

EOCCO'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.

EOCCO's Population Health Management and Engagement (PHME) team includes 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 utilizes the PDSA (Plan-Do-Study-Act) cycle to standardize the way we test change and monitor progress. Program performance is evaluated by analyzing medical and pharmacy claims, member and clinic-reported clinical outcomes, Patient Activation Measure change and member survey data. The results are

documented and reviewed and provide the rationale for continuing current quality initiatives and starting new activities. EOCCO measures the success of programs and initiatives comparing our plan-wide measure outcomes with state benchmarks and targets.

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

EOCCO Quality Improvement Specialists 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 are reviewed with clinic partners to promote clinic-based outreach and increase member engagement.

Additionally, EOCCO works with community partners to facilitate Community Benefit Initiative Reinvestments (CBIR) that promote improved health outcomes and increased quality metrics. EOCCO staff 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, EOCCO staff are also supported through various wellness initiatives to lead an active and healthy lifestyle. For example programs to encourage walking, eating healthy meals, and discount gym memberships are available.

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.

The EOCCO 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.

EOCCO processes or imports all referrals and prior authorizations into a central system. This system also encompasses our claims data. On a monthly basis, EOCCO imports 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?

N/A

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. EOCCO Case Management staff work within the same department, in the same location, as the case managers that work on the affiliated Medicare Advantage plan. When an EOCCO 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.

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.

County (List each desired County separately)	Maximum Number of Members-Capacity Level
Baker	4300
Gilliam	410
Grant	1620
Harney	2250
Lake	2000
Malheur	11000
Morrow	3250
Sherman	400
Umatilla	20950

Union	6750
Wallowa	1900
Wheeler	350

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.

See the EOCCO Publically Funded Health Care and Services Programs Table included in our submission response.

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.

The community was involved in the development of the community engagement plan for EOCCO. The Regional Community Advisory Committee (RCAC) reviewed and shared input on the Community Engagement Plan at its March 26, 2019 meeting. In addition, two major community engagement processes were used to identify strengths, needs and gaps as we look toward the future. First, between May and September of 2018 we conducted 21 community health assessment focus groups within the 12 counties comprising the EOCCO region (8 in English and 4 in Spanish) with three community health assessment areas: community health, health and healthcare disparities, and social determinants of health. Second, interviews with over 80 early childhood community partners and stakeholders were conducted between March and December of 2018 to identify strengths, gaps and needs in parenting (including pregnant women) and early childhood behavioral health. Our over-arching aim for our plan is to prevent and mitigate the impact of adverse childhood experiences (ACEs) through behavioral health promotion.

(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.

Per the EOCCO Publically Funded Health Care and Services Programs Table, we are contracted with each county health department and community mental health program through the county health departments.

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

N/A

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.

EOCCO is able to provide culturally relevant coordinated care services to our AI/AN population through our 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 our 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. Through this experience we are confident in our ability to uphold this partnership with Yellowhawk Tribal Health Center and continue to improve our collaboration moving forward to best support our AI/AN members in Umatilla and other parts of our service area.

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.

Yellowhawk Tribal Health Center is an Indian Health Service and is contracted with EOCCO, since July 1, 2014.

(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.**

EOCCO and Yellowhawk Tribal Health Center have been working together since the start of EOCCO. The relationship 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.

EOCOC 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.

EOCCO plans to reengage Yellowhawk Tribal Health Center and partner to provide support to achieve the goals of the health center and of CCO 2.0.

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. EOCCO's pharmacy benefit is 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) are coordinated by the same pharmacy team to ensure EOCCO 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, EOCCO is committed to program transparency, 100 percent pass-through of any savings, and affordable prescription drug coverage for members in our service area. EOCCO's pharmacy benefit includes the following:

- Adoption of OPDP in 2016 as the backbone of our pharmacy network and reimbursement strategy to better manage prescription drug costs.
- Transparent pricing – services are delivered for a low single administration fee per approved claim.
- 100 percent pass-through of pharmacy charges and payments – aggressive pharmacy network financial guarantees apply for brand and generic drugs. Any network over-performance is passed directly to EOCCO; there is no spread retained by EOCCO's PBM.
- 100 percent pass-through of manufacturer rebates, which 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 EOCCO 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 works daily with EOCCO 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.

EOCCO's drug formulary is facilitated through OPDP and is the cornerstone of medication therapy, quality assurance and cost containment efforts for our pharmacy benefit. EOCCO develops, maintains and administers a closed formulary which limits 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 (including an EOCCO physician), 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. EOCCO works 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 Meeting, 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 EOCCO 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 includes 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 EOCCO's pharmacy benefit. Positive formulary changes can occur quarterly after a product has been approved by the P&T Committee for inclusion in EOCCO's formulary. Negative changes can occur two times per year, in January and July. EOCCO uses 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 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.

EOCCO uses 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, EOCCO coordinates benefits with other insurers to help the member receive the full benefit of those plans. By coordinating benefits, EOCCO may be able to reduce the overall cost incurred for covered services.

Upon enrollment and annually thereafter, EOCCO requests 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 EOCCO 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 EOCCO.

(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 EOCCO 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.

EOCCO utilizes 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 EOCCO'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. EOCCO'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.**

EOCCO was the first CCO in Oregon to adopt OPDP to administer its pharmacy benefit. This relationship will continue with this application. 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 EOCCO, so there are no hidden or unforeseen charges.

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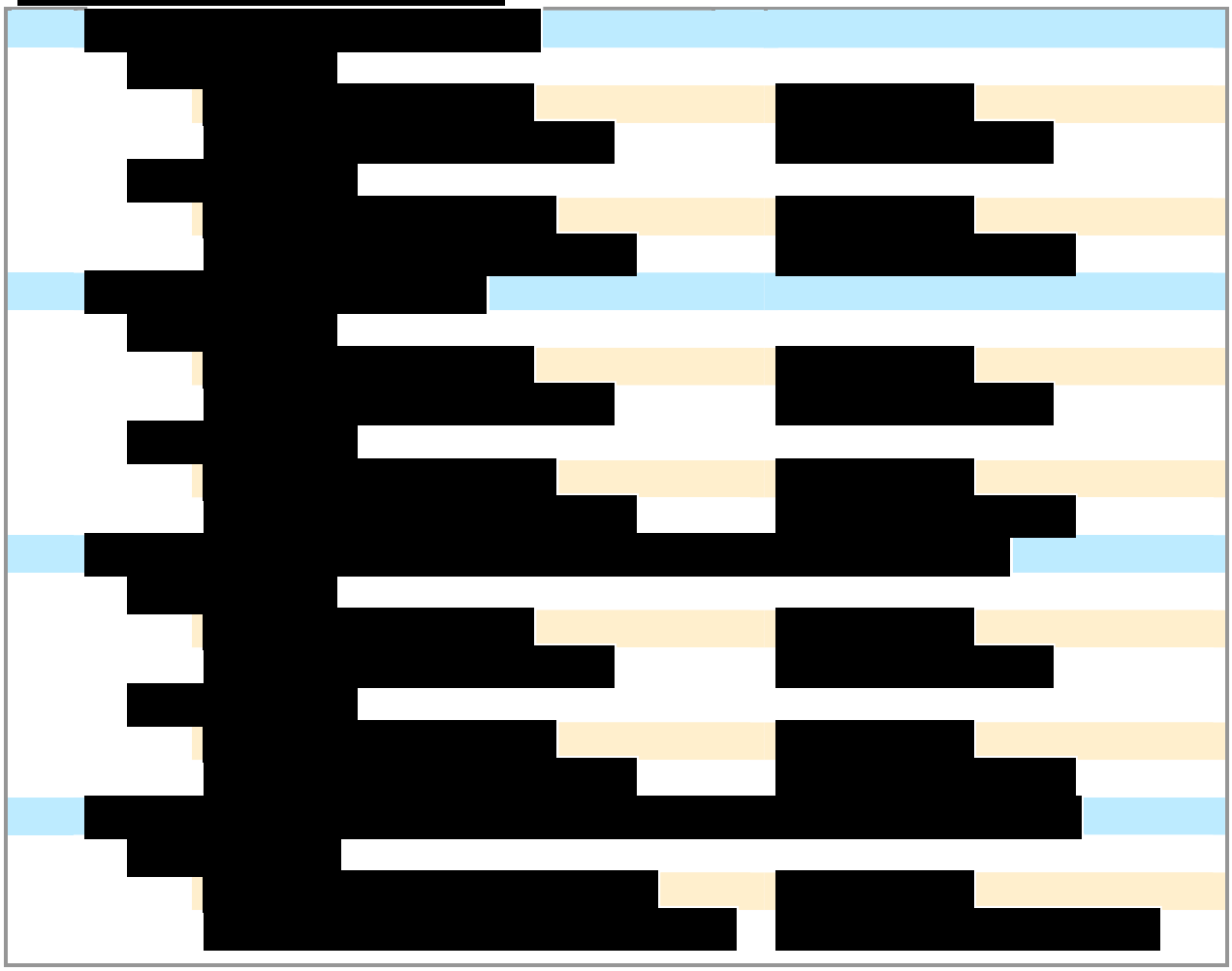

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(7) Describe Applicant's ability to engage and utilize 340B enrolled Providers and pharmacies as a part of the CCO including:

- **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.**

EOCCO 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, EOCCO will not initiate shared savings programs with 340B covered entities. No 340B spread will be retained by EOCCO.

An important consideration for PHS covered entities in EOCCO'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 (compared to a Medicaid rebate that is shared with the federal government). In recognition of the risk for potential duplicate discounts to OHA with a 340B program, EOCCO will work with its 340B community to apply the method established by OHA for PHS covered entities wherein 340B priced drugs dispensed to members in a 340B contract pharmacy will not create a duplicate discount. EOCCO will also coordinate with the PHS covered entities in its service area to develop programs that use 340B savings to benefit underserved populations, including those who cycle on and off Medicaid. These programs can include hiring more skilled workers, enabling community based healthcare outreach, coordinating with local schools to extend health and activity-based programs, etc.

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

EOCCO 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. Among the EOCCO-contracted PCPCHs, 61% are classified as Tier 4 or Tier 5. EOCCO continues to work with primary care providers to achieve PCPCH recognition and achieve higher tier designations. This work is financially supported through our existing 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).

EOCCO 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, EOCCO is launching 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, EOCCO will continue this service 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.

EOCCO currently publishes and maintains a list of formulary medications that is available to members and providers on our public site.

Additionally, EOCCO posts a list of drugs that require PA, as well as a document that outlines recent changes to the formulary. Providers 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, EOCCO and its provider partners allow the referral of an EOCCO member to a non-contracted provider for needed care.

EOCCO has contracts with Saint Alphonsus and St Lukes Hospitals in Idaho and Kadlec and Providence St. Mary's Hospitals in Washington. Additionally, we have special arrangements with Seattle's Children's Hospital.

EOCCO monitors 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 EOCCO 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.**

EOCCO provides education in the member handbook on how to appropriately access care from Ambulance, Emergency Rooms, and urgent care/walk-in clinics. EOCCO is also creating 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. EOCCO creates custom reporting that identify inappropriate utilization. These reports are used by case managers to assist member in managing their health outcomes. The reports are also 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).**

EOCCO follows state, federal and accreditation organization regulations when identifying and reviewing Adverse Events and HACs. EOCCO encourages 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.

EOCCO 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 are programmed into our claims adjudication software and will stop and are 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.

EOCCO outlines 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. EOCCO 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. Moda Health will make one payment for the combined service.

EOCCO's claims adjudication software has edits in place to detect for claims that may fall within the 15 day period. Additionally, our analytics team runs a set of four reports related to inpatient hospital billing and results are 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.

EOCCO is continuing 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. EOCCO is also expanding 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. EOCCO is also utilizing a program called 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 provide opportunity to coordinate care for those members who are dually eligible. All EOCCO 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. EOCCO Case Management staff work within the same department, in the same location, as the case managers that work on the affiliated Medicare Advantage plan. When an EOCCO 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 EOCCO'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.**

Applicants must submit the following details:

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

   EOCCO currently provides a per member per month (PMPM) payment to PCPCHs recognized by the State of Oregon for each member enrolled or assigned to the PCPCH. Our PMPM payments currently include a payment differential by PCPCH tier as follows:

PCPCH Tier	PMPM
1	$0
2	$0
3	$18
4	$21
5	$23

   EOCCO pays out approximately $11 million annually in PCPCH payments. Most providers who are receiving PCPCH payments are also getting payments from one or more of the higher LAN categories. HCP-LAN guidelines indicate that all payments to a provider count toward the highest or dominant category; therefore most of EOCCO's PCPCH funding falls into LAN category 2C+ for EOCCO as the majority of PCPCHs also participate in EOCCO's shared savings and pay-for-performance model. EOCCO estimates that .4% of EOCCO's PMPM payments fall into LAN category 2A and 44.9% of EOCCO's PMPM payments fall into LAN category 2C+.

   As EOCCO has made a significant investment in PCPCH funding, we will need to carefully evaluate the financial impact of annual increases in PCPCH payments, but will do so as required. 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, EOCCO is evaluating a modified PCPCH payment structure that is intended to take into account the risk profile of a PCPCH's Medicaid population, including performance on a number of other metrics that could result in payment differentials for PCPCH's in the future. For example, a tier 4 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)

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

As a result, EOCCO has provided enhanced funding to PCPCH's since 2013. State certified PCPCH's receive a PMPM payment for each EOCCO 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. EOCCO's 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.

EOCCO continuously works with its Clinical Advisory Panel, the Risk Contract Surplus/Incentive Measures Settlement Distribution (RCSIMSD) subcommittee and the EOCCO Board to determine the level of PCPCH funding needed. We know that it takes additional work to achieve and maintain advanced tier PCPCH status in our rural and frontier service area and that can also be financially supported. Based on the recommendations from our Clinical Advisory Panel and the RCSIMSD subcommittee, the EOCCO board approved increases in the PCPCH PMPM payments in 2015 and again in 2017.

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. EOCCO has provided $33.7 Million in PCPCH funding since 2013.

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.**

   EOCCO uses VBP budget mechanisms that take into account the risk profile of the populations served by each participating provider. We don't use national benchmarks. EOCCO utilizes 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 EOCCO 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.

   When calculating quality measure bonuses, EOCCO takes 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) would 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.

   Because VBPs often 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 collect encounter data from all of our

capitated providers, this gives insight into how people are utilizing services and performing on quality measures.

All of our data is stored centrally, including claims data, enrollment data, REAL+D data and demographic data; and all data is indexed with common keys. This allows EOCCO to run reports to show how different sub-populations have performed from an overall utilization and quality measures perspective.

As EOCCO adopts more VBPs, we will produce regular reporting to review the utilization and performance of various sub-populations. This will help us ensure that shifts to VPBs 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 to EOCCO 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

EOCCO uses our cost and utilization dashboards to monitor and address non-utilizers. We break out data by age, gender, race/ethnicity, and more, to look for any groups who might be underserved, and to try to understand how to increase appropriate utilization (e.g. preventive care or routine visits). Additionally, the EOCCO analytics team recently produced a report showing how members performed on quality metrics by race, ethnicity and language.

EOCCO will also monitor for population trends at the provider level through the grievance/appeal process and through notifications of member dismissals. When EOCCO 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 social needs. To date, no trends have been identified as a result of VBP's on a specific population.

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.**

   EOCCO will build upon its current VBP structure and work with its CAP, the RCSIMSD subcommittee, its contracted provider partners and the EOCCO board to implement the new and expanded care delivery area VBPs for 2020 and 2021.

   Using the Health Plan Quality Metrics committee's 2019 Aligned Measure Menu set, EOCCO will implement one new Children's health care measure in 2020. Additionally,

EOCCO will implement two new hospital quality metrics for the ten hospitals located within the service area and one maternity care metric into existing VBP arrangements:

Children's Health Care Metric:

- Well-Child Visits in the First 15 Months of Life or Kindergarten Readiness

EOCCO currently has VBPs in place for children's health care in the form of at risk quality bonus payments for meeting targets on metrics listed within the HPQM aligned measures menu set. At risk quality measures include Developmental Screening in the First Three Years of Life and new for 2019, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents. EOCCO's DCO partners are also at risk for meeting the Dental Sealants on Permanent Molars for Children measure.

For calendar year 2020 EOCCO will expand its current VBP to include a new Children's Health Care Metric. We understand that kindergarten readiness is not currently on the HPQM aligned measure menu set but that it is being evaluated for inclusion for the 2020 measure set.

Hospital Metrics:

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

EOCCO's current VBP with our local hospitals is a shared savings/shared risk model. Hospitals have 5% of their reimbursement withheld as part of their participation in the shared savings model. If EOCCO has a surplus, the reimbursement withhold including the hospitals portion of the shared savings surplus, is returned. In years when the shared savings model operates in a deficit position, a portion or all of the hospital's 5% withhold may be kept by EOCCO to cover the deficit. EOCCO's current shared savings model for inpatient and outpatient hospital services does not include a quality measure component and as a result our hospital VBP falls into LAN category 3N.

EOCCO intends to make two changes to the shared savings model for hospitals. First, EOCCO will incorporate the two hospital metrics noted above into the shared savings model by 2021. Hospitals will be at risk for meeting performance targets on the selected hospital metrics and up to 3% of the hospitals reimbursement will be at risk if they do not meet the selected hospital metric targets. Second, the amount of hospital withhold will be increased from 5% to 8% in line with CMS guidelines for meaningful risk. We believe that by implementing this change, we will move our hospital VBP from LAN category 3N to LAN category 3B.

Maternity Metric:

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

In addition to the hospital maternity care metric (Caesarian Rate) mentioned above, EOCCO will incorporate a second new maternity care metric in 2021 for providers. Today EOCCO provides our primary care practices an opportunity to earn a quality bonus payment based on their performance in meeting or exceeding quality targets on a subset of 7 of the current CCO quality metrics.

Currently, at least 30% of the quality pool funds EOCCO earns for a respective calendar year funds the PCP quality bonus payments. The available PCP quality bonus payments can be increased at the discretion of the EOCCO Board. For example, in calendar year 2017 the EOCCO Board allocated a total of $3.6 million to PCP quality bonus payments based on our formula, and chose to increase the 2017 distribution to $5 million. This amount was $1.4 Million more than the minimum required distribution outlined in the provider contracts.

EOCCO'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. Additionally, implementing this change will expand the service types and providers eligible for quality bonus payments under LAN category 2C and 3B depending on other aspects of the provider's agreement.

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.)**

   EOCCO believes that the implementation of Value Based Payment (VBP) models has been one of the keys to our success from both a financial and quality standpoint. Our VBP journey began with PMPM case management payments to PCPCH's in 2013 and we have slowly evolved and expanded our models up to the present: Below is a brief history of EOCCO's VBP evolution.

2013	EOCCO implemented Per member per month (PMPM) case management payments to PCPCH's. Payments varied by tier level of PCPCH certification**.**
2014	EOCCO implemented a shared savings model. The model was limited to primary care and hospital participation only. An actuarial budget target was set for certain services (primary care and hospital). Participants took risk via a 5% withhold off their payments from EOCCO for the opportunity to share in savings if EOCCO expenses were less than the budget target. This withhold represented the entity's maximum risk if EOCCO expenses were higher than the budget target. Along with implementing the shared savings model, EOCCO's equity partner, GOBHI assumed full risk for behavioral health services and EOCCO made quality bonus payments to PCP's based solely on membership attribution.
2015/2016	EOCCO created four funds within the shared savings model, Primary Care, Non Primary Care (hospital, specialty and pharmacy services),

	Behavioral Health and a Risk fund. Specialists were invited to participate in the shared savings model and we offered a full risk capitation option to PCP's. PCPCH payments for tier 2 and tier 3 providers were increased. Quality bonus payments to PCP's were partially based on performance for meeting performance targets on a subset of CCO quality measures.
2017/2018	EOCCO modified surplus/deficit splits within the shared savings model, 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. EOCCO also became a payer participating in CPC+ in 2017. With the progression EOCCO had made implementing VBP's to improve health care quality and delivery up to this point, participating in CPC+ was a natural next step in the evolution of our VBP's.
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. To date EOCCO's VBP's have focused heavily on primary care as outlined above. Hospital care and specialty care providers have participated in our shared savings model and take risk via a 5% withhold for the opportunity to share in savings.

<u>Behavioral Health, NEMT and Dental:</u>
EOCCO equity partner GOBHI is at full risk for the Behavioral Health and the NEMT benefit for EOCCO and participates in EOCCO's shared savings model. EOCCO's Dental Care Organizations (DCO) partners are also at full risk for the Dental benefit and receive quality bonus payments from EOCCO for meeting the dental related quality metrics. Additionally, EOCCO modified its 2019 DCO contracts to include withhold provisions for meeting access to care measures and quality bonus payment provisions at the DCO level.

EOCCO is aware that GOBHI and its DCO partners have a variety of VBP agreements with their contracted providers that include capitation and quality bonus payment provisions. EOCCO knows that it needs to work with each of its partners to fully understand their current state with respect to VBPs, the appropriate LAN category(s) the VBP arrangements fall into today and to ensure their quality bonus payment provisions are in alignment with the HPQM aligned measures menu set. EOCCO will work with each of these partners to help achieve its 70% VBP goal by 2024 as discussed further below.

Work plan for achieving 70% VBP by the end of 2024:
Building upon EOCCO's current VBP arrangements it is confident that EOCCO can achieve 70% VBP by the end of 2024.

The table below outlines its work plan for achieving a 70% VBP target by 2024 compared with its current/anticipated state for calendar year 2020. For each year below we have estimated the percent EOCCO expects to achieve based on LAN categories 2C+ and 3B+ along with the service type(s) it plans to implement for that calendar year and the LAN category it will focus on for the service type. EOCCO 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 for service type focus area
2020	44.9%	26.7%	Children's Health Care	2C, 4A
2021	47.5%	43.9%	Hospital Care/Maternity Care	2C, 3B
2022	52.2%	48.6%	Oral Health care	2C, 4A
2023	66.1%	62.5%	Behavioral Health care	2C and higher
2024	75.0%	62.5%	Recruitment of additional providers into VBPs (such as out of area and out of State hospitals and providers); enhancements to existing VBP arrangements as needed to achieve at least 70% VBP	2C and higher

On an annual basis EOCCO will evaluate its current state with respect to VBP targets in LAN categories 2C+ and 3B+ to ensure planned targets are met. Also, EOCCO will contact OHA as needed for technical assistance with implementation of its VBP strategy. For example, due to its rural service area and geography all tertiary hospital and most high level specialty care is provided out of area/out of State. There has been

reluctance by its out-of-state providers to participate in EOCCO's Value Based Payment models which could impact its ability to ultimately achieve a 70% VBP target. EOCCO may need assistance from OHA to work through some of these unique geographical challenges to meet its ultimate VBP goals.

EOCCO, its Clinical Advisory Panel, the RCSIMSD subcommittee and its provider partners will work throughout the term of the CCO 2.0 contract to develop and implement new VBPs 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: **EOCCO**
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 37,500 members. For 20 of payments to be in LAN category 2C+ and 26.7% of payments to be in LAN ca will focus on expanded VBP service type of Children's health Care.

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	$ 971,082
2B Pay for Reporting	bonuses for reporting data or penalties for not reporting data	$ -
2C Pay-for-Performance	bonuses for quality	$ 45,621,310
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	$ 66,807,521

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	**$ 113,399,913**
VBP 2C or higher sub-total	**$ 112,428,831**

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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	$ 126,384,969
3N: Risk-based payments not linked to quality	payments with upside and downside risk but no connection to quality	$ 10,388,304
4N: Capitated payments not linked to quality	capitation payments with no connection to quality	$ -

Total payments	**$**	**250,173,187**
Percent of payments that are VBP 2C or higher		**45%**

CCO RFA DATA COLLECTION - VALUE-BASED PAYMENTS

CONTRACTOR/CCO NAME: **EOCCO**
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 62,500 members. For 20 of payments to be in LAN category 2C+ and 26.7% of payments to be in LAN ca will focus on expanded VBP service type of Children's health Care.

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	$ 1,451,644
2B Pay for Reporting	bonuses for reporting data or penalties for not reporting data	$ -
2C Pay-for-Performance	bonuses for quality	$ 68,198,027
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	$ 99,868,705

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

VBP Sub-total	**$ 169,518,376**

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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	$ 188,929,376
3N: Risk-based payments not linked to quality	payments with upside and downside risk but no connection to quality	$ 15,529,187
4N: Capitated payments not linked to quality	capitation payments with no connection to quality	

Total payments	**$**	**373,976,939**
Percent of payments that are VBP		**45%**

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.

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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	
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

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

Primary Care (current):

- PCPCH
- Capitation
- Quality Incentive Measures (including children's health care)
- Shared Savings Model

Hospital & Specialty Care (current & future implementation):

- Shared Risk/Shared Savings Models
- Quality Incentive Measures (hospital care/maternity care for 2021 implementation)

Oral Health (2022 implementation):

- Capitation
- Quality Incentive Measures

Behavioral Health (2020-2024 implementation):

- Capitation
- Incentive Measures

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	$ 18.00
Tier 4 clinics	$ 21.00
Tier 5 clinics	$ 23.00

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		**APM Types - Subcategories**
	LAN APM Category	**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	X

	3	X
	3 or 4*	
	3 or 4*	
	3*	
	4*	X
	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. C) Future capitation payments will vary based on bo 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 expansion for 2020. generally all include PCPCH payments which would have fallen into 2 2C as the dominant mechanism. C) Future capitation payments will v the PCPCH tier level and the member risk, to ensure that members w 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	A) Primary Care. B) these contracts generally all include PCPCH paym have fallen into 2A, and quality bonuses which would fall into catego report 3A as the dominant mechanism. C) Future capitation paymer on both the PCPCH tier level and the member risk, to ensure that me needs have more resources allocated.

FFS-based Shared Risk	A) Hospital, Specialist. B) Many of these contracts include PCPCH pa extent that the health system provides primary care services, which into 2A, and quality bonuses which would fall into category 2C; but w the dominant mechanism. C) Future APM will tie quality metrics in with current shared risk for maternity care specialists in 2021. Shared risk budgets are based on members so that clinics with members having special needs, includin disparities, are not adversely affected.
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)	A) Primary Care, behavioral health, oral health. B) Many of these co PCPCH payments to the extent that the health system provides prim which would have fallen into 2A, and quality bonuses which would fa but we will report 4A as the dominant mechanism. C) Future APM m incorporate member's risk score in determining the capitation payme assigned primary care clinic. This will help compensate providers for with more complex health care needs. EOCCO intends to produce re by population sub-group to ensure that any disparities by racial/ethn addressed. Additionally, provider participation in a capitation based expanded.
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.

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B) these contracts
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ntracts include
ary care services,
ll into category 2C;
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caring for members
orts on utilization
nic/language/etc. are
model will be

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?**

   EOCCO sees no challenges or obstacles in signing the 2020 HIT Commons MOU and fulfilling its terms. EOCCO has a current MOU with the HIT commons and pays our portion of dues. Additionally, EOCCO currently serves on the HIT Commons Governance Board.

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?**

   EOCCO plans to continue with current assistance efforts as well as implement new ways to continue to promote EHR improvement to support increased rates of EHR adoption among contracted physical health providers.

   Currently, EOCCO works closely with contracted physical health providers surrounding the annual quality metric reporting process and quality metric tracking throughout 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, who's 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.

   Additionally, EOCCO provides per member per month (PMPM) payments to physical health providers based on their Patient Centered Primary Care Home (PCPCH) tier. One mechanism for gaining a higher tier level, and thereafter a higher PMPM, is to effectively implement an EHR. A large portion of the sections in the tiering program incorporate EHR adoption such as, Access to Care, Accountability, Comprehensive Whole Person Care, and Continuity Coordination and Integration.

   EOCCO also provides annual community benefit reinvestment initiative (CBRI) funds to physical health providers based on an application and review process. Many

of these CBRI's are directly related to EHR capabilities. One of EOCCO's CBRIs provides funding to support population health management efforts for chronic conditions through the use of EHR based data. Additionally EOCCO has a CBRI to support the implementation of Arcadia Analytics which requires an EHR to connect with this web-based platform. This tool then allows the clinic EHR data to be combined with EOCCO claims data in a format that is easily viewable and accessible for population health management.

By the contract effective date, EOCCO plans to continue current efforts as noted above and implement additional efforts to support our physical health providers EHR adoption and improvements. Specifically, EOCCO plans to assess the EHR adoption and improvement efforts of the public health departments and specialty care providers within our service area. We will review and document this within our cohesive EOCCO HIT Roadmap.

EOCCO is also in the process of creating a new performance based PCPCH payment methodology. This will better align with our value based payment plan as well as continue to provide PMPM payments to sustain EHR use and ensure we are paying for improved performance in a reasonable and equitable manner. This will be a future implementation to further support our efforts towards EHR adoption and improvements.

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

Currently, all EOCCO CMHPs are connected to an EHR. Our next approach is to determine the EHR adoption status of each of our non-CMHP behavioral health providers and residential treatment facilities and document this in our EOCCO HIT Roadmap by contract effective date. For those who have not yet adopted an EHR, we will provide technical assistance to support this adoption. This technical assistance and support will be determined based on each individual practitioners need. One example of planned support is for GOBHI on behalf of EOCCO to implement their own EHR that can be used by the independent practitioners through a set payment structure. This will help to alleviate a current barrier to EHR adoption based on lack in technical support at our non-CMHP behavior health practices.

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

EOCCO plans to determine the EHR status of our contracted oral health providers. In doing so we will also work to better outline the expectation and interoperability that defines an EHR.

EOCCO will then 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 amongst oral health, physical health and behavioral

health providers. Newly defined case management procedures will be shared with oral health providers.

EOCCO will work through our contracted dental plans to launch a dental office EHR campaign with the objective of promoting and increasing utilization. Through this process, we will prepare and distribute educational materials that explains the benefits of EHR in the dental practice. Additional efforts associated with this campaign will be follow-up phone calls, onsite visits and ongoing support. We will set targets and track our progress of EHR adoption in EOCCO's HIT Roadmap.

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?

EOCCO expects that physical health providers will face a variety of barriers when working towards adopting and improving their EHRs, including: staff workflow consistency, reporting capability, data sharing compatibility, and cost.

To alleviate these barriers, EOCCO partners with the Oregon Rural Practice Based Research Network (ORPRN) who works alongside clinics to assist with EHR use and workflow improvement. On example includes ORPRN working with our clinics to increase the colorectal cancer (CRC) screening rate. ORPRN spends time at the clinic and implements a workflow that standardizes the process of the medical assistant's intake and EHR documentation. This allows for standardization across all medical assistants which increases the likelihood of a patient being educated on CRC screening and for the documentation to be in a consistent reportable format. This partnership with ORPRN practice facilitators addresses staff usability of the EHR and improves reporting capabilities.

We also partner with an HIE, Arcadia Analytics, to allow for 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. We plan to continue to track the implementation process of Arcadia Analytics as a part of our EHR adoption strategy. Our goal is to have at least 17 of our largest physical health provider organizations live and utilizing the platform by 2024. This will be recorded and tracked within our EOCCO HIT Roadmap.

EOCCO plans to continue to provide a PMPM payment and technology based CBRIs to assist with the cost associated with EHR use to reduce this barrier. By the contract effective date, EOCCO plans to have a draft survey completed to send out to our providers regarding EHR adoption. This survey will allow us to better understand barriers that still exist and identify ways to address them based on need.

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?

Potential barriers that we expect our behavioral health providers to encounter include the cost of purchasing an EHR and the need for technical support of the EHR. To alleviate these barriers, GOBHI on behalf of EOCCO plans to implement an EHR that can be provided to our practices with a set payment structure. This will reduce the cost especially for our practices with fewer providers as they can all utilize this one platform. This system will also mitigate the barrier to needing to hire technical support staff for the EHR. GOBHI will have the necessary support in place that can then assist the practices as concerns arise.

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?

A significant barrier to oral health providers adopting an EHR is the general lack of understanding of what is meant by the term. A key component as described in the RFA, is that it will allow providers to better participate in care coordination and contribute clinical data for population health efforts. Many dentists have some digital capabilities such as scheduling and billing, and there are a growing number who have adopted a digital patient record. In either case, most oral health providers with any digital capacity perceive themselves to be utilizing an “EHR”. Most do not understand the goal of interoperability. An additional challenge for dentists is that there are very few certified digital systems available to them which would allow for interoperability.

There is a significant cost to implement an EHR. This includes the cost of the system, the cost to train staff and the cost of lost productivity as the provider’s office adapts to the new product. Oral health providers perceive changes like these to bring unnecessary administrative burden to their workflow, taking staff away from chairside patient care. They see very little return in value 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.

To address these barriers EOCCO will prepare and distribute educational materials that promote EHR/HIE adoption specifically for oral health providers. We will also define and promote EHR/HIE systems available in the service area such as OCHIN. We could also define and offer implementation grants for EHR/HIE adoption. We will take a partnership role with our providers by offering technical assistance, staff training and incentives and rewards for implementing and utilizing EHR/HIE systems.

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 EOCCO has a comprehensive understanding of the EHR status of our primary care practices and public health partners, we lack the specific knowledge of this with our specialty care providers. We would ask that OHA assist in prioritizing the specialty care providers we should outreach to and work with to adopt an EHR.

By the contract effective date, EOCCO plans to document in the EOCCO HIT Roadmap the physical health, behavioral health, and oral health providers that we plan to track for EHR use. We will then request assistance from OHA to determine a reasonable target for all of our providers. We plan to set a minimum member limit for physical health providers included in our calculations and targets to ensure a focus on the providers who can be the most impactful. This information will all be included in our EOCCO HIT Roadmap which will be used for continued tracking and improvement efforts.

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.

EOCCO currently plans to start with the EHR data from the primary care practices who report clinical quality measure data on an annual basis. This allows for a list of practices who have an EHR, the vendor type, and the version. Currently with this information, EOCCO knows that at least 87% of their membership is assigned to a clinic with a certified EHR.

EOCCO plans to reach out to our public health partners to determine their EHR adoption and implementation status by the contract effective date. EOCCO plans to request OHA's assistance in gathering a list of priority specialty care partners to also document and track EHR adoption. Based on the information we currently know, we plan to set a target of 90% for EHR adoption of our physical health providers however, this may change once more data on EHR utilization is collected.

EOCCO plans to survey providers on an annual basis to determine EHR adoption and improvement efforts. This will allow for continual tracking and support for improvement efforts. These updates will all be recorded and updated in our EOCCO HIT Roadmap.

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.

EOCCO will utilize an online survey, direct phone calls, annual practitioner survey, provider and facility application processes, site reviews, and contract negotiations to collect data on EHR adoption and utilization. We offer ongoing technical support to any contracted behavioral health providers adopting a new EHR or upgrading an existing EHR. During those instances of transitioning EHRs, EOCCO encourages adoption of certified technologies and best practices. EOCCO conducts site reviews at its CMHPs on an annual basis which focus on areas of quality and clinical documentation. EOCCO also provides technical assistance and encouragement of the adoption of these technologies during reviews. Once EOCCO has documentation of the EHR status for our non-CMHP behavioral health providers, we will determine an improvement target. We will then focus our improvement efforts on our non-CMHP behavioral health providers.

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.

Through our contracted dental partners EOCCO plans to conduct a survey by contract effective date of all oral health providers within the service area to determine which EHR systems they are utilizing and how many are certified. This information will be documented and tracked in our EOCCO HIT Roadmap. The survey will also include questions about providers overall interest in adopting an EHR including, but not limited to: paperless patient records, digital x-rays, information sharing, and patient portal in their clinic. The information gathered will help set targets and track utilization progress.

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.

EOCCO currently utilizes two distinct platforms that are capable of sharing health information electronically across the continuum of care: EDIE/PreManage and Arcadia Analytics. EOCCO meets with each vendor on a regular basis to assess current efforts, implementation status, utilization status, and to address any barriers that exist as soon as they arise. This allows for continued communication between the health plan and the vendors and ensure the platforms are being used for care coordination and other features as designed.

To further promote and support community adoption of EDIE/PreManage, EOCCO employs a Quality Improvement Clinical Integration Specialist whose role is to outreach to participating clinics to promote and assist in onboarding EDIE/PreManage technologies and implementing shared workflows across organizations.

For clinics that seek additional support, EOCCO offers Community Based Reinvestment Initiatives (CBRIs) with funding of up to $50,000, aimed at increasing the use of EDIE/PreManage or a similar program to identify and follow a cohort of patients to ultimately reduce ED utilization. The program encourages collaboration between hospitals, behavioral health and/or primary care to increase and reduce barriers to access, coordinate care, integrate new services or workflows. The CBRI programs also promote interventions based on shared information that:

- Target interventions for patients with mental/behavioral health needs and/or multiple chronic conditions,
- Facilitate the use of CHWs for care coordination and patient education,
- Increase utilization of telehealth services for low acuity complaints presenting to the ED, and
- Increase efficiencies between primary care and behavioral health organizations related to assessments and screenings.

Through EDIE/PreManage technology there is an opportunity to align and coordinate efforts to maximize the benefit of the HIE tool and to enhance cross-organizational care coordination. This coordination includes all relevant parts of the care continuum (e.g. Behavioral Health, Long Term Care; Oral Health, Primary Care) in the conversation as they adopt PreManage and identify roles, responsibilities, workflows and communication. This tool has the potential to be utilized as a way to coordinate care throughout the community by thoughtfully adding agencies such as public health, or correctional facilities in ways that allow for the sharing of information but maintain HIPAA regulations.

EOCCO in collaboration with community partners through participation in collaborative initiatives and pilots has identified several opportunities to coordinate and establish mutual workflows. Below are listed activities that EOCCO plans to implement as we increase the number of primary care practices that are connected to and utilize PreManage.

- Member/patient outreach following an ED or inpatient event:
    - Use mutual patient cohorts and agreed upon workflows to avoid duplicate calls.

- Primary care office would contact patient post-discharge for follow-up care and appointment scheduling.
- Include in the call mutual (best/common practice-based) scripting regarding:
  - Reason for the visit
  - Discharge plan
  - Assess current status
  - Medication changes
  - Appropriate follow-up scheduled
- If primary care and specialist/BH are both involved, they will work together to create the care recommendations that primary care generates (guideline for standard content developed).
- EOCCO will provide care management to members not actively managed by primary care. They will reach out to primary care to coordinate, discuss a mutual member/patient or hand-off to primary care to manage.
  - ED outreach specialist will provide short-term intensive care management for patients at high risk of readmission. They will review EDIE data for involvement of other care managers and contact as appropriate.

- ED high utilizers who have not seen a PCP for over one year are contacted by a care team:
  - Outreach is stratified by condition or risk
    - High prospective risk score
    - History of behavioral health issues
    - Inappropriate/avoidable 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.
  - Once established, care team members would coordinate care via follow-up documentation, reporting sessions and huddles.
  - All relevant information will be entered into EDIE/PreManage (Care Provider/Care Team section).

The other platform that can be used to share health information electronically across the continuum of care is Arcadia Analytics. 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. Data is aggregated from all of the different EHRs, claims software, and utilization management systems to allow care providers to 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. 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. EOCCO plans to document the current HIE status of both PreManage and Arcadia Analytics of their physical health providers and track this in the EOCCO HIT Roadmap. In addition, EOCCO's Quality Improvement Specialists will continue to assist organizations in connecting to this platform and ensure each organization is utilizing the platform to its upmost capabilities.

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.

EOCCO uses the same technology platforms with our behavioral health partners to share health information across the care continuum.

All hospitals, CMHPs and a few primary care clinics in the EOCCO region have access to EDIE/PreManage. This communication platform is being utilized in a number of ways to improve care coordination for EOCCO members.

- Discharge Planning: EOCCO collaborates with Community Mental Health Programs (CMHP) in discharge planning involving all members moving between levels of care and Episodes of Care. EOCCO Utilization Management (UM) monitors PreManage daily and notifies the CMHP the same day of an admission. The Enhanced Need Care Coordinator (ENCC) immediately begins the discharge planning process and communicates the plan with EOCCO 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 among the CMHP, EOCCO UM and EOCCO CM to ensure a timely and successful discharge.

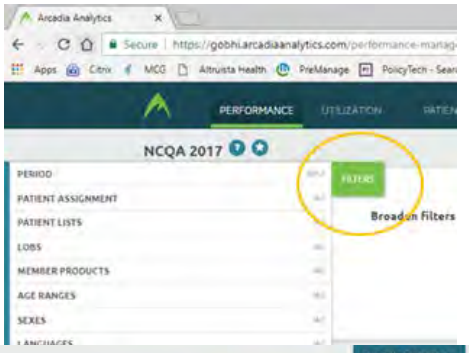
- Substance Abuse Disorder Medication Assisted Therapy (MAT) services: MAT care coordinator's work with member's engaged in services on a regular basis. They develop individualized care plans that are entered into PreManage as appropriate based on HIPAA regulations.

- Members with Severe and Persistent Mental Illness (SPMI): To coordinate care, in 2018 EOCCO CMHP staff entered PreManage care plans on all members with an SPMI that were currently receiving services. The goal of the

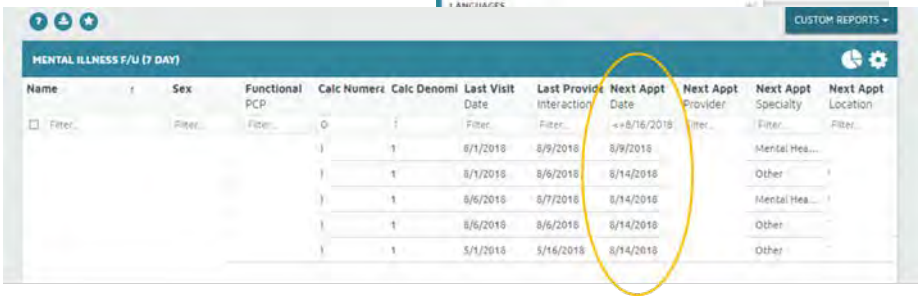
care plans were to provide the ED and Primary Care physicians key information when the member visits the ED. (Note: As part of the EOCCO's CMHP 2018 VBP program over 500 members now have active behavioral health care plans in Pre-Manage.)

EOCCO CMHPs, as part of the 2019 CMHP VBP program are required to enter a care recommendation into PreManage for every assigned member with an SPMI. This program will expand in 2020 to ensure that every member with 2 or more ED visits in a 6 month period has a care recommendation (including contact information for the local CMHP) entered into PreManage. Outreach to the EOCCO ED and primary care clinics will occur in 2019 to help facilitate the content and utilization of these care recommendations throughout the care continuum.

Arcadia Analytics, described above (Attachment 9.C.1.a), is also available to our CMHP providers. Below are examples of current utilization practices:



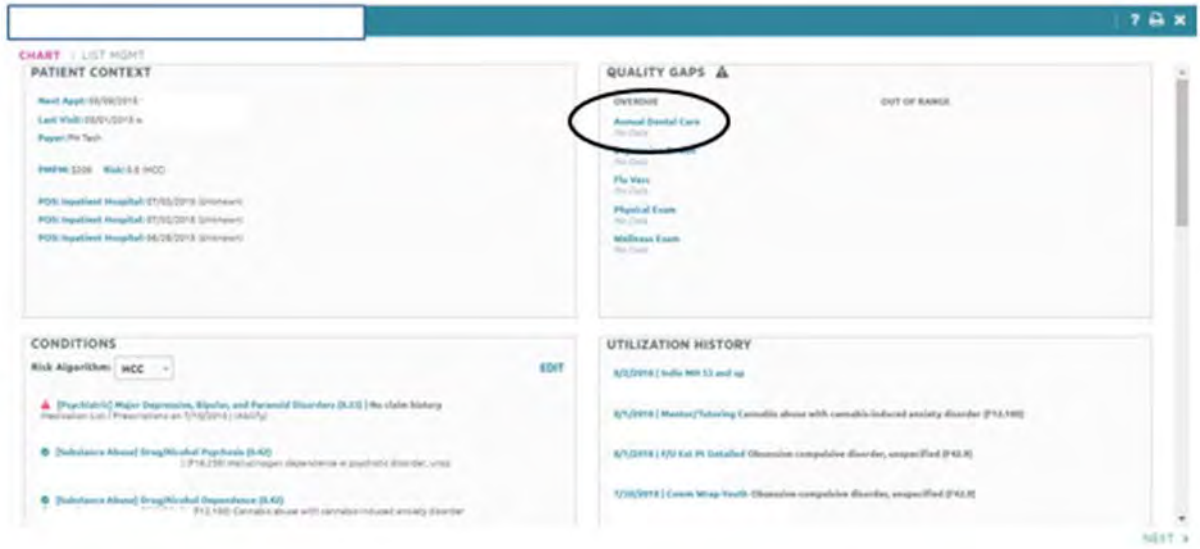
- SPMI: Once an individual is discharged the CMHP staff ensure that a 7-day visit follow-up occurs. Arcadia Analytics provides notifications when a member is discharged and in need of follow-up. This



information can be accessed in the platform in a number of different ways, including the generation of a list that shows each member who needs follow up, when they were last seen, and if they have an appointment scheduled. EOCCO also monitors if 7-day follow-up visits have occurred and when necessary, provides CMHP staff support in successfully making the 7-day follow-up visit is completed. (In 2018 78.51% of Members received a Follow-up with 7-days of Hospitalization for a Mental Illness, surpassing the goal of 66%.)

- Care Coordination: Arcadia Analytics provides a "whole" picture view 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, a complete medication list (see D2b(3)). **Note**: Information related to substance abuse is only shown to appropriate entities as outlined in CFR 42, Part B. For the example presented below 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.



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.

EOCCO plans to first document HIE systems currently available to oral health providers in our service area and determine how these systems interact with programs currently utilized by our providers. Additionally, because Arcadia Analytics is already integrated with many of our physical health and behavioral health providers, EOCCO plans to extend the contract to our oral health providers. The platform currently shows member level dental care utilization and has the ability to absorb dental claims data. EOCCO can grant access to our DCO partners to view this detail as a starting point. As our DCOs determine workflows to address utilization, plans to enhance current care coordination efforts using this specific tool can also be implemented.

Additionally, our DCO partners have access to PreManage. This tool 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. Dental case management is able to outreach to these specific members and ensure that in the future, the member is receiving the right care, in the right place, at the right time. This will allow the member to recognize their dental provider is available in the future for similar instances rather than initiating care at a traditional emergency department.

Lastly, we will meet with our contracted provider in Wallowa County, a medical/dental clinic that currently utilizes an oral health EHR that completely integrates with their medical EHR. This will allow us to learn best practices and use cases that demonstrate the value of integrated EHR. With this information combined

our current HIE options, we will finalize our provider outreach and tracking database with the intent of meeting our defined targets.

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.

As described in detail above, EOCCO supports the access to and implementation of PreManage for our physical health providers in a variety of ways. EOCCO also covers the cost to sponsor this platform amongst our provider groups. EOCCO's Quality Improvement Clinical Integration Specialist assists clinics in connecting to PreManage as well as implementing action plans to best serve our members when a hospital event notification is received.

One of the goals of increased PreManage use is to identify over-utilization of Emergency Department resources. Through the use of PreManage Care Recommendations ED and Hospital staff have insight into patients' behavior and tendencies during and event. EOCCO encourages physical health providers to enter Care Recommendation regarding higher risk populations. As additional physical health providers connect to PreManage, EOCCO plans to ensure the continued follow-up with patients to coordinate care appropriately based on hospital event notifications. (See: above in Care Coordination section - Attachment 9.C.1.a.)

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.

All EOCCO CMHPs use EDIE/PreManage to obtain real-time information about ED and inpatient hospitalization activity. EDIE/PreManage provides alerts/notifications when one of their Members is seen in the ED or admitted to the hospital. Providers can utilize the reporting functionality in EDIE/PreManage to look for patterns of high utilization. Providers also have the ability to find up to date information regarding the member's other Providers and care recommendations from Hospitals, PCP's, CMHPs and EOCCO staff. EOCCO provides a staff member with expertise in EDIE/PreManage to help support CMHP utilization of the tool.

We send daily reports of ED and Inpatient stays for behavioral health reasons to all CMHPs, requesting follow up and planning to prevent hospital reentry.

All EOCCO CMHPs also can utilize Arcadia Analytics for near-real time hospital event notifications. Arcadia Analytics utilizes a variety of sources to complete a "whole-person" picture of each member. If a member is seen in an ED or hospitalized, Arcadia Analytics provides a list to each CMHP alerting them that patient needs follow-up.

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.

Our contracted dental plan partners have access to PreManage which 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. Physical health and behavioral health care coordination teams to help ensure the member receives the appropriate follow up care.

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.

EOCCO utilizes PreManage technology to access and use timely Hospital event notifications. EOCCO will receive real-time notifications delivered to internal email distribution lists which are triaged according to established workflows. EOCCO also receives scheduled reports that track and inventory the cumulative notifications over time for aggregate reporting.

EOCCO has established internal PreManage cohorts that monitor EOCCO members who meet notification criteria for conditions "most likely to readmit" post discharge. These conditions include sepsis, pneumonia, COPD, and heart failure. These members are followed by EOCCO Nurse Case Managers.

EOCCO 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. Process in place includes:

- EOCCO 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.

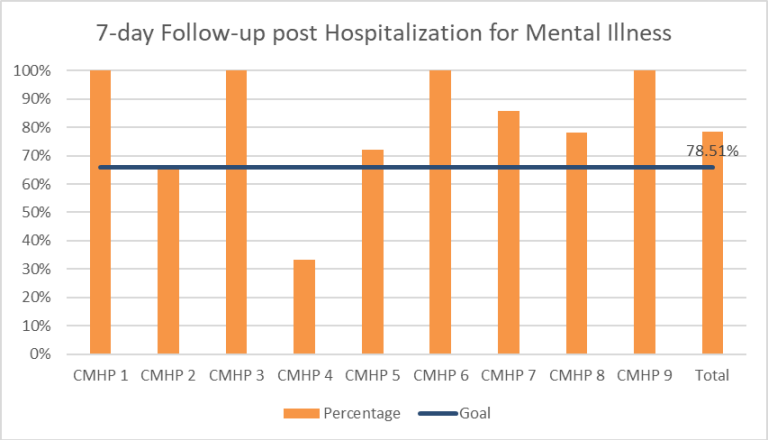
- EOCCO's utilization management team has a process in place for the daily monitoring of the EDIE/PreManage system specifically looking at behavioral health hospital admissions. The care management specialist receives the report and enters the patients in our utilization management tracking system, for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

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

- Our 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.

- The 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.

- The ENCC provides us with inpatient documentation and encounter notes within seven days of the patient discharge. Our 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.



- We used a pay for performance incentive in 2018 to increase the successful completion of this program with a goal of 66% or greater completion rate.

- This same process and methodology will be used for tracking follow-up post ED visits for behavioral health.

EOCCO has future plans to establish inter-organizational workflows with participating clinics to promote appropriate member outreach and coordinated care following an event (see above in Care Coordination section (C.1.a.).

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?

EOCCO recommends a review of Collective Medical's roadmap that shows use of PreManage across the state. This would also report PreManage utilization of clinics who are in the onboarding process and those that have yet to be engaged. 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.

EOCCO recommends statewide clinic surveying of all HIE utilization. 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 vendor utilized, barriers to implementation i.e. IT staff, financial barriers other clinic priorities.

Another area that EOCCO 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 strategies and planning.

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.

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

EOCCO will utilize online surveys, direct phone calls, provider and facility application processes, site reviews and contract negotiations to collect this data on an annual basis. These updates will be recorded in a tracking database and used to regularly amend our EOCCO HIT Roadmap. As this roadmap evolves, it will be used to track utilization metrics including the number of clinics adopting inter-organizational workflows through PreManage, Arcadia Analytics, and/or other HIE solutions. EOCCO will utilize this data to set a baseline of where we currently are at with the implementation and onboarding status. Using this baseline, we will set targets to ensure we have a significant number of our clinics connected to our HIEs so that the majority of our members are integrated into these systems.

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.

Similar to our physical health response, EOCCO will utilize online surveys, direct phone calls, provider and facility application processes, site reviews and contract negotiations to collect this data on an annual basis collect data on HIE utilization. This information will be recorded in our EOCCO HIT Roadmap. Once baseline HIE utilization has been determined, yearly increase targets will be determined. (Note: As of the end of 2018, all EOCCO CMHP are utilizing both Arcadia Analytics and PreManage).

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.

Similar to our physical health and behavioral health response, EOCCO is planning to survey our providers to establish a baseline of HIE utilization. This information will be recorded in our EOCCO HIT Roadmap. Once the data has been collected we will establish improvement targets for increased adoption of HIE with our oral health providers.

EOCCO also has a unique opportunity to develop HIE mechanisms for the oral health provider community. EOCCO affiliate and 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 EOCCO. 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. 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. EOCCO 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.

EOCCO 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?

EOCCO 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 has demographic data. Once matched, the data can then be used for general analytics and reporting purposes, in combination with any other existing EOCCO 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 EOCCO analytics team currently produces 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, to help develop plans for impacting this member 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 regular reporting identifies specific outreach and treatment opportunities to improve patient care and quality measure performance. For example, we regularly highlight members who have significant health issues but have not accessed primary care. We also highlight members who may need to receive a dental sealant from their oral health provider. 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.

The Arcadia Analytics online reporting platform offers additional enhanced data, using aggregated claims and EHR data to produce a wealth of provider and population health insights. Clinics can see updated views of their own performance on quality, cost, and utilization measures, and view services their patients have

received at other clinics connected to the platform; and individual physicians can see rates of quality measure compliance for their assigned population compared to others in their practice. Care coordinators can see upcoming appointments via the clinic EHR's scheduling system, to help organize intervention strategies. Additionally, clinics can review a provider's schedule for the day and determine gaps in care for the patients who will be coming into the office allowing specific preparation to complete the service gap when the patient arrives.

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 Coordinated Care Organizations 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.

EOCCO is in an outstanding position to leverage Children Health Complexity data to further strengthen EOCCO's Analytics infrastructure. For example, the Child Health Complexity:

- Risk stratification score can be integrated in our data reporting platform, Arcadia Analytics that provides a user-friendly portal to monitor Quality Performance indicators and sub-populations at high-risk

- Data can be in interfaced with EOCCO's growing portfolio of Information Systems that will expedite the effective screening, 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.

EOCCO has had advanced VBPs for several years, with most primary care practices already converted to HCP-LAN category 4A reimbursement methodologies. EOCCO maintains robust HIT infrastructure for administering these arrangements, developed

over many years of VBP leadership in Oregon insurance markets. Elements of this infrastructure include:

- Arcadia Analytics HIE platform for providers to access real-time cost, quality, and utilization metrics, with data on overall results plus drill down capability to individual members with care gaps
- Direct connections to provider EHRs which extract and store quality metric data in an automated way on a recurring schedule
- Information on upcoming patient visits, via the provider's own scheduling systems, integrated into the HIE
- 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
- Existing data sharing processes that capture EHR data from a variety of care settings, including physicians, hospitals, and ancillary providers
- Refined portfolio of existing provider-centered reports, including customized reports on cost, utilization, quality, care gaps, and resource use, which highlight progress and results for VBP mechanisms currently in effect
- User-friendly provider portal where providers can access their reports, including all standard reports plus additional ad hoc and custom reports that may be produced from time to time as needs arise
- 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 VBP 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 VBPs

- 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 Arcadia Analytics platform provides participants with a bidirectional exchange of aggregated health and wellness information collected from a variety of data sources and disciplines. The HIE works to empower its participants by not only providing access to unified health and wellness records across its growing network, but in also supplying each entity with a robust analytics platform focused on tracking performance metrics, cost drivers, utilization trends, and operational functions. Unlike many traditional HIEs, connectivity and participation is not reliant on standardized data file exchange and instead connects directly to EHRs; thus 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.

The HIE aggregates incoming data from a vast array of physical and behavioral health EHRs, physical health claims, mental health claims, substance use disorder claims, 7-11 drug claims, prescription claims files, and Medicaid eligibility files to create singular patient records to be shared across the exchange. This process not only facilitates the creation of meaningful, integrated clinical documentation across the exchange, it also ensures a high level of data quality as each data source is continually tested, combined, and ran against existing information in the data warehouse. EOCCO and Arcadia Analytics staff provide technical, legal, and training support throughout the development and post-production phases to ensure the both the project success of participants as well as the integrity of the exchange.

The Arcadia Analytics platform creates a comprehensive health record for each CCO member describing quality gaps in care, conditions history, utilization history, upcoming appointments, medications, problem list, demographics, attributions, preventive care gaps, and relations to the populating of quality metrics. The health record contains the following information:

- Patient Context
    - Next Appointment
    - Last visit
    - Follow-up
    - PMPM Amount
    - Risk score
    - Payer/CCCO
- List of Conditions
    - Past diagnosis
    - Past procedures
- Upcoming Appointments
- Preventative
    - BMI
    - Medication Reconciliation
    - Blood Pressure
    - Osteoporosis Screen
    - Colorectal Cancer Screen
    - Physical Exam
    - Depression Screen
    - Pneumo Vaccination
    - Fall Risk
    - Tobacco Cessation
    - Flu Vaccination
    - Wellness Exam
    - High Risk Medication
    - Mammogram
- Quality Gaps (Overdue or Out of Range)
    - Any Preventative measures that are overdue or out of range
- Problem List
    - List of current problems with start date and provider that documented
- Utilization History
    - Past appointments including where, practitioner seen, diagnosis and CCO
- Medication List
- Demographics
    - Date of Birth
    - Member Product
    - Member Number
    - Member Product 2
    - Member Number
    - Age
    - Sex
    - Language
    - Race
    - PMPM Cost (12mo Avg)
    - Ethnicity
    - Phone
    - MRNs
    - Email
- Attribution
    - List of practitioners who contribute information to patient record

This detailed patient health record allows all caregivers access to the medications, diagnosis, upcoming appointments, and other information that will improve handoffs, avoid duplication, and improve care. The referring provider will also be able to check and see if the patient referral took place.

Patients are stratified into 25 different risk categories driven by diagnosis, social determinants, and utilization data, to assist providers and care coordinators with prioritizing outreach and interventions. Providers can run reports and identify gaps related to more than 300 different performance, cost and utilization, and outcomes metrics with merely a one day lag. HEDIS, NQF, CCO incentive, and internally produced measures drive VBP activities across our network.

EOCCO is working with Arcadia Analytics to connect with other community partners. Goals include adding connections with jails/prisons, public health agencies, and non-CMHP behavioral health providers. EOCCO would also like to work with the Oregon State Hospital, and other state programs such as WIC and SNAP to further build out our HIE to provide a holistic view of our members. Other items on our wish list include finding ways to connect with early learning hubs. Adding additional connections beyond traditional health care providers will expand our ability to design VBPs that affect not just health care, but the health and overall wellbeing of our members.

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:

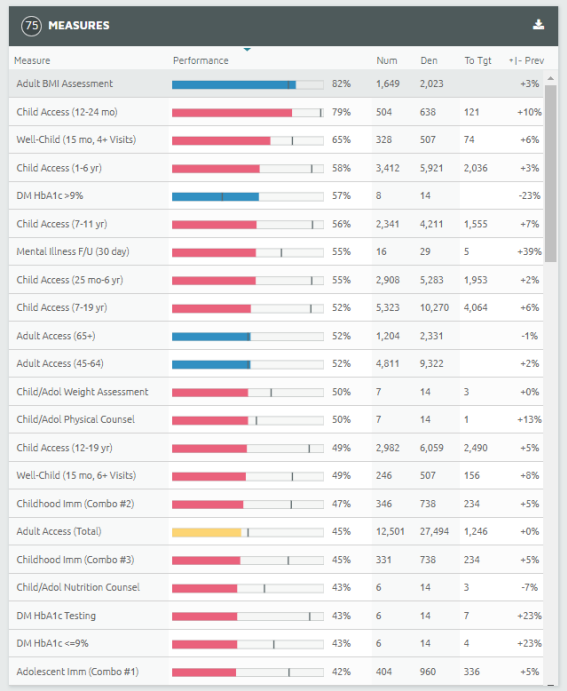
(1) Timely (e.g., at least quarterly) information on measures used in the VBP arrangement(s) applicable to the Providers;
(2) Accurate and consistent information on patient attribution; and
(3) Identification of specific patients who need intervention through the year, so the Providers can take action before the year end.

Successful communication and collaboration with providers is a cornerstone of the success of any VBP. To that end, Moda Health on behalf of EOCCO has 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, EOCCO 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 (“C3” program)
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

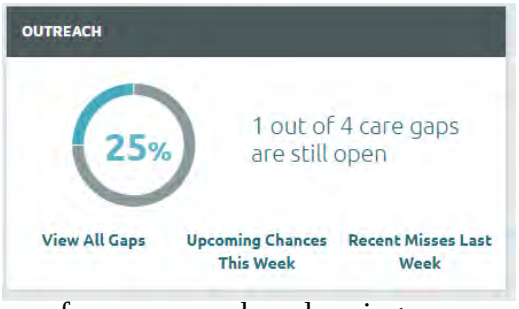
2014	Provider reporting	Development and population of a new provider contact database, to allow secure electronic transmission of VBP reporting to provider personnel involved with VBP management (beyond the traditional contracting personnel)
2014	Provider reporting	First incentive measures progress reports distributed to EOCCO providers, showing current and active list of all 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 EOCCO shared savings models – all of which performed favorably and resulted in shared savings distributions
2016	Data exchange	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 EOCCO primary care practices
2018	Payment models	EOCCO 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 value based payment team, all in one place



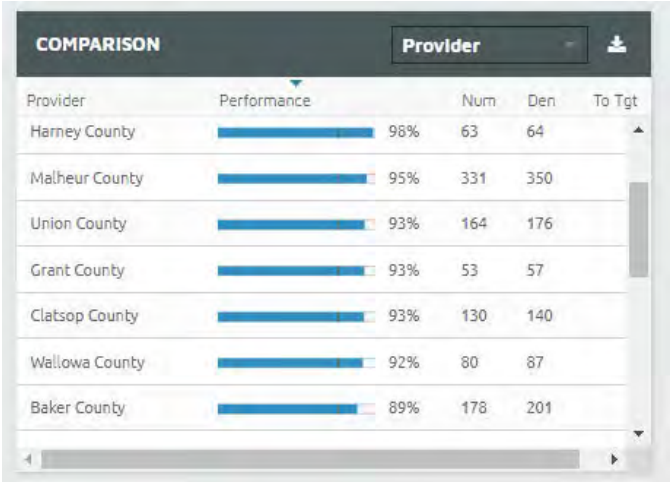
Arcadia Analytics delivers data that is updated nightly to all connected providers. The providers have a dashboard that allows them to see how they are doing on a variety of metrics, and allows them to drill down to the member level. They can also see which members are coming in for an appointment in the upcoming week, and if they are missing any screenings (i.e. depression, tobacco, colorectal cancer…) or have an indicator that is out of normal range (i.e. blood pressure, or blood sugar).

EOCCO Quality Improvement staff work with Arcadia Analytics and 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 when providers need to make changes in their EHR that may affect the link to the platform.



At a higher level, EOCCO has the ability to see how all the different providers are doing. Data can be summarized at various levels, for example by county, or for the EOCCO as a whole. This system wide view provides an opportunity to look for best practices that can then be prepared among providers.

For providers not connected to Arcadia Analytics, and for communicating financial information such as performance on shared savings contracts, EOCCO has its own provider reports portal, where all providers can go to access reports and information described above, such as:



- Rosters 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)

- Performance reports showing bonuses (or penalties) incurred under VBPs

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 Reports 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.

In addition to Arcadia Analytics and the EOCCO Provider Reports portal described above, EOCCO has an extensive data warehouse of claims, enrollment, and clinical data, including all of the information collected by Arcadia Analytics but not displayed in dashboards. As previously described, this wealth of information can then be analyzed and turned into actionable information utilizing tools like SAS and Tableau. Based on our current data capabilities and action plans, we are positioned to deploy these data sets by the contract effective dates. Any additional data not previously described will be developed upon necessity.

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, EOCCO dedicates 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.

Throughout the year, EOCCO provides technical support to its behavioral health and physical health provider network in the adoption and maintenance of HIT tools provided by the CCO as well as to HIT projects that build capacity in the region. Once a provider is live and connected to Arcadia Analytics they receive training and assistance in pulling reports, recognizing care gaps, identifying metrics pertinent to their practice, creating attribution lists, and tracking the utilization and outcomes of

their patients. We provide training and education in HIT platforms as well as assistance in analytics projects related to the CCO upon request from the provider.

Below is a table that outlines the EOCCO data deliverables and support provided to ensure continued adherence and success.

Date	Topic	Activity / Milestone
Q1 Annually	New incentive measures	Staff updates provider clinics regarding the current year incentive measures via email and EOCCO 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 calendar year metrics.
Weekly	Arcadia Analytics touchpoint	Staff meets weekly with Arcadia Analytics staff to review current status of the onboarding process and allow for continual communication to ensure any barriers are addressed
Quarterly	Arcadia Analytics focus group	Staff facilitates meeting with Arcadia Analytics and on-boarded clinics to address common questions/concerns and identify resolutions.
Bi-weekly	Collective Medical touchpoint	Staff meets with Collective Medical staff on a bi-weekly basis to review current status of the onboarding process and allow for continued communication to ensure barriers are addressed as they arise.
Continually	QI clinic support	Clinic staff have continual access to QIS's through a shared email EOCCOMetrics@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	EOCCO's Clinical Advisory Panel coordinates an annual conference for providers and staff. Relevant updates to our technology plans are presented each year.
Annually	Behavioral Health Yearly Conference	GOBHI Spring Conference includes presentations and hands on learning labs with hands on support for Arcadia Analytics, PreManage, and MyStrengths

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, EOCCO 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, EOCCO already provides data on risk stratification and member characteristics to providers, both via Arcadia Analytics for connected providers, and for all other providers via monthly reporting. 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 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.).

Currently, EOCCO uses a combination of claims, authorizations, EHR data, encounter data, EDIE/PreManage, Arcadia Analytics, 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 and dental claims data is generated continuously and fed into the Analytics Data Warehouse (ADW) on a weekly basis. Pharmacy claims are received from our 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 EOCCO's actuarial and data science teams, and 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 systems several times per week so that it can be summarized and reported out to PCPs immediately.

EHR data is collected in several ways. Many EOCCO providers have automated direct connections to Arcadia Analytics, via which EHR data flows into a central repository. There the data is transformed, summarized, and combined with claims data via an automated process. The setup process for each provider data feed involves a significant amount of testing and validation, as different providers may store data differently even though they use the same EHR.

Additionally, clinical quality measure data is collected annually from participating providers for the annual data submission process. The data received is based on clinic, EHR, and HIE capability and determined at the individual clinic basis. Data is submitted to EOCCO in patient level, PDF, and Excel format. The clinics and EOCCO work together to ensure validity and reliability in the data.

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.

EOCCO utilizes PreManage technology to access and use timely Hospital event notifications. EOCCO staff receive real-time notifications delivered to internal email distribution lists which are triaged according to established workflows. EOCCO staff also receive scheduled reports that track and inventory the cumulative notifications over time for aggregate reporting. EOCCO has established internal PreManage cohorts that monitor EOCCO members who meet notification criteria for conditions "most likely to readmit" post discharge. These conditions include sepsis, pneumonia, COPD, and heart failure. These members are followed by EOCCO Nurse Case Managers. EOCCO 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.

EOCCO utilizes 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 members PAM scores are reviewed and entered into CaseTracker Dynamo 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 accessible by over 150 analysts and data users. The ADW has complete redundancy, and complete change history is captured and stored for validation, audit, and backup purposes.

In addition, the Arcadia Analytics Unified Data Warehouse combines the ADW data with additional health data sources including Provider EHR data, hospitalization episode tracking software, and self-help health management software.

(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. In addition, the Arcadia Analytics platform contains an extensive library of web-based reports maintained centrally by Arcadia Analytics in its core systems.

(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 the Arcadia Analytics, 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.

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 service category, PCP utilization, drug costs, etc., with benchmarks	Quarterly	Current
Quality Summary Report	Shows YTD progress compared to targets for 14 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
Population Health Management	Displays current quality measure performance and gap reports with collated EHR and Moda Health claims data	Real-time Access	Current
Upcoming Appointments	Shows members upcoming appointments at participating health centers	Real-time Access	Current
Access Reporting	Tracks access to behavioral healthcare within required timeframes	Quarterly	Current
Patient Safety	Tracks behavioral health patient safety reporting requirements	Quarterly	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, with the exception of the Arcadia Analytics web reports. Arcadia Analytics reporting is 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. This larger analytics community 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?

The Arcadia Analytics platform is a web based tool that all connected EOCCO providers can access, to find complete claims and quality measure data on their assigned members.

For other reports produced by the EOCCO Analytics team, the primary method of report distribution is via the Provider Reports portal. Providers can log in and see the complete history of their clinical and financial reports that pertain to VBPs (the reports listed above). EOCCO maintains 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 spring 2019, a new version of the Provider Reports portal will go live. This new tool will provide vastly improved navigation and organization features, with added ability for providers to access any and all custom and ad hoc analysis produced by the EOCCO 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. That activity will begin in late 2019, with the first reports available sometime in 2020.

Within EOCCO, internal management reports are reviewed on a regular basis. These reports are generally distributed via intranet links or direct e-mail attachments. In addition, a Management Reports intranet site is updated monthly with performance metrics and statistics on cost and utilization. By mid-2019, 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.

EOCCO orchestrates 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?

Our EOCCO HIT Roadmap review and updates will be incorporated into our Incentive Measure Workgroup meeting twice a year. This meeting is currently held bimonthly and consists of a team of individuals from physical, behavioral, and dental health. The group was created to unify efforts toward reaching the incentive measure targets and improving overall quality of our delivery systems. This will be the most relevant space to monitor progress and effectiveness of our HIT efforts.

There are a multitude of other ways we plan to monitor progress. For example, providers receive quarterly updates showing VBP performance. In addition, internal management reports are reviewed on a monthly or quarterly basis, as appropriate, to inform VBP management efforts. For example, in reviewing the status of overall quality metric performance across the organization, issues and/or opportunities are sometimes discovered which lead to resource allocation for targeted interventions – additional provider outreach, member mailings, etc. Currently, the Incentive Measures team for EOCCO meets on a regular basis for this purpose. In addition, shared risk VBP performance is monitored by the analytics and actuarial teams on a regular basis.

Given the importance and prominence of VBPs in the EOCCO, 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.

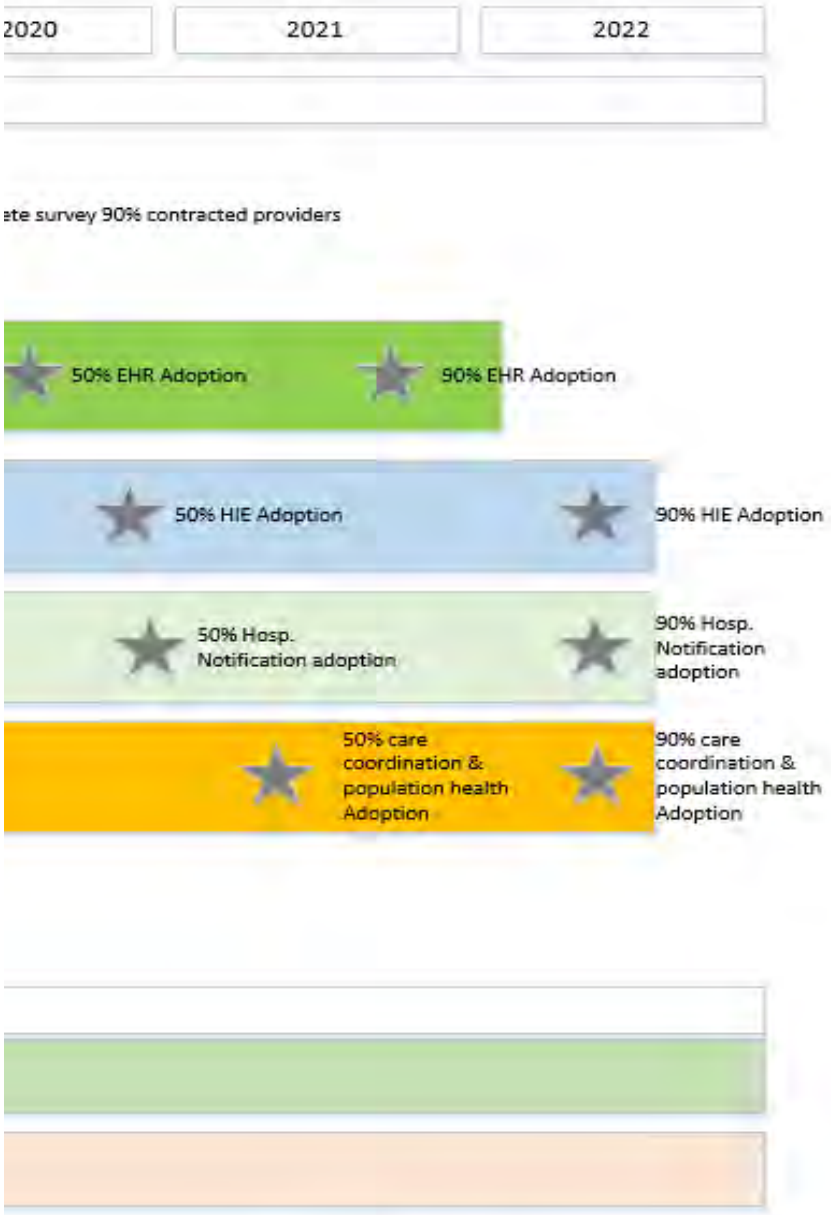
On a tactical level, usage tracking has been enabled on the Provider Reports portal, so that the team can gain insights into which providers are viewing and downloading which reports. Although the next-generation update to the Portal will to some extent create some obsolescence in that data, continued tracking of provider usage will enable refinement of the HIT tools through late 2019 and beyond. For reporting and information delivered via secure e-mail, we maintain the ability to track not only the delivery of reports, but also whether or not a particular recipient has opened the report for review.

(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?

EOCCO already possess the technology, infrastructure, people, and processes to fully support a wide range of VBPs. There is always room for improvement, and planned upgrades are in the works for our technology and reporting platforms such as the new Provider Reports portal and online reports via Tableau Server 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. EOCCO also has dedicated staff members and a direct email for ad-hoc and planned support to our providers. These staff members are readily available to address questions and concerns as they arise. Additionally, these staff members meet with providers in person to mitigate challenges before they arise and to inform providers of this direct resource.

EOCCO HIT Roadmap Data Collection


2020
2021
2022
ete survey 90% contracted providers
50% EHR Adoption
90% EHR Adoption
50% HIE Adoption
90% HIE Adoption
50% Hosp. Notification adoption
90% Hosp. Notification adoption
50% care coordination & population health Adoption
90% care coordination & population health Adoption

EOCCO HIT Roadmap Data Collection

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	
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Q3 2019

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Q3 2020

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Q3 2021

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Q3 2022

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Q3 2023

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Q3 2024

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Utilizing HIE for Care Coordination	
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EOCCO HIT Status: Physical Health

		Organization Name
1	Primary Care	Asher Community Health Center
2		Blue Mountain Hospital
3		CHI St. Anthony Hospital
4		Columbia River Community Health Services
5		Elgin Health Center
6		Encore Health & Wellness
7		Good Shepherd Medical Group
8		Grande Ronde Hospital and Clinics
9		Grande Ronde Hospital and Clinics
10		Grande Ronde Hospital and Clinics
11		Grande Ronde Hospital and Clinics
12		Grant County Health District
13		Harney District Hospital
14		Harrison Family Medicine
15		Hermiston Family Medicine and Urgent Care
16		La Pine Community Health Center
17		Lake Health District
18		Malheur Memorial Health Center
19		Morrow County Health District
20		Morrow County Health District
21		Pediatric Specialists of Pendleton
22		Praxis Medical Group
23		Praxis Medical Group
24		Praxis Medical Group
25		Providence St. Mary's Medical Group
26		Saint Alphonsus Health System
27		Saint Alphonsus Health System
28		Sherman County Health District
29		Snake River Pediatrics
30		South Gilliam Health District
31		St. Luke's Health System
32		Stark Medical Group
33		Urgent Health Care Center
34		Valley Family Health Care
35		Valley Family Health Care
36		Valley Family Health Care
37		Valley Family Health Care
38		Valley Family Health Care
39		Valley Family Health Care

40		Valley Family Health Care
41		Walla Walla Clinic
42		Wallowa Memorial Hospital
43		Warner Mountain Medical
44		Winding Waters Medical Clinic
45		Yakima Valley Farm Workers
46		Yakima Valley Farm Workers
47		Yellowhawk Tribal Health Center
48	Public Health	North Central Public Health
49		Baker County Health Department
50		Grant County Health Department
51		Harney County Public Health
52		Lake County Public Health
53		Malheur County Health Department
54		Morrow County Health Department
55		Public Health Of Umatilla County
56		Center for Human Development & Public Health
57		Wheeler County Public Health
58	Specialty Care	
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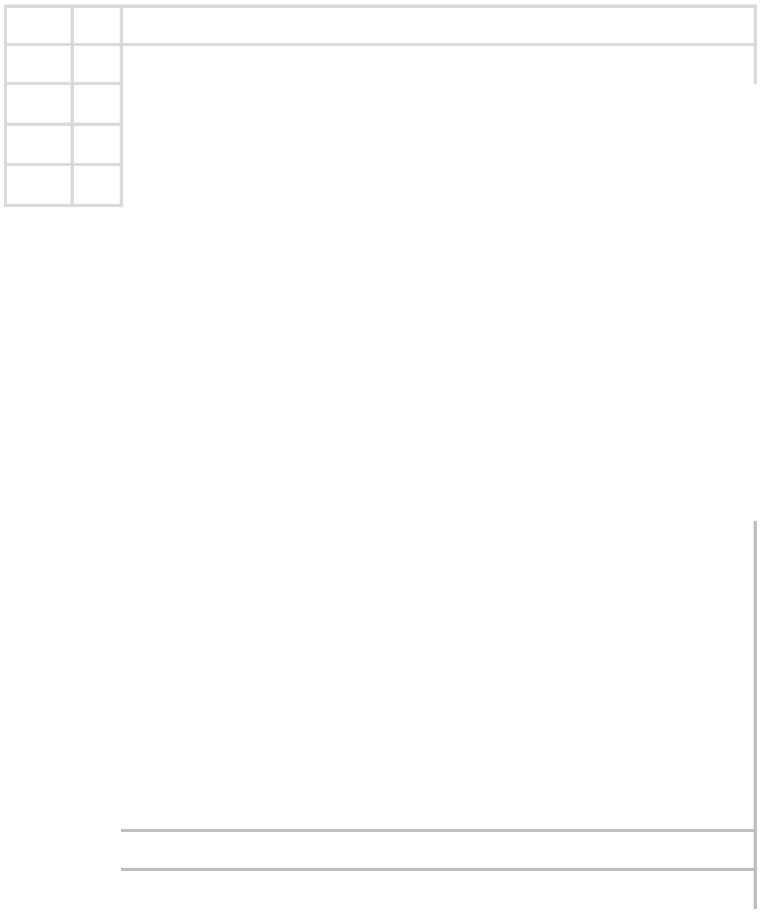

Practice Name	Address
Asher Community Health Center	712 Jay St, Fossil, OR 97830
Strawberry Wilderness Clinic	180 Ford Rd, John Day, OR 97845
St. Anthony Hospital Family Clinic	3001 St Anthony Way, Pendleton, OR 97801
Columbia River Health	450 Tatone St, Boardman, OR 97818
Elgin Health Center	720 Albany St Elgin, OR 97827
Encore Health & Wellness	82346 Bucks Lane Umatilla, OR 97882
Good Shepherd Medical Center	600 NW 11th St, Hermiston, OR 97838
Grande Ronde Hospital Union Clinic	142 E. Dearborn St. Union, OR 97883
Grande Ronde Hospital Elgin Clinic	570 N 8th Ave, Elgin, OR 97827
Grande Ronde Hospital Regional Medical Clinic	506 Fourth St, La Grande, OR 97850
Grande Ronde Hospital Children's Clinic	710 Sunset Dr e, La Grande, OR 97850
Grant County Health Department	528 E Main St E, John Day, OR 97845
Harney District Hospital Family Care	559 W. Washington Burns, Oregon 97720
Harrison Family Medicine	1100 Southgate, Ste 6 Pendleton, OR 97801
Hermiston Family Medicine and Urgent Care	236 E Newport Ave Hermiston, OR 97838
Christmas Valley	87520 Bay Rd. Christmas Valley, OR 97641
Lake Health Clinic	700 S J St, Lakeview, OR 97630
Malheur Memorial Health Center	410 Main St, Nyssa, OR 97913
Pioneer Memorial Clinic	564 E Pioneer Dr Heppner, OR 97836
Irrigon Medical Clinic	220 N. Main Street Irrigon, OR 97844
Pediatric Specialists of Pendleton	2461 SW Perkins Ave, Pendleton, OR 97801
Family Health Associates of Hermiston	600 NW 11th St # E15, Hermiston, OR 97838
La Grande Family Medicine	2011 Fourth St, La Grande, OR 97850
Pendleton Family Medicine	2450 SW Perkins Ave, Pendleton, OR 97801
PMG SE WA	1111 S. 2nd Ave Walla Walla, WA 99362
Baker Clinic Family Medicine	3175 Pocahontas Rd., Baker City, OR 97814
Fruitland Health Plaza	910 NW 16th, Suite 101, Fruitland, ID 83619
Sherman County Health District	110 Main St Moro, OR 97039
Snake River Pediatrics	840 SW 4th Ave, Ste 105, Ontario, OR 97914
South Gilliam Health District	422 N Main St Condon, OR 97823
Eastern Oregon Medical Associates	3950 17th St, Baker City, OR 97814
Stark Medical Group	932 W Idaho Ave # 100, Ontario, OR 97914
Pendleton Primary Care Clinic	1100 Southgate, Pendleton, OR 97801
VFHC Treasure Valley Pediatric Clinic	1219 SW 4th Ave Unit 1, Ontario, OR 97914
Valley Family Health Care - Emmett	207 E 12th St, Emmett, ID 83617
Valley Family Health Care - Nyssa	17 S. Third, Nyssa, OR 97913
Valley Family Health Care - Vale	789 W. Washington, Vale, OR 97918
Valley Family Health Care - Payette	1441 NE 10th Avenue, Payette, ID 83661
Valley Family Health Care - Ontario	2327 SW 4th Ave, Ontario, OR 97914

Valley Family Health Care - New Plymouth	300 N. Plymouth, New Plymouth, ID 83655
Walla Walla Clinic	55 W. Tietan St. Walla Walla, WA 99362
Mountain View Medical Group	603 Medical Pkwy, Enterprise, OR 97828
Warner Mountain Medical	620 South J St Lakeview, OR 97630
Winding Waters Medical Clinic	603 Medical Pkwy, Enterprise, OR 97828
Family Medical Center	1120 Rose Street, Walla Walla, WA 99362
Mirasol Family Health Center	589 NW 11th St, Hermiston, OR 97838
Yellowhawk Tribal Health Center	46314 Timine Way Pendleton, OR 97801
North Central Public Health	419 E 7th St The Dalles, OR 97058
Baker County Health Department	3330 Pocahontas Road Baker City, OR 97814
Grant County Health Department	528 E Main St Ste E John Day, OR 97845
High County Health & Wellness	420 N Fairview Ave Burns, OR 97720
Lake County Public Health	100 North D Street Suite 100 Lakeview, OR 97630
Malheur County Health Department	1108 SW 4th Street Ontario, OR 97914
Morrow County Health Department	110 N Court St Heppner, OR 97836
Umatilla County Public Health	200 SE 3rd St Pendleton, OR 97801
Center for Human Development & Public Health	2301 Cove Ave La Grande, OR 97850
Wheeler County Public Health	712 Jay St, Fossil, OR 97830

				Q3
Phone Number	EHR Product Name	EHR Version Number	2015 Certified EHR	Access to Hospital Event Notifications
(541) 763-2725				
(541) 575-0404				
(541) 966-0535				
(541) 481-7212				
(541) 437-0239				
(541) 922-1750				
(541) 567-5305				
(541) 562-6180				
(541) 437-2273				
(541) 663-3138				
(541) 663-3150				
(541) 575-0429				
(541) 573-2074				
(541) 215-1564				
(541) 567-1137				
(541) 576-2343				
(541) 947-7312				
(541) 372-2211				
(541) 676-9133				
(541) 922-5880				
(541) 276-0250				
(541) 567-6434				
(541) 963-4139				
(541) 276-1700				
(509) 897-3700				
(541) 524-7950				
(208) 452-8000				
(541) 565-3325				
(541) 881-2380				
(541) 384-2061				
(541) 523-1001				
(541) 889-2244				
(541) 966-6916				
(541) 889-2668				
(208) 365-1065				
(541) 372-5738				
(541) 473-2101				
(208) 642-9376				
(541) 889-2340				

(208) 278-3335
(509) 525-3720
(541) 426-3111
(541) 947-2331
(541) 426-4502
(509) 525-6650
(541) 567-1717
(541) 966-9830
(541) 506-2600
(541) 523-8211
(541) 575-0429
(541) 573-2271
(541) 947-6045
(541) 889-7279
(541) 676-5421
(541) 278-5432
(541) 962-8800
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3 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

		Q3 2021	
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 2022			
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

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

Q3 2024			
Access to Hospital Event Notifications	Status of Hospital Event Notifications	Access to HIE	Status of HIE

Using HIE for Care Coordination

EOCCO HIT Status: Behavioral Health

		Organization Name
1	Behavioral Health	Adapt Inc.
2		Addictions Recovery Center
3		Albertina Kerr
4		All Heart Counseling
5		Bestcare Treatment Center
6		Bradley Houck, LCSW (Deaf & Hard of Hearing Couns
7		Center for Human Development
8		Central City Concern
9		Change Point, Inc.
10		Christina Clark, LCSW
11		CODA, Inc.
12		CODA, Inc. - Rolfson House
13		Columbia River Community Heath Services
14		Columbia River Community Heath Services
15		Community Counseling Solutions
16		Community Counseling Solutions
17		Community Counseling Solutions
18		Community Counseling Solutions
19		Community Counseling Solutions
20		Community Counseling Solutions
21		Community Counseling Solutions
22		CRC Health Group
23		DePaul Hillsboro Outpatient Services (DePaul Treatm
24		Eastern Oregon Alcoholism Foundation Inc.
25		Family Solutions (SOCSTC)
26		Grande Ronde Hospital
27		Grande Ronde Hospital, Inc. - Regional Medical Cente
28		Grande Ronde Hospital, Inc. - Regional Medical Cente
29		Greater Oregon Behavioral Health, Inc.
30		Heart Steps Counseling Services Inc.
31		Homestead Youth & Family Services
32		Integrated Health Clinic
33		Intermountain Hospital Inc.
34		Jasper Mountain
35		Joel Rice DBA Grande Ronde Recovery
36		Kairos Northwest (SOASTC dba Kairos)
37		Kara Pattinson MD, PC
38		Kartini Clinic PC
39		Lake Coutny Mental Health

40		Lake Health District Hospital
41		Legacy Emanuel Hospital Health Center Adult Psych I
42		Legacy Good Sam Hospital Medical Center
43		Life Works of Central Oregon
44		Lifeways
45		Lifeways
46		Lifeways
47		Lifeways Malheur
48		Lifeways Umatilla
49		Lifeways Umatilla Inc. (Westgate House)
50		Lifeways Umatilla, Inc.
51		Lifeworks NW
52		Looking Glass Youth/Family Services
53		Mental Health for Children DBA The Child Center
54		Mid-Columbia Center for Living
55		Mid-Columbia Center for Living (MCCFL)
56		Milestone Family Recovery Program
57		Morrison Child & Family Services
58		New Directions Northwest
59		New Directions Northwest (NDNW) Baker House Me
60		New Directions Northwest (NDNW) Baker House Wo
61		New Directions Northwest (NDNW) Recovery Village
62		New Perspectives Center
63		Ontrack Inc.
64		Options for Southern Oregon
65		Polk Adolescent Day Treatment Center (PADTC)
66		Portland Adventist Medical Ctr (Legacy)
67		Providence Health & Services Oregon
68		Rainrock Treatment Center (Monte Nido & Affiliates,
69		Raise the Bottom Training & Counseling
70		Rimrock Trails Adolescent Treatment Services, Inc.
71		Sacred Heart Medical Center
72		St Charles Medical Center
73		St. Mary's Home for Boys
74		Symmetry Care
75		Tara Mahoney DBA TM Counseling
76		The Next Door, Inc.
77		The Power House Drug Residential Treatment Center
78		Transformation Wellness Center
79		Treasure Valley Pediatric Clinic
80		Treasure Valley Physical Therapy
81		Trillium Family Services Inc.
82		Umatilla County Human Services - Umatilla County A
83		Valley Family Health Care
84		Valley Family Health Care - Payette
85		Valley Family Health Care Inc. (VFHC)

86		Wallowa County Center for Wellness
87		Wallowa Valley Center for Wellness - Wallowa River
88		Willamette Family Treatment Services (Willamette F
89		William Trueblood, Ph.D
90		Winding Waters Medical Clinic
91		Winding Waters Medical Clinic
92		Winding Waters Medical Clinic
93		Winding Waters Medical Clinic
94		Yakima Valley Farm Workers Clinic
95		Yakima Valley Farm Workers Clinic

Practice Name
Adapt Inc.
Addictions Recovery Center
Albertina Kerr
All Heart Counseling
Bestcare Treatment Center
Bradley Houck, LCSW (Deaf & Hard of Hearing Counse
Center for Human Development
Central City Concern
Change Point, Inc.
Christina Clark, LCSW
CODA, Inc.
CODA, Inc. - Rolfson House
Columbia River Community Heath Services
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CRC Health Group
DePaul Hillsboro Outpatient Services (DePaul Treatme
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Homestead Youth & Family Services
Integrated Health Clinic
Intermountain Hospital Inc.
Jasper Mountain
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Kara Pattinson MD, PC
Kartini Clinic PC
Lake Coutny Mental Health

Lake Health District Hospital
Legacy Emanuel Hospital Health Center Adult Psych U
Legacy Good Sam Hospital Medical Center
Life Works of Central Oregon
Lifeways
Lifeways
Lifeways
Lifeways Malheur
Lifeways Umatilla
Lifeways Umatilla Inc. (Westgate House)
Lifeways Umatilla, Inc.
Lifeworks NW
Looking Glass Youth/Family Services
Mental Health for Children DBA The Child Center
Mid-Columbia Center for Living
Mid-Columbia Center for Living (MCCFL)
Milestone Family Recovery Program
Morrison Child & Family Services
New Directions Northwest
New Directions Northwest (NDNW) Baker House Men
New Directions Northwest (NDNW) Baker House Won
New Directions Northwest (NDNW) Recovery Village
New Perspectives Center
Ontrack Inc.
Options for Southern Oregon
Polk Adolescent Day Treatment Center (PADTC)
Portland Adventist Medical Ctr (Legacy)
Providence Health & Services Oregon
Rainrock Treatment Center (Monte Nido & Affiliates, I
Raise the Bottom Training & Counseling
Rimrock Trails Adolescent Treatment Services, Inc.
Sacred Heart Medical Center
St Charles Medical Center
St. Mary's Home for Boys
Symmetry Care
Tara Mahoney DBA TM Counseling
The Next Door, Inc.
The Power House Drug Residential Treatment Center
Transformation Wellness Center
Treasure Valley Pediatric Clinic
Treasure Valley Physical Therapy
Trillium Family Services Inc.
Umatilla County Human Services - Umatilla County Alc
Valley Family Health Care
Valley Family Health Care - Payette
Valley Family Health Care Inc. (VFHC)

Wallowa County Center for Wellness
Wallowa Valley Center for Wellness - Wallowa River H
Willamette Family Treatment Services (Willamette Fa
William Trueblood, Ph.D
Winding Waters Medical Clinic
Winding Waters Medical Clinic
Winding Waters Medical Clinic
Winding Waters Medical Clinic
Yakima Valley Farm Workers Clinic
Yakima Valley Farm Workers Clinic

Address	Phone Number	EHR Product Name
621 W Madrone St., Roseburg, Or 97470	(541) 672-2691	
1003 East Main St , Medford, Or, 97504	(541) 779-1282	
832 Ne 162Nd Ave.Portland, Or 97230	(503) 408-5021	
114 Se 1St St , Pendleton, Or 97801	(541) 429-9000	
908 Ne 4Th St Suite 100, Bend, Or 97701	(541) 617-7365	
161 High St Se, Salem, Or 97301	(503) 585-1907	
2301 Cove Avenue , La Grande, Or 97850	(541) 962-8800	ECHO
727 W Burnside, Portland Or, 97209	(503) 294-1681	
1949 Se 122Nd Avenue, Portland Or 97233	(503) 253-5954	
2143 Ne Broadway St. Ste 8, Portland, Or 97232	(971) 912-9505	
1027 E Burnside St, Portland, Or 97214	(503) 239-8400	
720 Se Washington St, Hillsboro, Or 97123	(503) 648-0753	
201 Sw Kinkade Rd , Boardman, Or 97844	(541) 481-7212	
450 Tatone St , Boardman, Or 97818	(541) 481-7212	
104 Sw Kincade Avenue, Boardman, Or 97818	(541) 481-2911	Credible
422 N. Main, Condon, Or 97823	(541) 384-2666	Credible
120 S Main, Heppner, Or 97836	(541) 676-9161	Credible
68982 Willow Cr Rd, Heppner, Or 97836	(541) 676-5143	Credible
528 East Main Street Suite E, John Day, Or 97820	(541) 575-0429	Credible
104 Sw Kincade Avenue, Boardman, Or 97837	(541) 481-2911	Credible
68982 Willow Cr Rd, Heppner, Or 97836	(541) 676-5143	Credible
2600 Se Belmont St, Portland, Or 97214	(503) 465-5586	
205 Se 3Rd Ave Suite 100, Hillsboro, Or 97123	(503) 535-1151	
216 Sw Hailey Ave , Pendleton, Or 97801	(541) 276-3518	
1014 Main St, Vancouver, Wa 98660	(360) 695-1014	
900 Sunset Dr , La Grande, Or 97850	(541) 963-8421	
506 4Th Street , La Grande, Or 97850	(541) 663-3138	
710 Sunset Dr Ste F , La Grande, Or 97850	(541) 663-3100	
804 Chenowith Loop Rd W , The Dalles, Or 97058	(877) 875-4657	NetSmart (MyEvolv)
105 Fir St Suite 321 , La Grande, Or 97850	(541) 963-4005	
816 Se 15Th St , Pendleton, Or 97801	(541) 276-5433	
3610 Ne 82Nd Ave, Portland, Or 97220	(503) 408-9585	
303 N Allumbaugh St, Boise, Id 83704	(208) 377-8400	
89124 Marcola Rd, Springfield, Or 97478	(541) 741-7402	
1101 I Ave, La Grande, Or 97850	(541) 786-2543	
715 Sw Ramsey Ave, Grants Pass, Or, 97527	(541) 956-4943	
1306 Nw Hoyt St, Portland, Or 97209	(503) 224-7171	
3530 N Vancouver Ave Ste 400, Portland, Or 97227	(503) 249-8851	
215 N G St, Lakeview, Or 97630	(541) 947-6021	

700 S J Street , Lakeview, Or 97630	(541) 947-2114	
2801 N Gantenbein Ave, Portland, Or 97227	(503) 413-2200	
1015 Nw 22Nd Ave, Portland, Or 97210	(503) 413-7711	
233 Sw Wilson Ave # 201, Bend, Or 97702	(541) 382-8862	
702 Sunset Drive , Ontario, Or 97914	(541) 889-9167	
290 Willamette Ave., Umatilla, Or 97882	(541) 922-0880	
331 Se 2Nd St, Pendleton, Or 97801	(541) 276-6207	
686 Nw 9Th St, Ontario, Or 97914	(541) 889-2490	
595 Nw 11Th Street, Hermiston, Or 97838	(541) 567-2536	
2575 Westgate Bldg 2, Pendelton, Or 97801	(541) 240-8030	
600 Nw 11Th St, Hermiston, Or 97833	5415672536	
5010 Ne 33Rd Ave , Portland, Or, 97211	(503) 645-9010	
2655 Martin Luther King Jr Blvd, Eugene, Or 97401	(541) 342-4293	
3995 Marcola Rd, Springfield, Or 97477	(541) 726-1465	
100 Main St Unit 2 , Moro, Or, 97039	(541) 296-5452	
419 E 7Th St Room 207, The Dalles, Or, 97058	541.296.5452	
306 Sw 8Th St, Corvallis, Or 97333	(541) 753-2230	
1507 Ne 122Nd Ave, Portland, Or 97230	(503) 258-4555	
2100 Main Street, Baker City, Or 97814	(541) 523-7400	Streamline
2100 Main Street, Baker City, Or 97814	(541) 523-7400	Streamline
2100 Main Street, Baker City, Or 97814	(541) 523-7400	Streamline
2100 Main Street, Baker City, Or 97814	(541) 523-7400	Streamline
565 Union St Ne # 105, Salem, Or 97301	(503) 585-0351	
221 W Main St , Medford, Or, 97501	(541) 622-6160	
1545 Harbeck Rd, Grants Pass, Or 97527	(541) 476-2373	
2200 E Ellendale Ave, Dallas, Or 97338	(503) 623-5588	
10201 Se Main St, Portland, Or 97216	(503) 255-7550	
4400 Ne Halsey St, Portland, Or 97213	(503) 215-1111	
1333 Nw 9Th St , Prineville, Or, 97754	(541) 447-2631	
9196 W Barnes St, Boise, Id 83709	(208) 433-0400	
548 Sw 13Th St, Bend, Or 97702	(541) 388-8459	
1255 Hilyard St, Eugene, Or 97401	(541) 686-6931	
180 Ford Rd , John Day, Or 97845	(541) 388-1636	
16535 Sw Tualatin Valley Hwy, Beaverton, Or 97006	(503) 649-5651	
348 W Adams , Burns, Or 97720	(541) 573-8654	
920 Sw Frazer Ave # 214, Pendleton, Or 97801	(844) 314-1580	
965 Tucker Rd, Hood River, Or 97031	(541) 386-6665	
32405 Diagonal Rd , Hermiston, Or 97838	(541) 314-2781	
3647 Or-39, Klamath Falls, Or 97603	(541) 884-5244	
1219 Sw 4Th Ave Ste 1 , Ontario, Or 97914	(541) 889-2668	
2671 Sw 4Th Ave , Ontario, Or 97914	(541) 889-2221	
3415 Se Powell Blvd. , Portland , Or, 97202	(503) 234-9591	
17 Sw Frazer Avenue Ste 282, Pendleton, Or 97801	(541) 278-6330	
17 N 6Th St, Nyssa, Or 97913	(541) 372-2606	
1441 Ne 10Th Ave , Payette, Id 83661	(208) 642-9376	
2327 Sw 4Th Ave , Ontario, Or 97914	(541) 889-2340	

207 Sw 1St St, Enterprise, Or 97828	(541) 426-4524	EPIC
207 Sw 1St St, Enterprise, Or 97828	(541) 426-4524	
687 Cheshire Ave , Eugene, Or, 97402	(541) 684-4100	
745 Northwest Mount Washington Drive Suite 303, Bend, Or 9770	(541) 385-5203	
603 Medical Parkway , Enterprise, Or 97828	(503) 943-2500	
507 S River St , Enterprise, Or 97828	(503) 943-2500	
301 W Main St , Enterprise, Or 97828	(503) 943-2500	
401-B N Main St, Joseph, Or 97846	(541) 432-6555	
589 Nw 11Th St , Hermiston, Or 97838	(541) 567-1717	
73265 Conferated Way , Pendleton, Or 97801	(541) 966-9830	

Q3 2019				
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 2020				
Access to Hospital Event Notifications	Status of Hospital Event Notifications	Access to HIE	Status of HIE	Using HIE for Care Coordination

			Q3 2021	
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 2022				
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

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

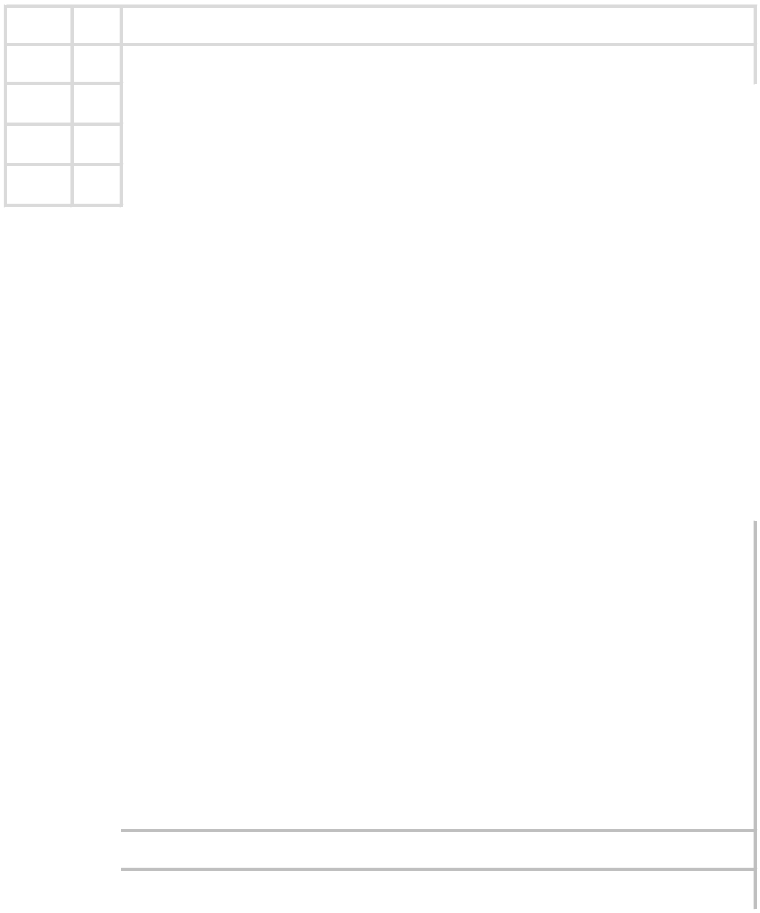
Q3 2024				
EHR Version Number	2015 Certified EHR	Access to Hospital Event Notifications	Status of Hospital Event Notifications	Access to HIE

Status of HIE	**Using HIE for Care Coordination**

EOCCO HIT Status: Oral Health

		Organization Name
1	Oral Health	Grant County Advantage Dental
2		Harney County Advantage Dental
3		Lake County Advantage Dental
4		Barinaga Orthodontics
5		Charles Bond DMD
6		Childrens Dentistry
7		Eastern Oregon Dental Clinic
8		Jacob Atkinson
9		Lake Dental
10		Right Bite Dentures
11		Valley Family Health Care
12		Morrow County Advantage Dental - Boardman
13		Morrow County Advantage Dental - Heppner
14		Advanced Pediatric Dentistry of Hermiston
15		Advantage Dental Clinic - Milton Freewater
16		Advantage Dental Clinic - Umatilla
17		Advantage Dental Clinic - Pendleton
18		Advantage Dental Clinic - Hermiston
19		James West Orthodontics
20		Medical Center Dental
21		Pendleton Family Dental
22		Robert A Meharry DDS
23		Robert Alan Pratt DMD
24		Cornerstone Dentistry LLC
25		Elisha Mayes DDS
26		Mark Harris DMD
27		Union Family Dental Clinic
28		Asher Community Health Center
29		Oregon Healthy Smiles PC
30		Benjamin T Peterson DDS PC
31		Childrens Dentistry
32		Dr Jacob L Atkinson DMD
33		Eric N Dahle DMD
34		European Denture Center
35		Munk Family Dental
36		Right Bright Dentures
37		Advanced Pediatric Dentistry of Hermiston LLC
38		Dale D Moore LD
39		Elgin Family Dental Clinic LLC

40		South County Health District
41		Asher Dental Services
42		Asher Dental Services
43		Eastern Oregon Dental Clinic



Practice Name	Address
Advantage Dental Group PC	750 W Main St, John Day, OR 97845
Burns Dental Group	555 W Adams St, Burns, OR 97720-1408
Advantage Dental Group PC	628 N 1st St, Lakeview, OR 97630
Barinaga Orthodontics	2256, 780 W Idaho Ave, Ontario, OR 97914
Charles Bond DMD	618 Bower Ave, Nyssa, OR 97913
Childrens Dentistry	515 W Idaho Ave, Ontario, OR 97914
Eastern Oregon Dental Clinic	475 SW 12th St, Ontario, OR 97914
Jacob Atkinson	475 SW 12th St, Ontario, OR 97914
Lake Dental	286 SW 4th St, Ontario, OR 97914
Right Bite Dentures	975 SW 1st Ave, Ontario, OR 97914
Valley Family Health Care	2327 SW 4th Ave, Ontario, OR 97914
Advantage Dental Group PC	300 Tatone, Boardman, OR 97818
Advantage Dental Group PC	143 N Main St, Heppner, OR 97836
Advanced Pediatric Dentistry of Hermiston	1060 W Elm Ave Ste 115, Hermiston, OR 97838
Advantage Dental Group PC	112 NE 5th Ave, Milton Freewater, OR 97862
Advantage Dental Group PC	200 6th St, Umatilla, OR 97882
Advantage Dental Group PC	310 SE 2nd St #203, Pendleton, OR 97801
Advantage Dental Group PC	1050 W Elm Ave Ste 230, Hermiston, OR 97838
Columbia Orthodontics	1100 Southgate #12, Pendleton, OR 97801-3973
Medical Center Dental	1100 Southgate #17, Pendleton, OR 97801
Pendleton Family Dental	118 SW 20th St, Pendleton, OR 97801
Robert A Meharry DDS	896 W Orchard Ave, Hermiston, OR 97838
Robert Alan Pratt DMD	916 SW Court Ave, Pendleton, OR 97801
Cornerstone Dentistry LLC	8XR3+FH Island City, Oregon
Elisha Mayes DDS	1502 N Pine St #2, La Grande, OR 97850
Mark Harris DMD	1809 3rd St, La Grande, OR 97850
Union Family Dental Clinic	142 East Dearborn, Union, OR 97883-0605
Asher Community Health Center	106 2nd St, Spray, OR 97874
Oregon Healthy Smiles PC	165 NW 1st St, John Day, OR 97845
Benjamin T Peterson DDS PC	271 SW 13th St, Ontario, OR 97914
Childrens Dentistry	515 W Idaho Ave, Ontario, OR 97914
Dr Jacob L Atkinson DMD	130 Court St S, Vale, OR 97918
Eric N Dahle DMD	478 SW 12th St, Ontario, OR 97914
European Denture Center	188 E Lane Ste 3, Ontario, OR 97914
Munk Family Dental	300 Main St, Nyssa, OR 97913
Right Bright Dentures	975 SW 1st Ave, Ontario, OR 97914
Advanced Pediatric Dentistry of Hermiston LLC	1060 W Elm Ave Ste 115, Hermiston, OR 97838
Dale D Moore LD	1514 Jefferson Ave, La Grande, OR 97850
Elgin Family Dental Clinic LLC	570 S 8th Ave, Elgin, OR 97827

South County Health District	142 East Dearborn, Union, OR 97883
Asher Dental Services	712 Jay St, Fossil, OR 97830
Asher Dental Services	340 SE High St, Mitchell, OR 97750
Eastern Oregon Dental Clinic	135 N Whitley Dr, Fruitland, ID 83619

				Q3 2
Phone Number	EHR Product Name	EHR Version Number	2015 Certified EHR	Access to Hospital Event Notifications
(541) 628-6206				
(541) 573-7778				
(541) 417-7022				
(541) 889-9490				
(541) 372-3311				
(541) 709-5500				
(541) 881-8700				
(541) 881-8700				
(541) 889-7050				
(541) 889-3750				
(541) 889-0052				
(541) 945-4008				
(541) 256-7002				
(541) 289-5433				
(541) 809-7043				
(541) 275-7005				
(541) 276-4768				
(541) 303-7084				
(541) 276-2512				
(541) 276-1561				
(541) 276-7051				
(541) 567-3321				
(541) 276-4257				
(541) 963-6445				
(541) 963-8585				
(541) 963-0924				
(541) 562-2222				
(541) 468-2211				
(541) 575-0363				
(541) 889-9407				
(541) 709-5500				
(541) 473-9166				
(541) 881-1794				
(541) 881-3912				
(541) 372-3950				
(541) 889-3750				
(541) 289-5433				
(541) 963-5803				
(541) 437-6321				

(541) 562-2222
(541) 763-2725
(541) 462-3313
(208) 452-7000

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

EOCCO's HIT Narrative

Questions

How is EOCCO using HIT To achieve desired outcomes?
Where is EOCCO implementing its own HIT system?
Where is EOCCO 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.

Eastern Oregon Coordinated Care Organization
Community Health Improvement Plan

Updated June 30, 2016

Introduction

In 2010, the President of the United States signed the Affordable Care Act (ACA) into law with the goal of making healthcare more available and better managed. The law strives to achieve the Triple Aim: better health for all, better quality services and lower costs. The State of Oregon applied for a Medicaid Waiver to create its own plan to meet the Triple Aim. This plan uses Coordinated Care Organizations (CCOs) with the goal to deliver better care and lower costs across the state.

With the mission of the Triple Aim in mind, the Oregon Health Authority (OHA) recommended that each CCO to conduct a Community Health Assessment (CHA) and create a Community Health Improvement Plan (CHIP) to assess the needs and service gaps in each community across the state. The Eastern Oregon Coordinated Care Organization (EOCCO) CHIP is the outcome of all 12 Local Community Advisory Councils (LCACs) and meets the OHA's request. The EOCCO Regional Community Advisory Council (RCAC) developed this CHIP. RCAC membership includes two members from each of the 12 LCACs appointed by the EOCCO Board of Directors as well as the chairperson of each LCAC and a government official (usually a county commissioner or court member).

In July of 2014, less than a year after the formation of CCOs, the RCAC provided the Regional CHIP to the OHA. Now that there is a more established understanding of the CCO's role from theory to practice, the EOCCO agreed to provide the OHA with a more recently updated CHIP with the intent to guide activities until 2018.

Members of the EOCCO RCAC

Officers

Chair: Megan Gomeza (Malheur County)
Vice chair: Vacant
Secretary: Sheree Smith (Morrow County)

Members

Marji Lind (Baker County)
Robin Nudd (Baker County)
Steve Shaffer (Gilliam County)
Vicki Winters (Gilliam County)
Chris Labhart (Grant County)
Greg Armstrong (Grant County)
Pete Runnels (Harney County)
Darbie Kemper (Harney County)
Charlie Tveit (Lake County)
Ken Kestner (Lake County)
Maria Vargas (Malheur County)
Terry Tallman (Morrow County)
Mike Smith (Sherman County)
Caitlin Blagg (Sherman County)
George Murdock (Umatilla County)
Catie Brenaman (Umatilla County)
Jack Howard (Union County)
Bob Coulter (Union County)
Pepper McColgan (Wallowa County)
Bridget Brown (Wallowa County)
Lynn Morley (Wheeler County)
Candy Humphreys (Wheeler County)

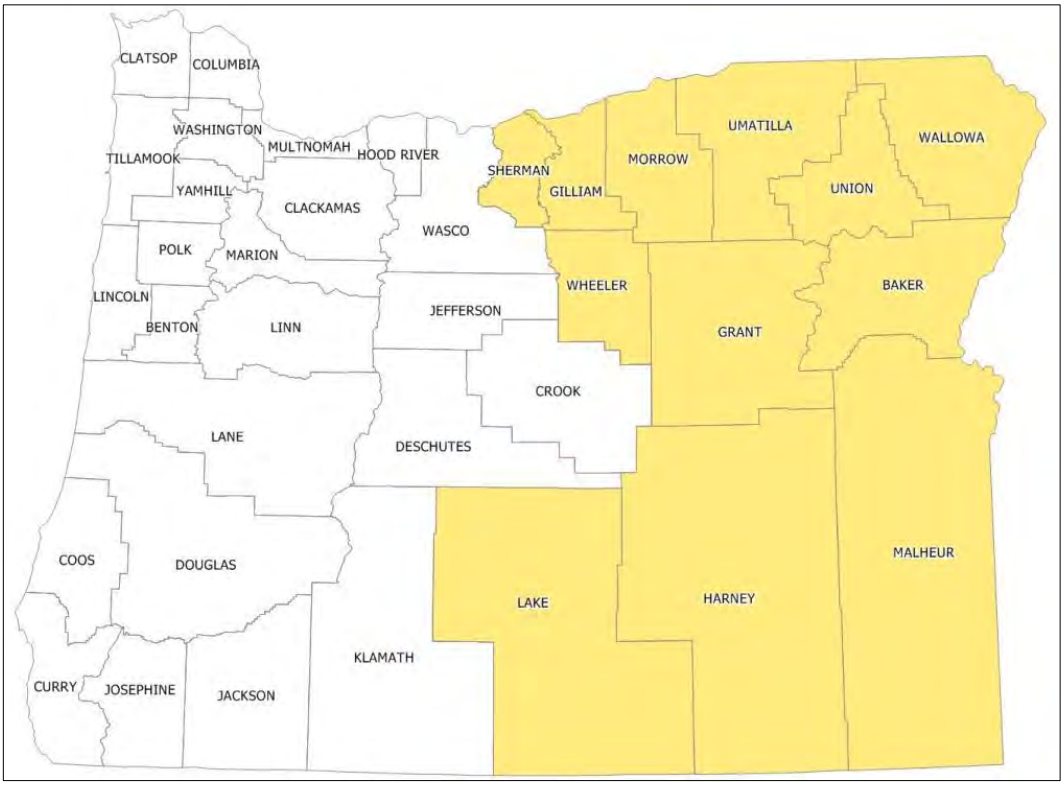
Funding

The RCAC understands that a variety of funding sources will be required to support CHIP implementation. These resources include funds generated by the Eastern Oregon Healthy Living Alliance (EOHLA) a private non-profit 501c3 organization, created by the RCAC in 2014. EOCCO contributions and where possible, private foundations and donors can also be used to support CHIP implementation. Activities in this CHIP will be carried out by using existing staff support, partner organizations and community volunteers.

EOCCO Service Area

The EOCCO service area includes 12 counties varying in population from 1,440 to 78,340. This vast territory covers almost 50,000 square miles (roughly the size of the state of New York) with a total population of 198,895. As of May 1, 2016, there were 46,361 EOCCO plan members in the service area representing 23.3% of the entire service area population. Ten of the 12 counties are considered "frontier," meaning fewer than six people per square mile inhabit the area. Each county is unique. Each county formed a LCAC and conducted a CHA specific to its county. Each LCAC developed its own CHIP specific to the priorities and needs of that particular county. The Regional CHIP reflects the needs across all 12 counties. Each individual LCAC CHIP and its associated CHA can be found at www.eocco.com/community/chas-chips.shtml.

Figure 1: Map of EOCCO Service Area



EOCCO CHA and CHIP Processes

Each LCAC updated their CHAs using data sources that expressed recent (2015) demographic, socioeconomic, and health status data. Additional data that was also reviewed as part of the CHA update that was NOT available in 2014 included: *Medicaid Behavioral Risk Factor Surveillance System (M-BRFSS)* data for Oregon, a 2014 vs. 2015 EOCCO plan member expenditure breakdown *Cost and Utilization Report* for each county, *Oregon Housing Alliance* breakdown of affordable housing by county, poverty specific data by county from *Community in Action*, and EOCCO Incentive Measure progress by county. Disparity data (white vs. non-white) was also included and shared with the LCACs, when available. The EOCCO was able to run cross-reports regarding the shared metrics between Early Learning Hubs and CCOs, which include: percentage of children age 0-6 assigned to a Patient Centered Primary Care Home (PCPCH) and developmental screenings for children (0-36 months). These additional

data sets provided a more comprehensive assessment of the communities in each county as well as the EOCCO population and health improvement as they relate to the social determinants of health.

Between 2013 and early 2014, each LCAC prepared a CHA using various strategies to mix quantitative and qualitative assessments highlighting locally-driven assessments of knowledge sharing, attitudes and beliefs around healthcare coverage and needs. EOCCO plan members assisted with the qualitative assessments in 2014, which included the household survey. According to the survey, 226 people responded that they use the Oregon Health Plan (OHP) for health insurance, while another 268 respondents reported not having any health insurance coverage. Individuals receiving Medicaid were not specifically recorded; however, community members representing all aspects of the population in each county participated in one-on-one interviews, community visioning meetings (using the Nominal Group Technique) and focus groups. Spanish-language focus groups were conducted in Morrow and Malheur County. Morrow County also conducted one-on-one interviews with the Hispanic population. Umatilla County conducted a health assessment specific to the needs of the Hispanic population.

This mixed methodology approach allowed the LCACs to reference these past assessments (2013-2014) review the new quantitative data (mentioned above) and outline priorities in each county's CHA to supplement their approach in updating their CHIP.

EOCCO Plan Membership and Diversity

Consumer and EOCCO plan member engagement on the LCACs has been a priority for LCACs over the past two years. LCACs have focused on recruitment and retention of EOCCO plan members by ensuring that their opinions and desires were reflected during meetings and discussions.

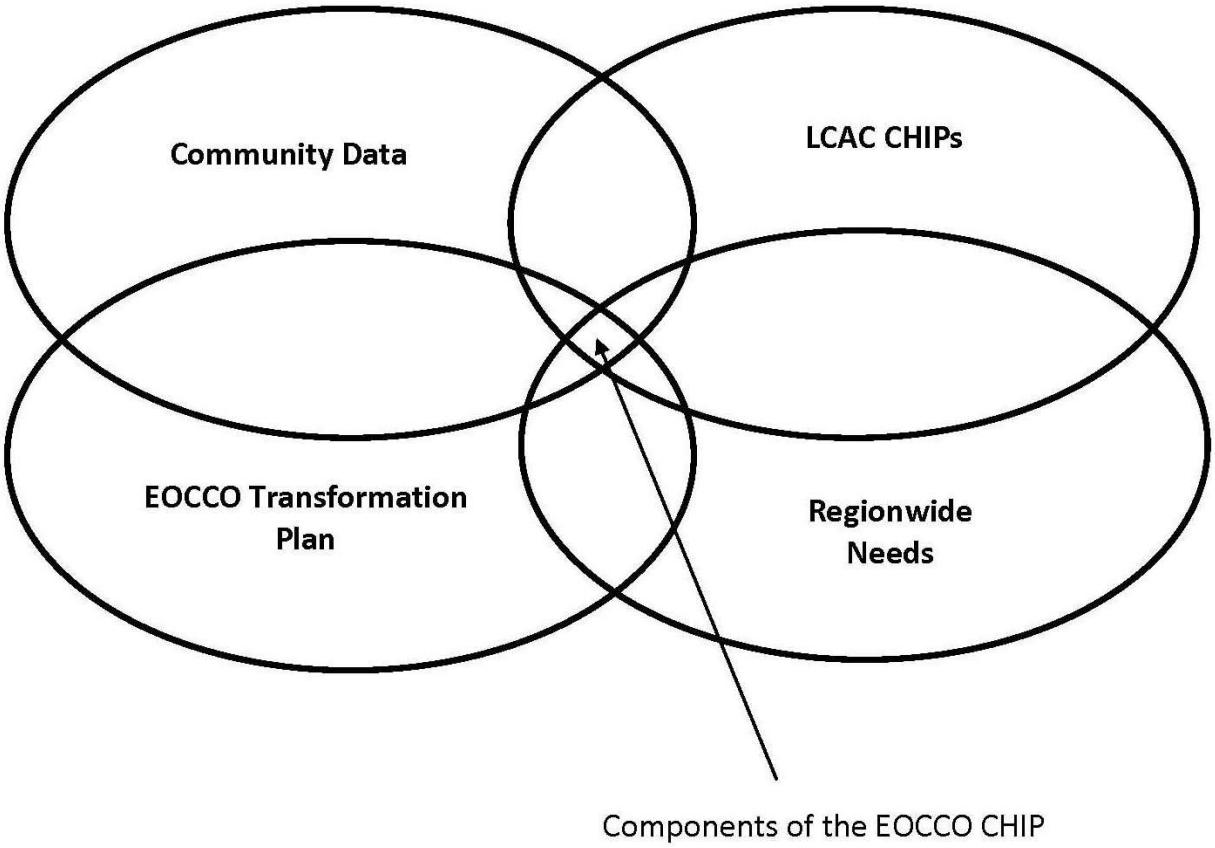
In addition to the diversity of EOCCO plan members representing the consumer, LCACs in all 12 counties also consist of various local and community organizations such as Early Learning Hubs (ELHs), school-based health centers, public health departments, community mental health programs, hospitals and clinics. These local resources have been valued members of the LCACs and their input was taken into consideration when defining priority areas for the CHIP.

Regional Prioritization Process

The challenge in creating the EOCCO CHIP is to find common areas of interest and priority among the 12 diverse counties. The RCAC determined the priorities using audience participation software to rank and select issues. Figure 2 illustrates four major components influential to the development of a comprehensive EOCCO CHIP. A description of each area follows:

- Community Data: Demographics, socioeconomics and health status information, among others.
- LCAC CHIPs: 12 LCAC CHIPs, sorted according to the issues addressed in each one. This sorting allowed the RCAC to see the number of counties that addressed a particular issue and the strategies purposed.
- EOCCO Transformation Plan: Activities required within the EOCCO Transformation Plan.
- Region-wide Needs: RCAC member perceptions and priorities of need.

Figure 2: EOCCO CHIP Areas of Interest and Priority

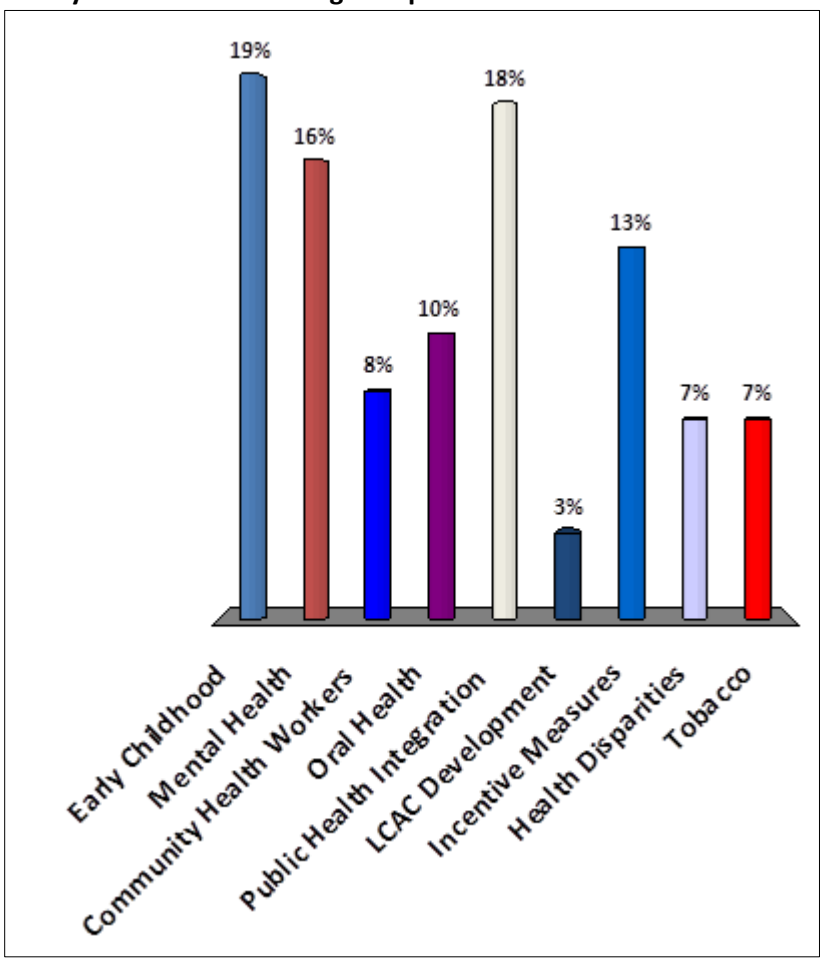


The RCAC selected issues to include in the 2016 EOCCO CHIP. Issues from the 2014 CHIP as well as new issues defined by the LCACs were added to the list and prioritized using Turning Point Technology. The priority order can be found in Table 1 and Graph 1.

Table 1: EOCCO Priority Issues and Weighted Response

Issue	Weighted Response
Early Childhood Prevention and Promotion	130
Public Health Integration	128
Mental Health	110
Incentive Measures	88
Oral Health	68
Community Health Workers	54
Tobacco	52
Health Disparities	48
LCAC Development	22

Graph 1: EOCCO Priority Issues and Percentage Response



EOCCO Regional CHIP

The progress narrative from the 2014 CHIP is included in the sections below. Much of the work continues through activities that are already initiated, or carried forward in the 2016 CHIP as elements that were not initiated in 2014-2015. New activities are also outlined to reflect the changing dynamics of CCOs.

Early Childhood: Progress on Implementation from 2014 CHIP

The March 30, 2015 RCAC meeting was dedicated to allow time for the directors from all five ELHs operating in the EOCCO service area and LCACs to meet and coordinate activities focused on early childhood. As a result of this meeting, the group generated a document displaying cross over elements between the strategic plans of the ELHs and LCAC CHIPs. Turning Point Technology (audience participation software) was used to generate ideas for consistent collaboration at the local and regional levels. Since that meeting, each quarterly RCAC meeting has an agenda item dedicated to ELH progress, and ELH representation on the LCACs is encouraged.

Early Childhood Support: The OHA received a 42-month grant from the Center for Medicare and Medicaid Innovation for its State Innovation Models: Model Testing Initiative (SIM). The SIM grant aims

to support on-going health system transformation and spread Oregon's coordinated care model to other payers. The Center for Human Development was one of the recipients of this SIM award, with the intent to support the EOCCO region's implementation of universal developmental screening. The grant provides for one full-time staff member and resources. While the funding for this grant expires September 2016, the position has been permanently funded by an EOCCO owner (Greater Oregon Behavioral Health, Inc. [GOBHI]). GOBHI/EOCCO Field Team staff has been dedicated to attend ELH meetings and coordinate activities.

PRIORITY AREA: Early Childhood Prevention/Promotion
GOAL: Improve the health outcomes for children ages 0-5 through integrated services.

OBJECTIVE # 1: Coordinate LCAC activities with Early Learning Hubs.

- STRATEGY: Continue system of regular communication and strategic planning with each ELH in the EOCCO region.
- JUSTIFICATION: EOCCO and ELHs are each accountable for similar goals including health and screening.
- EVIDENCE BASE: Collective Impact

ACTION PLAN

Activity	Lead	Measurement	Completion date
Coordinate with hub leaders to attend RCAC meetings to share ELH goals, strategies and information	Linda Watson	Inclusion/communications	Quarterly
Provide data sharing with ELHs	Linda Watson	Updated data sets	Ongoing
Updated reporting to RCAC members of LCAC activities that relate to overlapping metrics strategies	Linda Watson	Documentation/ presentation	Quarterly
Maintain communications through attending ELH governance board and early childhood meetings	Linda Watson	Attendance	As scheduled

OBJECTIVE #2: Improve developmental screening rates for children ages 0-36 months.

- STRATEGY: Continue to use OHA Community Prevention Grant (Healthy Eastern Oregon Project).
- JUSTIFICATION: Although the grant funds end September 30, 2016, the EOCCO has committed funds to continue the effort to improve the developmental screening rates for 0-36 month olds.
- EVIDENCE BASE: https://brightfutures.aap.org; Collective impact

ACTION PLAN

Activity	Lead	Measurement	Completion date
Ages & Stages Questionnaires (ASQ) resources and trainings	Nora Zimmerman	Tracking number of clinics and community-based organization that have received resources	Ongoing

Clinic outreach and support to implement and conduct ASQs	Nora Zimmerman Jill Boyd	Incentive measure target rates	Ongoing
Identify primary care gaps in ASQ delivery and/or documentation	Nora Zimmerman Jill Boyd	Incentive measure target rates and clinic-specific data	Ongoing
Support LCAC efforts to increase developmental screenings	Nora Zimmerman	Incentive measure target rates	Ongoing
Maintain communication with state around development of systems that include nurse home-visiting and early learning teams	Nora Zimmerman	Number of ASQs conducted by public health and early learning programs	Ongoing

OBJECTIVE #3: Increase prenatal care.

- STRATEGY: Strengthen partnership with public health for nurse-based home visiting using OHA Community Prevention Grant (Healthy Eastern Oregon Project).
- JUSTIFICATION: Nurse-based home visiting increases parental engagement and follow-through on doctors' recommendations for high-risk groups related to prenatal care, case management and care coordination.
- EVIDENCE BASE: Nurse Family Partnership evaluation results

ACTION PLAN

Activity	Lead	Measurement	Completion date
Partner with EOHLA and county partners to conduct depression screens through in-home visiting	Nora Zimmerman John Adams	County interest and capacity	August 2016
Public health outreach and support	Nora Zimmerman	Determine number of ASQs delivered through public health departments by county and program	September 2016
Identify number of nurse home visitors by county and program	Nora Zimmerman	Number of nurse home visitors by county and program	August 2016
Identify number of home visits conducted by public health departments in each county	Nora Zimmerman	Number of home visits conducted by each county's public health department and by program	September 2016
Coordinate collaboration meeting(s) between public health and mental health	Nora Zimmerman	Hold the meeting(s)	September2016 and December 2016

OBJECTIVE #4: Increase immunization rates.

- STRATEGY: Increase the number of children fully immunized by age 3.
- JUSTIFICATION: CCO Incentive Measure. According to the US Department of Health and Human Services, for each U.S. birth cohort, routine vaccination during childhood prevents approximately 33,000 deaths and 14 million cases of vaccine-preventable disease, reduces direct healthcare costs by $9.9 billion, and saves $33.4 billion in indirect costs.
- EVIDENCE BASE: United States Preventive Services Task Force and Centers for Disease Control; Oregon Health Authority CCO Resource Guide-Strategies to Improve Immunization Rates

ACTION PLAN

Activity	Lead	Measurement	Completion date
Routinely monitor immunization rates	Nora Zimmerman	Incentive measure target rates	Ongoing
In partnership with Moda Health, share information about CCO's rates with primary care and public health	Nora Zimmerman	More outreach with public health and primary care to improve the metrics. Incentive measure target rates.	Ongoing
Assist in assessment and implementation of quality improvement strategies	Nora Zimmerman	Incentive measure target rates	Ongoing
Promotion and collaboration with LCAC around community education regarding early childhood immunizations	Nora Zimmerman	Incentive measure target rates	Ongoing
Support efforts to implement evidence-based legislation and policy	Nora Zimmerman	Incentive measure target rates	Ongoing

<u>Public Health Integration: Progress on Implementation of 2014 CHIP</u>

Members of the EOCCO and the directors from 11 public health agencies (North Central Public Health District serves two EOCCO counties) met to discuss targeted case management, however, OHA delayed this conversation based on the need to define more targeted requirement for case management. Living Well with Chronic Illness and the National Diabetes Prevention Program classes were implemented across the 12 county region using funding from a Moda Foundation grant which included funds for "train the trainer" classes.

PRIORITY AREA: Public Health Integration (Chronic Disease Management)
GOAL: Provide enhanced alignment between public health services and EOCCO activities for population health management.

OBJECTIVE #1: Coordinate services to prevent and treat chronic health conditions in children.

- STRATEGY: Strengthen relationships between public health home-visiting programs and primary care physicians for clients jointly served through WIC, CaCoon and Babies First to increase care coordination and use of public health programs.
- JUSTIFICATION: Public health provides in-home services for children with special healthcare needs that can enhance the primary care treatment plan and health outcomes. WIC staff and home-visiting nurses provide information on and access to nutritional food choices, decreasing the risks for obesity and diabetes.
- EVIDENCE BASE: Nurse Home Visiting Waiver

ACTION PLAN

Activity	Lead	Measurement	Completion date
Conduct outreach plan to physicians about the availability, services and effectiveness of partnering with public health programs	Nora Zimmerman	Number of enrollees with special healthcare needs enrolled in public health programs	July 2017
Improve coordination, collaboration, and communication between nurse home-visiting programs, primary care providers, and Early Learning Hubs and state partners	Nora Zimmerman	Number of enrollees with special healthcare needs enrolled in public health programs	Ongoing
Promote increased collaboration and coordination among OHA, CCO, Oregon Department of Human Services, Oregon Department of Education's Early Learning Division, and community-based organizations.	Nora Zimmerman	Number of enrollees with special healthcare needs enrolled in public health programs	Ongoing

OBJECTIVE # 2: Create systems for formal interaction between public health and EOCCO.

- STRATEGY: Create Public Health Advisory function for EOCCO.
- JUSTIFICATION: Public health and EOCCO serve common high-risk populations, though local coordination among primary care and public health services varies widely throughout the EOCCO region. Many of the EOCCO goals and priorities are consistent with the expertise and existing programming provided through public health.
- EVIDENCE BASE: Collective impact

ACTION PLAN

Activity	Lead	Measurement	Completion date
Convene public health administrators from EOCCO region around common work areas (e.g., developmental screening, home visiting, etc.)	Paul McGinnis Public Health Administrators in EOCCO region		
Develop action plan for care coordination for specific target populations, to be determined (e.g., diabetic patients)	Paul McGinnis		

OBJECTIVE # 3: Emphasize Living Well with Chronic Conditions

- STRATEGY: Encourage better use of existing Living Well with Chronic Conditions education programs, including *Tomando Control* for Spanish speakers.
- JUSTIFICATION: The burden of chronic disease is extensive in the EOCCO area, with high numbers of residents self-reporting at least one of the following chronic diseases: high blood pressure, high cholesterol, arthritis, diabetes or depression/anxiety. Individuals trained under a prior grant are available.
- EVIDENCE BASE: http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/LivingWell/Pages/Index.aspx

ACTION PLAN

Activity	Lead	Measurement	Completion date
Identify Living Well programs and certified trainers in each county	12 County LCACs Nora Zimmerman	Report on active programs (20 people representing 8 counties have completed LW training)	January 2017
Community Health Workers can deliver evidence-based education in group settings. Encourage Community Health Workers to become Living Well leaders	Charlotte Dudley Oregon State University NEON Family Advocates Institute for Professional Care and Education (IPCE)	Number of CHWs trained as Living Well leaders	Ongoing
Remind primary care	Jill Boyd	Contact with primary care	Ongoing as needed

providers and their care coordinators of the resource and encourage referrals	Carissa Bishop Paul McGinnis	clinics	
Conduct Living Well classes	Living Well Leaders	Number of classes and participants	Ongoing

OBJECTIVE # 4: Implement National Diabetes Prevention Program.

- STRATEGY: Provide education to reduce the number of new diabetics.
- JUSTIFICATION: Individuals trained under a prior grant are available.
- EVIDENCE BASE: http://www.cdc.gov/DIABETES/prevention/index.htm

ACTION PLAN

Activity	Lead	Measurement	Completion date
Identify existing NDPP trained leaders Invite program representatives to speak to LCACs to describe program	LCACs Charlotte Dudley	Report and number of presentations to LCACs 27 people completed the NDPP training. They represent 10 counties	January 2017
Community Health Workers can deliver evidence-based education in group settings. Encourage Community Health Workers to become National Diabetes Prevention Program (NDPP) coaches/ leaders	Charlotte Dudley Oregon State University NEON Family Advocates IPCE	Number of CHWs trained as NDPP coaches / leaders	Ongoing
Remind primary care providers and their care coordinators about the resource and encourage referrals	Jill Boyd Carissa Bishop Paul McGinnis	Contact with primary care clinics	Ongoing as needed
Conduct National Diabetes Prevention classes	NDPP Coaches/ Leaders	Number of classes and participants	Ongoing

Mental Health: Progress on Implementation of 2014 CHIP

Mental Health First Aid training has been identified as an important training priority for community members. Funding has been secured through the OHA CHIP Implementation Grant on behalf of the EOHLA to provide Youth, Adult and Law Enforcement Mental Health First Aid training to teachers and law enforcement in targeted areas of Eastern Oregon. GOBHI has certified trainers and is willing to partner with EOHLA to serve these requests. The EOCCO, with managed contracts through GOBHI, has offered Tier 3 PCPCHs an additional $2 per member per month contract to increase integration of mental/behavioral services delivered in the primary care setting.

PRIORITY AREA: Mental Health
GOAL: Improve the skill sets of residents of EOCCO to recognize and seek treatment (or encourage others) for mental health issues.

OBJECTIVE #1: Provide mental health/prevention education.

- STRATEGY: Create, develop and implement collaborative partnerships with education systems, public safety, public health, mental health, faith-based organizations/groups and other community entities in providing awareness of Mental Health First Aid.
- JUSTIFICATION: Mental Health First Aid is a public education program that helps the public identify, understand and respond to signs of mental illness and substance abuse disorders.
- EVIDENCE BASE: Substance Abuse and Mental Health Service Administration's (SAMHSA) National Registry of Evidence-based Programs and Practices
  For more information about the Mental Health First Aid program, please visit: aocmhp.org/mhfaor www.mentalhealthfirstaid.org

ACTION PLAN

Activity	Lead	Measurement	Completion date
Promote Mental Health First Aid/Youth Mental Health First Aid and partner with National Mental Health Certified Instructors to conduct trainings with school districts, law enforcement and community partners throughout EOCCO	Erin Rust Linda Watson	Track number of individuals who become certified in Adult/Youth Mental Health First Aid	Ongoing
EOHLA grant support to provide funds to paying teachers and law enforcement substitute time to attend Youth Mental Health First Aid trainings	Erin Rust John Adams	Track number of individuals who become certified Youth Mental Health First Aiders	October 2016

OBJECTIVE #2: Encourage integration of mental health/behavioral health and physical health.

- STRATEGY: Increase knowledge-base and receptivity to EOCCO incentive structure for primary care practices who are recognized Patient-Centered Primary Care Homes (PCPCH), specifically with a strong focus on mental and behavioral health integration/co-management.
- JUSTIFICATION: PCPCH Program aligns with the focus of the Triple Aim towards better care, better population health and lowering healthcare costs. State and federal incentive programs focused on coordination and integration also serve as external drivers for practice transformation.
- EVIDENCE BASE: Oregon PCPCH Program Policy Background and Program Development; evidence from the Safety Net Medical Home Initiative demonstration project

ACTION PLAN

Activity	Lead	Measurement	Completion date
Use OHA Technical	OHA Technical	Report Generated	October 2016

Assistance Resources to conduct an environmental assessment of levels of integration currently in process in 8 larger EOCCO primary care practices	Assistance Bank Jill Boyd (Facilitation Support)		
Conduct an inventory of GOBHI resources available to provide technical assistance to communities to promote integration	Jill Boyd	Report Generated	October 2016
Support a Learning Collaborative to share learnings on Behavioral Health Integration	GOBHI	Collaborative Started	January 2017
Provide data analytics combining individual patient physical, mental health, and oral health utilization to identify those patients consuming high levels of health expenditures who have high mental and physical health needs	Ari Wagner Jill Boyd Carissa Bishop Paul McGinnis	Number of data sets analyzed through use of statistical software and the number of meetings held jointly between primary care providers and mental health professionals	Ongoing
Facilitate planning between primary care and mental health around "hot spotting" patient data	Ari Wagner Jill Boyd Carissa Bishop Paul McGinnis	Establishment of care plans	Ongoing
Continue to offer enhanced payments to PCPCHs that use the local community mental health program to provide services in primary care settings	GOBHI (Facilitated by Jill Boyd and Paul McGinnis) Henry O'Keefe	Number of new contracts	Ongoing

OBJECTIVE #3: Reduce community stigma.

- STRATEGY: Work with local faith community leaders to educate the communities they serve about mental health issues and encourage them to seek care when needed.
- JUSTIFICATION: Significant response to Household Survey question related to mental health or substance abuse treatment "t*hinking about the past six months, was there a time when you or someone in your household needed treatment for mental health or substance abuse?"* only 7 percent responded "yes." However, 28 percent responded "several days, more than half or every day" to this question: "In the past two weeks, how often have you been bothered by little interest or pleasure in doing things?" Further, 26 percent responded "several days, more than half or every day" to the question: "In the past two weeks, how often have you been bothered by feeling down,

depressed or hopeless?".

- EVIDENCE BASE: Depression treatment preferences for older rural adults; SAMHSA Faith-based and community initiatives for the reduction of substance abuse and support mental health services. Clinical Gerontologist. 2013;36(3). doi: 10.1080/07317115.2013.767872. **Depression Treatment Among Rural Older Adults: Preferences and Factors Influencing Future Service Use.** Kitchen KA, McKibbin CL, Wykes TL, Lee AA, Carrico CP, McConnell KA.

ACTION PLAN

Activity	Lead	Measurement	Completion date
Work with clergy to develop information packet for community faith leaders (talking points, education material, resource sheet)	GOBHI/EOCCO Field Team	Document produced	November 2016
Coordinate with LCACs and faith community associations and fellowships in each county to encourage the use of the Mental Health Information Resource Packet to get their members to seek help if needed	LCAC	Number of meetings	March 2017
Promote faith community events and activities during the National Mental Health Awareness Month (May 2017)	Clergy	Number of events or sermons given	May 2017

Community Health Workers (CHW): Progress on Implementation of 2014 CHIP

The EOCCO has supported the role of Community Health Workers through dedicated funding from the 2014 Incentive Measure Withhold. State certified Community Health Workers can now submit billing claims for services in the EOCCO 12 county region. The EOCCO has also contracted with the Oregon State University School of Public Health to develop a comprehensive, predominantly web-based CHW Training Program. The trainings will be offered on a regular basis and the web-based nature will allow for more remote training opportunities. In addition, several Transformation Grants supported by the EOCCO highlight the services of Community Health Workers throughout the region.

PRIORITY AREA: Community Health Workers

GOAL: To promote the utilization of trained state-certified Community Health Workers throughout the region.

OBJECTIVE #1: Support training of community health workers.

- STRATEGY: Use existing training resources such as Oregon State University, Northeast Oregon Network (NEON) and Family Advocates to increase the number of community health workers.
- JUSTIFICATION: CHWs apply a broad range of skills to provide holistic or wrap-around services to

community members. They provide assistance to community members in variety of settings with a focus on where the community member is comfortable (e.g. a home visit, the library, in a coffee shop, etc.). CHWs are involved in providing equitable and culturally responsive access to information and services for historically disenfranchised populations and individuals.

- EVIDENCE BASE: OHA CHW certification requirements

ACTION PLAN

Activity	Lead	Measurement	Completion date
Work with LCACs to promote training opportunities provided by Oregon State University, NEON and Family Advocates throughout the EOCCO region	GOBHI/EOCCO Field Team staff assigned with each LCAC Oregon State University NEON Family Advocates IPCE	Number of trainings and individual participants Number of organizations that are able to bill for services	Ongoing
Work with LCACs to promote continuing education requirements for community health workers	GOBHI/EOCCO Field Team staff assigned with each LCAC Oregon State University NEON Family Advocates IPCE	Number of trainings and individual participants Number of organizations that are able to bill for services	Ongoing

OBJECTIVE# 2: Assist in creating financially viable and sustainable community health worker positions.

- STRATEGY: Promote exiting EOCCO payment reimbursement.
- JUSTIFICATION: Billing and collection of payments for services by EOCCO to enhance sustainability of workforce in rural/frontier communities.
- EVIDENCE BASE: Self sufficiency

ACTION PLAN

Activity	Lead	Measurement	Completion date
Monitor claims submitted by community health workers to EOCCO for services provided	Moda Health Data Analytics EOCCO Field Team	A report of claims processed by county every four months	Ongoing
Serve as a liaison between community health workers and EOCCO for identification of issues regarding billing	Charlotte Dudley	Written communications to Moda Health	As needed; ongoing
Conduct an annual webinar with community health workers to gain further insight on issues of implementation	Charlotte Dudley and representatives from Oregon State University, NEON and Family Advocates IPCE	Webinars conducted and numbers of participants	Annually beginning in January 2017

OBJECTIVE #3: Measurement of community health worker impact on expenditures.

- STRATEGY: Partner with Moda Health's Data Analytics team and Arcadia to collect expenditure data on specific patients.
- JUSTIFICATION: Community health worker program supervisors and EOCCO should understand the financial impact of expenditures on patient health outcomes.
- EVIDENCE BASE: Cost benefit analysis

ACTION PLAN

Activity	Lead	Measurement	Completion date
Use claims data to identify patient who use CHW services and monitor individual health expenditure trends	Paul McGinnis and Moda Health's Data Analytics Team	Pre and post expenditures of individual patients	Semi-Annually beginning in January 2017
Encourage the use of CHWs to manage moderate risk patients using "hot spotting" analysis of data	Jill Boyd Carissa Bishop Paul McGinnis	Cross reference the number of mental health/ primary care teams using community health workers and expenditures of individual patients to develop cost/benefit analysis of CHWs	Ongoing

Oral Health: Progress on Implementation of 2014 CHIP

Advantage Dental has taken the lead in this area as the major Dental Care Organization (DCO) serving 37,226 of the 46,211 dental EOCCO plan members. They have offered, and continue to offer First Tooth training in primary care and public health. Advantage also provides ongoing, school-based services throughout the EOCCO region, including dental screenings, fluoride treatment and dental sealants. Advantage is also involved in Community-Based Participatory Research through an application for "virtual dental services."

PRIORITY AREA: Oral Health

GOAL: Improve oral health for toddlers, children and adolescents under the age of 21.

OBJECTIVE #1: Implement First Tooth Project

- STRATEGY: Use primary care clinicians to provide preventive oral health services to children ages 0–36 months. Services may also be provided by WIC workers, Head Start staff, etc.
- JUSTIFICATION: In 2012 only 15 percent of all children ages 0–23 months received preventive services from dental care organizations in Oregon.
- EVIDENCE BASE: Children see primary care providers during well-child visits, and that is the time to deliver oral healthcare; First Tooth Project: http://public.health.oregon.gov/preventionwellness/oralhealth/firsttooth/pages/index.aspx.

ACTION PLAN

Activity	Lead	Measurement	Completion date
Create awareness of First Tooth Project trainings	Advantage Dental, ODS, and Capitol Dental Charlotte Dudley	Number of trainings administered based on awareness campaigns sent out	Ongoing

Recruit primary care providers to participate in First Tooth trainings	LCACs Jill Boyd Paul McGinnis	Number of primary care practices trained	Ongoing
Conduct trainings for providers, including staff members at WIC and Head Start	Advantage Dental, ODS, and Capitol Dental	Number of trainings administered for First Tooth Project	Ongoing

OBJECTIVE #2: Conduct oral health screenings and education in schools grades K-12.

- STRATEGY: To conduct oral screenings in schools.
- JUSTIFICATION: Most children and adolescents are in schools; new legislation requires oral health screening in schools ; Early treatment and services prevents tooth decay.
- EVIDENCE BASE: United States Preventive Services Task Force; fluoridealert.org/researchers/states/oregon/

ACTION PLAN

Activity	Lead	Measurement	Completion date
Establish Memorandum of Understanding between school districts and Advantage Dental	Advantage Dental / EOHLA and school districts	Number of schools under agreement and percentage of children assigned to those schools by county	Annually
Conduct screenings and assess each child's needs into good, needs referral, needs immediate referral	Advantage Dental	Number of children screened and data collection describing oral health status by county	Annually
Provide oral health education and supplies	Advantage Dental	Number of children given education and supplies	Annually

OBJECTIVE #3: Apply fluoride varnish and dental sealants

- STRATEGY: While assessing oral health status, provide needed preventive services.
- JUSTIFICATION: Dental sealants are an incentive measure.
- EVIDENCE BASE: Fluoride and sealants prevent decay.

ACTION PLAN

Activity	Lead	Measurement	Completion date
Service delivery requires an "active consent" from parents. Promote participation	LCACs Advantage Dental	Percentage of active consent forms returned	Every Fall
Apply fluoride varnish	Advantage Dental	Number of children receiving fluoride treatment	Annually
Apply dental sealants	Advantage Dental	Number of children/adolescents receiving sealants	Annually

PRIORITY AREA: Social Determinants of Health
GOAL: To emphasize and introduce the concepts that health status is closely tied to housing, transportation, education and socioeconomic status.

OBJECTIVE # 1: Improve affordable housing opportunities.

- STRATEGY: Provide education about housing programs statewide and rental assistance for high needs EOCCO plan members.
- JUSTIFICATION: Housing is part of the new waiver proposed by OHA to Centers for Medicaid and Medicare Services.
- EVIDENCE BASE: Collective impact

ACTION PLAN

Activity	Lead	Measurement	Completion date
Provide LCACs with updated data sheets from the Oregon Housing Alliance	LCAC Staff	Presentations	As available
Dedicate a portion of an RCAC meeting annually to staff from the Oregon Housing and Community Services	Troy Soenen	Presentations at RCAC	September 2016 and 2017
Conduct a regional Health and Housing Forum with staff from Oregon Housing and Community Services; LIFT Program	Troy Soenen	Forum Held	June 2017
Provide LCACs with information about rental assistance programs provided through GOBHI	Dan Schwanz	Presentations to LCACs	Annually

OBJECTIVE #2: Improve use of non-emergency transportation service.

- STRATEGY: Collect utilization data and share.
- JUSTIFICATION: Improved awareness of how to use the service.
- EVIDENCE BASE: Transportation is a barrier to accessing services

ACTION PLAN

Activity	Lead	Measurement	Completion date
Create a utilization presentation	Dan Schwanz	Data Set Created	January 2017
Present information to LCACs	Dan Schwanz	Presentations	January to June 2017
Seek LCAC and consumer involvement in promoting use of non-emergency transportation	LCAC Staff	Materials created	June 2017

PRIORITY AREA: School-based Services
GOAL: To better coordinate health services delivered in the school setting.

OBJECTIVE #1: Improve knowledge of and coordination of services provided in school setting.

- STRATEGY: Assess services delivered in school settings.
- JUSTIFICATION: Levels of services are being provided in schools is not quantified.
- EVIDENCE BASE: Collective Impact

ACTION PLAN

Activity	Lead	Measurement	Completion date
Identify school districts in EOCCO service area employing an RN level school nurse and funding source for the position	Jamie Smith, OHA School Nurse Consultant Paul McGinnis	Report	June 2017
Create measurement system on the effectiveness of school-based mental counseling positions	Erin Rust	Tool Created; results shared	June 2017
Provide presentation on the status of any local School-based Health Centers to the LCAC	LCAC Support Staff	Presentations	Annually

LCAC Development: Progress on Implementation of 2014 CHIP

The Regional CAC members have dedicated a significant amount of time and energy to increase EOCCO plan membership on the LCACs, beginning with a training from the OHA Technical Assistance Bank during the RCAC meeting on December 22, 2014. Each of the LCAC representatives at the RCAC meeting brought information back to their LCAC with the task to identify activities and materials to engage EOCCO plan member participation. In 2016, EOCCO plan member representation increased across the region. In addition, some LCACs received training on Understanding Poverty with Empathy and diversity trainings/technical assistance through the OHA Office of Equity and Inclusion were also offered to LCACs and affiliated organizations.

PRIORITY AREA: LCAC Skill Development
GOAL: Improve the skill set of all local community advisory council members.

OBJECTIVE # 1: Develop cultural competency among clinicians and other community health and social service organizations.

- STRATEGY: Assess and train on cultural competency needs/gaps by using 15 National CLAS (Culturally and Linguistically Appropriate Services) Standards in Health and Health Care.
- JUSTIFICATION: Requirement of 3 of 8 EOCCO Transformation Plan elements
    - EOCCO Plan Element #6: Assuring communications, outreach, member engagement and services are tailored to cultural, health literacy, and linguistic needs
    - EOCCO Plan Element # 7: Assuring provider network and staff ability to meet culturally diverse needs of the community (cultural competence training, provider composition reflects member diversity; nontraditional healthcare workers composition reflects member

diversity)
    - EOCCO Plan Element #8: Developing a quality improvement plan focused on eliminating racial, ethnic and linguistic disparities in access, quality of care, and outcomes.
- EVIDENCE BASE: http://www.usc.edu/hsc/ebnet/Cc/awareness/ccare.htm

ACTION PLAN

Activity	Lead	Measurement	Completion date
Coordinate and conduct a series of educational programs with LCACs emphasizing promotion of health equity best practices: • Client civil rights • Language access services • Cultural competency • Diversifying the health workforce	OHA Office of Equity and Inclusion staff, Armenia Sarabia	Number of health equity webinars, pre post survey assessment, in person presentations and online formats	Ongoing

OBJECTIVE # 2: Understanding poverty with empathy.

- STRATEGY: Build empathy among LCAC members for understanding the struggles faced by people caught in multigenerational poverty.
- JUSTIFICATION: Many EOCCO plan members frequently use health and social services.
- EVIDENCE BASE: Bridges Out of Poverty; www.ahaprocess.com/solutions/community/

ACTION PLAN

Activity	Lead	Measurement	Completion date
Identify a competent trainer	Troy Soenen	Contract to deliver webinar	As funds are generated
Training Event	Troy Soenen	Number of participants at workshop	June 2018

OBJECTIVE #3: Implement positive community norms.

- STRATEGY: Introduce LCACs to the Positive Community Norms framework.
- JUSTIFICATION: Positive behaviors can be encouraged across the community by emphasizing strengths rather than needs.
- EVIDENCE BASE: www.mostofus.org

ACTION PLAN

Activity	Lead	Measurement	Completion date
Presentation to LCACs	OHA MORE Program and GOBHI/EOCCO Field Team staff	Number of presentations	June 2018
Select subjects for training to test changes in community norms facilitated by Most of Us	Paul McGinnis and Montana State University	Training Event	June 2018

OBJECTIVE # 4: Increase EOCCO plan member engagement.			
STRATEGY: Increase participation of EOCCO plan members in LCAC activities. JUSTIFICATION: Involvement of people who are most affected by the group's activities makes for better programs. EVIDENCE BASE: OHA Requirement of 51% LCAC Membership			
ACTION PLAN			
Activity	Lead person/ organization(s)	Measurement	Completion date
Utilize resources available from the Oregon Health Authority Transformation Center such as: marketing materials, PSAs, smart goals, and technical assistance.	OHA Transformation Center Charlotte Dudley LCACs	Increased usage of materials Increased number of EOCCO plan members involved in LCAC activities	Ongoing
Exchanging ideas and materials between LCACs. Share information about focus groups, round tables, marketing materials, agenda items and success stories.	LCACs LCAC member engagement subcommittees Charlotte Dudley Carissa Bishop	Increased member engagement activities across the EOCCO region Increased number of EOCCO plan members involved in LCAC activities Increased number of member engagement resources or information found on the EOCCO website	Ongoing
Increase the number of EOCCO plan members who are involved in LCAC activities. Retain new LCAC members.	LCACs LCAC member engagement subcommittees	Host member engagement activities Provide orientation information to new members	Ongoing

<u>Community-based Participatory Research : Progress on Implementation of 2014 CHIP</u>

Community-based Participatory Research has been conducted in two areas of the EOCCO. First LCACs were involved in focus groups through the Oregon Health & Science University Knight Cancer Institute program to understand Colorectal Cancer Screening knowledge, attitudes and beliefs in the community. Second, Advantage Dental partnered with two LCACs and the University of Washington to submit a grant to the Advanced Practice of Dental Hygienists with the intent to test the effectiveness of "virtual dental services," primarily through tele-dentistry.

PRIORITY AREA: Community-based Participatory Research
GOAL: Allow LCACs to use their local knowledge to test innovations in science in partnership with university-based researchers.

OBJECTIVE #1: Be available to academic researchers for community-based participatory research.

- STRATEGY: Create a "ready" community to participate in research.
- JUSTIFICATION: Tools exist and staff is knowledgeable.
- EVIDENCE BASE: U.S. Department of Health and Human Services, Clinical and Translational Science Awards Consortium *Principles of Community Engagement (2nd edition*), June 2011

ACTION PLAN

Activity	Lead	Measurement	Completion date
Be available to academic researchers for community projects which improve Incentive Measures or implement CHIP strategies	Paul McGinnis	Number of opportunities explored	Ongoing

Fundraising/EOHLA: Progress on Implementation of 2014 CHIP

In the 2014 CHIP, this subject heading was listed as Fundraising, with the intent to create a 501c3 non-profit to raise funds in support of the EOCCO Regional CHIP. EOHLA was formed and staffed by an Executive Director, with a guarantee of three years of support from GOBHI. The Board of Directors for EOHLA consists of recommended partners from each of the 12 LCACs, which provides monthly updates to EOHLA activities at each LCAC meeting. In addition, EOHLA's Executive Director has designated time at each RCAC meeting to report EOHLA updates as they align with the RCHIP. In the last year, EOHLA has secured almost $400,000 in grant projects, including funding to implement the following: Mental Health First Aid training for three EOCCO sites ($30,000), two school-based oral health projects ($280,000, and a project measuring the effectiveness of promotional materials for colon screening ($25,000).

PRIORITY AREA: Eastern Oregon Healthy Living Alliance
GOAL: Support EOHLA as it seeks private, corporate and government funding to implement strategies across the EOCCO region.

OBJECTIVE # 1: Improved communications between EOHLA and LCACs

- STRATEGY: Presence of EOHLA Board Members at LCAC meetings and EOHLA Executive Director at RCAC.
- JUSTIFICATION: EOHLA supports funding for CHIP.
- EVIDENCE BASE: Collective Impact

ACTION PLAN

Activity	Lead	Measurement	Completion date
EOHLA Director to present at quarterly RCAC meetings	John Adams	Quarterly presentations and updates	Ongoing
EOHLA Board member to convey EOHLA progress at LCAC meetings	EOHLA Board Member	Presentations	Ongoing

PRIORITY AREA: Incentive Measures
GOAL: Encourage LCACs to understand potential contributions to the Incentive Measure targets established for the EOCCO by the OHA.

OBJECTIVE #1: Keep LCACs informed of incentive measure progress.

- STRATEGY: At least twice yearly presentations.
- JUSTIFICATION: Incentive measure progress reports from Moda Health.
- EVIDENCE BASE: Outcome and quality measures have been developed by the Metrics and Scoring Committee to show how well CCOs are improving care, making quality care accessible, eliminating health disparities, and curbing the rising cost of healthcare. Technical Specifications and Guidance Documents for CCO Incentive Measures; www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx

ACTION PLAN

Activity	Lead	Measurement	Completion date
Presentation to each LCAC about Incentive Measure progress per county	Jordan Ann Rawlins, Moda Health Troy Soenen, Facilitator	Bi-yearly presentations	Ongoing; at least twice yearly
Target low performance EOCCO County(ies)and encourage use of LCAC Incentive Measure resources for improvement	LCAC Support Staff	Improved performance toward targets	Ongoing

OBJECTIVE # 2: Best practices to improve incentive measures.

- STRATEGY: Share best practices.
- JUSTIFICATION: Creating and sharing new knowledge.
- EVIDENCE BASE: Incentive Measures Data; www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx

ACTION PLAN

Activity	Lead	Measurement	Completion date
Share Incentive Measure dictionary and measurement process with LCACs	Jordan Ann Rawlins, LCAC Support Staff	Presentations	Ongoing
Share opportunities for improvement webinars sponsored by OHA	Estela Gomez, Jordan Ann Rawlins and LCAC Support Staff	Communications	Ongoing
Share knowledge of “best practices” from high performing counties to lower performing counties	GOBHI/EOCCO Field Team staff	Incentive measure performance increase; review of shared knowledge between LCACs	Ongoing

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								

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)			
Baker CAC-8, Gilliam CAC-2, Grant CAC-1,	Names on file	Provides diverse input	Strengthen engagement and communication with OHP Consumers through in-person orientation, orientation manuals, a set agenda item for community member input, and enhanced CCO website with CAC information materials. Include OHP member input on enhancing the CCO website.
Harney CAC-5, Lake CAC-0, Malheur CAC-3	Names on file	Provides diverse input	Engagement and communication
Morrow CAC-1, Sherman CAC-3, Umatilla CAC-1	Names on file	Provides diverse input	Engagement and communication
Union CAC-7, Wallowa CAC-0, Wheeler CAC-6	Names on file	Provides diverse input	Engagement and communication

Community-based organizations that address disparities and SDOH-HE (list in first column below)			
Oregon Food Bank	Lynn Knox	Partner in food projects	Continue regular meetings to maintain and strengthen relationship with stakeholder. Continue to share and discuss community needs and the opportunity to partner on sharing resources with the community.
Community in Action (Malheur and Harney CAP)	Barb Higinbotham	Malheur CAC facilitation, rental assistance; weatherization; housing development	Continue regular meetings and joint work on 40 unit housing build
Community in Action Program of East Central Oregon	Helena Wolf	Partner in housing, rental assistance, weatherization, and food banks	Continue regular meetings
Lake County Library	Amy Hutchinson	SDOH partner	Continue regular meetings
Lake Health District	Charlie Tveit	Community benefit programs	Continue regular meetings
Lake County School District	Brandi Harris	SDOH partner	Continue regular meetings
Blue Mountain Community College	Carol Johnson	SDOH partner	Continue regular meetings
Clearview	Darrin Umbarger	Partner for providing wheelchair charging stations	Continue regular meetings
Oregon State Extension Office	Angie Treadwell	SDOH partner	Continue regular meetings
Community Connection Neo Transit	Margaret Davidson	Transportation, rental assistance, and weatherization; housing development	Continue regular meetings
Umatilla Morrow Community Head Start	Catie Brenaman	Provides early learning input	Continue regular meetings
Home 4 Hope Coalition	Heidi Zeigler	SDOH partner	Continue CAC support
Department of Health and Human Services	Heidi Zeigler	SDOH partner	Continue regular meetings
Building Healthy Families	Beverly DuBosch	SDOH partner	Continue regular meetings
Condon Child Care Center	Jennifer Bold	Provide children knowledge	Continue regular meetings
Families First/Early Learning	Teresa Aasness	SDOH partner	Continue regular meetings
Senior Services	Angie Lamborn	Provide senior input and housing partner for 20 unit build in Burns / Hines	Continue regular meetings
Early Learning Education	Donna Schnitker	Provide early learning input	Continue regular meetings
Northeast Oregon Housing Authority	Sarah Parker	Developed process to successfully accept Rental Assistance program recipients into HUD vouchers	Continue regular meetings and collaboration

Lakeview Education Services District	Jack Thompson	SDOH partner	Continue regular meetings
Oregon Child Development Coalition	Joni Delgado	Partner in child knowledge	Continue regular meetings
Malheur Education Service District	Kelly Poe	Partner in education	Continue regular meetings
Veterans Administration	Kelly Holland	SDOH partner	Continue regular meetings
Union County Veteran's Affairs	Byron Whipple	Housing partner	Continue regular meetings and exploring new opportunities
Union County Cares	Sherlyn Roberts	Union County Farmers market, doubling up food bucks program for farmers market vouchers	Continue regular meetings and collaboration
North East Oregon Network	Eric Griffin	Warming shelter	Continue regular meetings
Area Health Education Center	Meredith Liar	Partnering on campus for rural health	Continue regular meetings and developing nurse practitioner students
Union County Neighbors Together	Gary Bieberdorf	Support warming shelter, food bank	Continue regular meetings and developing partnership
EUVALCREE	Xavier Romano	Hispanic/Latino community capacity building and advocacy	Continue to engage
Eastern Oregon Health Living Alliance	John Adams	SDOH Partner	Continue regular meetings and project support
Providers, physical health, including culturally specific providers as available (list in first column below)			
Arlington Medical Center	David Anderson	Partner in health care environment	Continue regular meetings
Asher Community Health Center	Susan Moore	Partner in health care environment	Continue regular meetings
Blue Mountain Hospital; Strawberry Wilderness Clinic	Derek Daly, Marcia Wasiluk	Provides culturally & linguistically appropriate services	Continue regular meetings
Columbia River Health	Sonja Neal	Partner in health care environment	Continue regular meetings
Eastern Oregon IPA	Christopher Zadeh	Partner in health care environment	Continue regular meetings
Elgin Health Center	Gina Montgomery, Tempie Bartell	Partner in health care environment	Continue regular meetings
Encore Health & Wellness	Kelly Payan	Partner in health care environment	Continue regular meetings

Family Health Associates of Hermiston	Jennifer Sword	Partner in health care environment	Continue regular meetings
Good Shepherd Medical Center	Dennis Burke	Provides culturally & linguistically appropriate services	Continue regular meetings
Grande Ronde Hospital & Clinics	Jeremy Davis, Tammy Winde	Partner in health care environment	Continue regular meetings
Harney District Hospital & Family Care Clinic	Dan Grigg, Debbie Peterson	Partner in health care environment	Continue regular meetings
Harrison Medical Clinic	Shawn Gee	Partner in health care environment	Continue regular meetings
Hermiston Family Medicine & Urgent Care	Tami Foster, Bruce Carlson	Partner in health care environment	Continue regular meetings
High County Health & Wellness	Kelly Singhose	Provides culturally & linguistically appropriate services	Continue regular meetings
La Grande Family Medicine	McKenzie Kennedy	Partner in health care environment	Continue regular meetings
La Pine Community Health Center	Marie Manes	Partner in health care environment	Continue regular meetings
Lake District Hospital; Lake Health Clinic	Charlie Tveit, Susan Campbell, Namrata Dave	Provides culturally & linguistically appropriate services	Continue regular meetings
Malheur Memorial Health Center	Susan Dean	Partner in health care environment	Continue regular meetings
Pediatric Specialists of Pendleton	Erin Blair	Partner in health care environment	Continue regular meetings
Pendleton Family Medicine	Jennifer Perry	Partner in health care environment	Continue regular meetings
Pendleton Primary Care	Tami Foster, Bruce Carlson	Provides culturally & linguistically appropriate services	Continue regular meetings
Pioneer Memorial Hospital, Clinic & Irrigon Medical Clinic	Bob Houser; Kris Jones	Provides culturally & linguistically appropriate services	Continue regular meetings

Saint Alphonsus Medical Group (Hospital & Clinics)	Kenneth Hart; Raylyn Wilson, Kathie Pointer	Partner in health care environment	Continue regular meetings
Sherman County Medical Clinic	Caitlin Blagg	Partner in health care environment	Continue regular meetings
Snake River Pediatrics	Chelsey Bidwell	Provides culturally & linguistically appropriate services	Continue regular meetings
South Gilliam Health Center	Michael Takagi	Partner in health care environment	Continue regular meetings
St Luke's Eastern Oregon Medical Associates	Ned Ratterman	Partner in health care environment	Continue regular meetings
St. Anthony Hospital & Clinic	Harry Geller, Cheryl Pearce	Provides culturally & linguistically appropriate services	Continue regular meetings
Stark Medical Clinic	Brenda Stark	Partner in health care environment	Continue regular meetings
Valley Family Health Care	Karina Carbajal, Stephanie Neys	Provides culturally & linguistically appropriate services	Continue regular meetings
Wallowa Memorial Hospital, Mountain View Medical Clinic	Larry Davy, Jenni Word, Michelle Gardner	Partner in health care environment	Continue regular meetings
Warner Mountain Medical	Darla Pardue	Partner in health care environment	Continue regular meetings
Winding Waters Medical Clinic	Nicolas Powers, Meg Bowen	Provides culturally & linguistically appropriate services	Continue regular meetings
Yakima Valley Farm Workers Clinics	Carlos Olivares, Justine Taylor, Matt Davy	Provides culturally & linguistically appropriate services	Continue regular meetings
Yellowhawk Tribal Health Center	Angie Dearing, Karen Cook	Provides culturally & linguistically appropriate services	Continue regular meetings
Providers, behavioral health, including culturally specific providers as available (list in first column below)			
Community Counseling Solution	Kimberly Lindsay	Partner in behavioral health	Continue regular meetings
New Horizons	Jose Garcia	Partner in behavioral health	Continue regular meetings

Symmetry Community Mental Health	Chris Siegner	Partner in behavioral health	Continue regular meetings
Lifeways (Umatilla)	Micaela Cathey	Partner in behavioral health	Continue regular meetings
New Directions Northwest	Shari Selander	Partner in behavioral health	Continue regular meetings
Center for Human Development	Aaron Grigg	Partner in behavioral health	Continue regular meetings
Lifeways (Malheur)	Tim Hoekstra	Partner in behavioral health	Continue regular meetings
Wallowa Valley Center for Wellness	Chantay Jett	Partner in behavioral health	Continue regular meetings
Lake District Wellness Center	Trace Wonser	Partner in behavioral health	Continue regular meetings
Mid-Columbia Center for Living	Barbara Seatter	Partner in behavioral health	Continue regular meetings
Umatilla County Alcohol and Drug Program	Amy Ashton-Williams	Partner in behavioral health	Continue regular meetings
Providers, oral health, including culturally specific providers as available (list in first column below)			
Advantage Dental	Mary Ann Wren	Provide oral health information	Continue regular meetings
Burns Dental Group	Barb Crafts	Provide oral health information	Continue regular meetings
ODS Community Dental	Nancy Avery	Provide oral health information	Continue regular meetings
Providers, long term services and supports, including culturally specific providers as available (list in first column below)			
Aging & People with Disabilities (All 12 Counties)		Partner on senior health	Continue partnership
District 12, Hermiston, ADP	Angel Moreno	Senior Health	Continue partnership
District 12, Pendleton, ADP	Mike Warner	Senior Health	Continue partnership
ADP District 13, Ontario	Sandy Hata	Senior Health	Continue partnership
ADP District 13, La Grande	Kim Norton	Senior Health	Continue partnership
ADP District 13, Burns	Jeanette Wilson	Senior Health	Continue partnership
ADP District 11,	Gloria Pena	Senior Health	Continue partnership
Assisted Living Wallowa Senior Living	Jennifer Olson	Partner on senior health	Continue partnership
Pioneer Place in Vale	Betsy Bates	Partner on senior health	Continue partnership
Juniper Ridge Acute Care, John Day	Kimberly Lindsay	Behavioral Health	Continue partnership
Lakeview Heights, Lakeview	Kimberley Lindsay	Behavioral Health	Continue partnership
McNary Place, Hermiston	Tim Hoekstra	Behavioral Health	Continue partnership
Providers, traditional health workers, including culturally specific providers as available (list in first column below)			
Asher Community Health Center	Joan Field	Community Health Worker	Continue partnership
Saint Alphonsus Medical Center Baker City	Kathy Pointer, Elisha Schlett	Community Health Workers	Continue partnership
Saint Alphonsus Medical Group Fruitland	Mandi Peterson	Community Health Worker	Continue partnership
High County Health and Wellness	Kelly Novak	Community Health Worker	Continue partnership
Yakima Valley Farm Workers Clinic	Carolina Delgado, Cuong Thai, Anthony De Los Reyes, Sandra Echavarria, Elena Piceno	Community Health Workers	Continue partnership

Malheur County Health Department	Hilda Meja, Michelle Marines	Community Health Workers	Continue partnership
Stark Medical Group	Luke Owens	Community Health Worker	Continue partnership
Good Shepherd Health Care System/Community Paramedic Program/ConneXions	Andrea Crane, Maritza Madrigal-Guzman, Jessica McKay, Marisol Mendoza, Nazario Rivera, Miguel Ascencio	Community Health Workers	Continue partnership
St. Anthony's Hospital	Amanda Waterland, Summer Murphy	Community Health Workers	Continue partnership
Warner Mountain Medical Clinic	Dala Purdue	Community Health Worker	Continue partnership
St. Anthony's Hospital & Family Clinic	Janet McFarlane, Gabby Webster	Community Health Workers	Continue partnership
Valley Family Health Care	Brenda Estrada, Catalina Gutierrez, Estela Urrutia, Karina Carbajal, Onie Mansor	Community Health Workers	Continue partnership
Winding Waters Medical Clinic	Ysenia Perez, Isaac Skillings	Community Health Workers	Continue partnership
St. Luke's Eastern Oregon Medical Associates	Michelle Dix	Community Health Worker	Continue partnership
Community Counseling Solutions	Catrina Webster, Lydia Judd, Michelle Deming, Patricia Sneed, Rita Martin	Community Health Workers	Continue partnership
Elgin Health Center	Gina Montgomery	Community Health Worker	Continue partnership
Harney District Hospital Family Care	Annette Thomas	Community Health Worker	Continue partnership
Grande Ronde Hospital Regional Medical Clinic	Arline Franco, Jeff Dulzo	Community Health Workers	Continue partnership
Lake District Wellness Center	Jama Nelson	Community Health Worker	Continue partnership
Providers, health care interpreters (list in first column below)			
Greater Oregon Behavioral Health, Inc (GOBHI)	Armenia Sarabia, Rachel Amaya, Adriana Garcia, Beatriz Olivan	Provide interpretation services	Communicate services to CACs various
GOBHI	Language Line for Personal Interpreter Services	Resource	
Passport to Languages	Telephonic and in-person interpreter service personnel	Telephonic interpretation services	Continue regular partnership
Early learning hubs (list in first column below)			
Blue Mountain Early Learning Hub	Erin Bartsch	Provide education information	Continue regular meetings
Frontier Early Learning Hub	Patti Wright	Provide education information	Continue regular meetings
Eastern Oregon Community Based Services	Kelly Poe	Provide education information	Continue regular meetings
Four Rivers Early Leaning Hub	Christa Rude	Provide education information	Continue regular meetings
South Central Oregon Early Learning Hub	Brian Burke	Provide education information	Continue regular meetings
Local public health authorities (list in first column below)			
All 12 CACs have public health participation	Terri Thalhofer	Provide public health input	Continue regional meetings

Local mental health authorities (list in first column below)			
Lifeways (Umatilla)	Micaela Cathey	Behavioral health input	Continue regular meetings and partnership
Lifeways (Malheur)	Tim Hoekstra	Behavioral health input	Continue regular meetings and partnership
New Directions Northwest	Shari Selander	Behavioral health input	Continue regular meetings and partnership
Community Counseling Solutions (Morrow, Gilliam, Wheeler, Grant)	Kimberly Lindsay	Behavioral health input	Continue regular meetings and partnership
Symmetry Community Mental Health	Chris Siegner	Behavioral health input	Continue regular meetings and partnership
Wallowa Valley Center for Wellness	Chantay Jett	Behavioral health input	Continue regular meetings and partnership
Mid-Columbia Center for Living	Barbara Seatter	Behavioral health input	Continue regular meetings and partnership
Lake District Wellness Center	Trace Wonser	Behavioral health input	Continue regular meetings and partnership
Center for Human Development	Aaron Grigg	Behavioral health input	Continue regular meetings and partnership
Umatilla County Alcohol and Drug Program	Amy Ashton-Williams	Behavioral health input	Continue regular meetings and partnerships with other SUD providers
Other local government (list in first column below)			
County Commissioner, Baker	Mark Bennett	Provide local county input	Continue to engage and
Baker School District	Rob Dennis	Provide local county input	Continue to engage and
County Commissioner, Gilliam	Leslie Wetherell	Provide local county input	Continue to engage and
County Commissioner, Grant	Sam Palmer	Provide local county input	Continue to engage and
County Commissioner, Harney	Patty Dorroh	Provide local county input	Continue to engage and
County Commissioner, Lake	Mark Albertson	Provide local county input	Continue to engage and
County Commissioner, Malheur	Don Hodge	Provide local county input	Continue to engage and
County Commissioner, Morrow	Don Russell	Provide local county input	Continue to engage and
County Commissioner, Sherman	Tom McCoy	Provide local county input	Continue to engage and
County Commissioner, Umatilla	George Murdock	Provide local county input	Continue to engage and
County Commissioner, Union	Paul Anderes	Provide local county input	Continue to engage and
County Commissioner, Wallowa	Susan Roberts	Provide local county input	Continue to engage and
County Commissioner, Wheeler	Debbie Starkey	Provide local county input	Continue to engage and

Tribes, if present in the service area (list in first column below)			
Burns Paiute Tribe			Need to engage new member
Confederated Tribes of Umatilla Reservation			Need to engage new member
Regional Health Equity Coalitions, if present in the service area (list in first column below)			
2017 Health Equity Coalition meeting	Sub-committee of Umatilla CAC	Held equity meetings	Need to reengage committee
Oregon Child Development Coalition	Joni Delgato, Rebecca Gardner	Provide child development	Continue regular meetings
Add additional stakeholder types here (list in first column below)			
Senior Services	Angie Lamborn	Provide senior information; partner in housing	Continue regular meetings
Northeast Oregon Housing Authority	Sarah Parker	Housing	Continue regular meetings
Klamath Housing Authority	Angelique	Housing	Continue regular meetings
Umatilla County Housing Authority		Housing	Need to engage new member
Housing Authority of Malheur County		Housing	Need to engage new member
Mid-Columbia Housing Resource Center		Housing	Need to engage new member
Grow EO/Building Healthy Families	Lea Nunamaker	Provide family information	Continue regular meetings
Murray's Drug Store	John Murray	Pharmacy partner	Continue regular meetings
Add additional stakeholder types here (list in first column below)			
Lakeview ESD	Jack Thompson	SODH partner	Continue regular meetings
Building Healthy Families	Beverly DuBosch	SODH partner	Continue regular meetings
Oregon Infant Mental Health Association	Sherri Alderman	Early learning partner	Continue regular meetings
Add additional stakeholder types here (list in first column below)			
Malheur County Juvenile Department	Susan Gregory	SDOH partner	Continue regular meetings
Lake County Sheriff's Office	Daniel Tague	SODH partner	Continue regular meetings
Add additional stakeholder types here (list in first column below)			
Lake County Planning	Darwin Johnson	County partner	Continue regular meetings

Table 2: Major activities and deliverables for which the CCO will engage the community	
All applicants must complete this	
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. Kindergarten readiness: Build capacity for social and emotional mastery by Kindergarten - Developmental screening and follow-up services - Communications, parent training and education - Expand quality early learning and mental health consultation in child care settings	The Parenting and Early Childhood Initiative was launched in the Spring of 2018 beginning with a community stakeholder process to identify strengths, needs and gaps in the early childhood system. A white paper summarizing this analysis will be completed in May 2019. Inform LCACs, RCAC and entire stakeholder community by sharing concept paper, fact sheets, data, press releases, media, and web site. Consult parenting and early learning community through in-person and teleconference events. Collaborate with and facilitate shared decision-making with local public health authorities, CMHPs, early learning hubs and parenting education hubs through governance councils and project specific agreements.
2. Expand access to telehealth: Provide direct to Member telehealth services	Tele-behavioral health services delivery was started in January 2019. Expansion of services will take place throughout 2019, with additional HRSA grant funding available in Fall of 2020 and 2021. Consult with CACs, CMHPs, SUD providers and PCPCHs on ideas on how to best utilize technology. Involve care delivery partners on how to best design, develop and roll-out tele-behavioral health services with goals of improving access, decreasing barriers to care, and reducing costs. Collaborate with Members and partners on innovative ways to utilize tele-behavioral health.
3 Integrate community health workers into ED	Consult and share decision making with current community health workers that are providing services in the ED to determine best practices. Provide technical assistance to hospital systems with EDs to encourage use of CHWs as well as provide training on EOCCO's billing policy. EOCCO is working to expand the current billing policy to include telephonic services. Additionally, EOCCO plans to collaborate with OSU to implement a CHW continued education course around the role of CHWs in the ED. EOCCO will utilize the THW liaison for support in creating training materials in consultation with the THW Commission.

4. Naloxone distribution and first responder training	Consult and collaborate with law enforcement and other first responders, primary care providers, CMHPs and behavioral health providers to distribute Naloxone. Collaborate and share decision-making with Regional Opioid Prescribers Group (ROPG) on Naloxone administration training and distribution. Involve people with lived experience and family members in spreading the word about this initiative. (This effort is supported by a grant from OHA.)
5. Expand access to affordable, safe and supportive housing	Collaborate with local housing authorities including community action agencies throughout the region, building partnerships and looking for opportunities for shared actions and investments. Share decision-making through collaborative investments and project-specific partner groups focused on development. Keep LCACs and RCAC informed about these efforts. Inform broader community through media releases, social media, web site information, and fact sheets.
6. Equip behavioral health and allied systems to serve people with more complex needs - Expand MAT capacity - Create welcoming, co-occurring/complex-capable system of care with no wrong door	Inform providers and stakeholders about the initiative through fact sheets, web sites, and LCAC and RCAC agendas. Collaborate with OHA and planning committee (to be formed) representing regional provider network from at least five eastern counties with a focus on increasing medication assisted treatment capacity. Coordinate with other counties receiving funding under the Targeted Opioid Response grant program in the region. Consult with people and families with lived experience with Opioid Use Disorders in order to bring relevance to the activities and efforts in this initiative. Share information about the framework for creating complex-capable systems with all providers and stakeholders through annual conference and technical assistance events in the region. Share decision-making with OHA and behavioral health providers about implementing MAT services and utilizing the COMPASS framework (Zia Partners - Minkoff, Cline) Keep LCACs and RCAC informed of this initiative through regular agendas. (This effort is supported in part by a grant from OHA for MAT expansion.)

7. Expand access to on-line pain school	Inform the community of the online pain school initiative to expand access to alternative pain management services. Each pain school cohort consists of four, 90 minute sessions. The sessions included a pain education component, cognitive behavioral therapy, and movement therapy. Participants are required to complete both pre and post-test screenings that include self-reported physical and behavior changes. This data is used to involve participant feedback in the delivery of services. Currently this program is grant funded but EOCCO is looking toward expanding coverage of this service. Prior to doing this, EOCCO will consult with the Regional Opioid Prescribing Group (ROPG) to obtain community feedback based on analysis of attendance, pre/post-test screenings, and satisfaction surveys.
8. Address food insecurity	Share decision-making with LCACs on use of Community Benefit Reinvestment funds. Consult with local farmer's markets regarding participating in the Double Up Food Bucks program. Share decision-making with Frontier Veggie Rx Advisory Council, comprised of counties where Frontier Veggie Rx is operated. Inform Oregon Food Bank of food insecurity screenings that are to take place and potential increase in referrals to food banks. Inform Food Corps in Union and Lake of these activities via phone calls/in-person conversations. Inform community gardens about the opportunities to participate in these efforts through in-person conversations.

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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)					
Baker County Health Department	Coordination with public health occurs on all 12 CACs		Working on Regional projects that public health and CCO can partner on	Share CHA resources and align timing of data collection prior to the next CHA. This is part of EOCCO's ongoing work with the CHA and progress will be reported in EOCCO's June 2020 CHP report.	
North Central Public Health	Coordination	Early learning	Same as above	Share CHA resources	
Harney Public Health	Coordination		Same as above	Share CHA resources	
Lake Health District	Coordination		Same as above	Share CHA resources	

Malheur County Public	Coordination		Same as above	Share CHA resources	
Grant County Health	Coordination		Same as above	Share CHA resources	
Morrow County Health	Coordination		Same as above	Share CHA resources	
Umatilla County Health	Coordination		Same as above	Share CHA resources	
Union Center For Human	Coordination		Same as above	Share CHA resources	
Wheeler Public Health	Coordination	Early learning	Same as above	Share CHA resources	
Non-profit hospitals (list in this column below)					
Good Shepherd Hospital	Coordination with hospitals and 9 CACs that have hospitals		Time Alignment of CHA	Share CHA resources and align data collection prior to next CHA. Explore web-based portal so all partners can share collective data and information to inform CHAs by 12/31/19. By 3/31/20, put agenda item on LCACs regarding EOCCO web-site resources and tools (where this data will be housed).	
Grande Ronde Hospital	Coordination		Time Alignment of CHA	Same as above.	
St. Anthony Hospital	Coordination		Time Alignment of CHA	Same as above.	
Harney District Hospital	Coordination		Time Alignment of CHA	Same as above.	
Blue Mountain Health	Coordination		Time Alignment of CHA	Same as above.	
Lake Health District	Coordination		Time Alignment of CHA	Same as above.	
Saint Alphonsus	Coordination		Time Alignment of CHA	Same as above.	
Pioneer Memorial	Coordination		Time Alignment of CHA	Same as above.	
Wallowa Memorial	Coordination		Time Alignment of CHA	Same as above.	
Harney Health District	Coordination		Time Alignment of CHA	Same as above.	

Current coordinated care organizations, as of 2019 (list in this column below)M					
Columbia Gorge CCO	Collaboration and cooperation established	Share CHA Surveys	We are partnering by integrating our efforts to survey our collective Member populations.		
Federally recognized tribes that have or are developing a CHA/CHP (list in this column below)					
Confederated Tribes of Umatilla	Plan to cooperate and coordinate			Share CHA/CHP and re-engage with this partner by 9/31/19	
Burns Paiute Tribe	Plan to cooperate and coordinate			Share CHA/CHP and re-engage with this partner by 9/31/19	

*****

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 with an existing CHA and CHP must complete Parts 2, 3 and 4. Applicants that intend to change their service area must also complete Parts 2, 3, and 4.**	**Applicants without an existing CHA and CHP or that intend to change their service area 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 Umatilla		Past, but no current participation due to staff turnover.	Engage and recruit new representative by 9/31/19		
Burns Paiute Tribe		Past, but no current participation due to staff turnover.	Engage and recruit new representative by 9/31/19		
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 at present time					
Local government,					
Public health authorities	Participation in CHA	Timelines not aligned (challenge, but not a gap)			

City and County gov	Participation in CHA	Commissioner engagement varies across counties.	Targeted efforts for Commissioners not engaged in LCACs. Reach out to commissioners who have not been participating in meetings and engage them by 9/31/19.		
Organizations that address the four key domains of social determinants of health* (list in this column below).					
All early learning hubs	Represented on LCACs and RCAC	No gaps identified	N/A		
Oregon Food Bank	Participation in CHA	No gaps identified	N/A		
CAPECO	Participation in CHA	No gaps identified	N/A		
Community Connections of NE Oregon	Participation in CHA; Americorp program; population surveys	No gaps identified	N/A		

OSU Extensions	Participate in several LCACs; coordination in supporting Community Health Workers	Disconnect between practice and outcomes – need better information sharing re: outcomes	Discuss ways of sharing results and outcomes for global audience in EOCCO region; strengthen epidemiology capacity in the region. Develop plan for OSU to share data with LCACs via webinars by 1/31/20.		
North East Oregon Network (NEON)	Participation in CHA (active partner in Union, Wallowa and Baker)	No gaps identified	N/A		
Housing Matters (Union)	Participation in CHA; Funding for warming station in Union County	No gaps identified	N/A		
Northeast Oregon Housing Authority	Familiar with organization and mission; invited to participate in CHA	In early stages of engagement and partnership development.	Reach out to partner; ensure representation with LCACs and RAC Focus on more intensive engagement between now and the end of September 2019. Identify and document shared goals and strategies by 1/31/20.		
Klamath Housing Authority	Familiar with organization and mission; invited to participate in CHA	In early stages of engagement and partnership development.	Same as above.		
Umatilla County Housing Authority	Familiar with organization and mission; invited to participate in CHA	In early stages of engagement and partnership development.	Same as above.		

Housing Authority of Malheur County	Familiar with organization and mission; invited to participate in CHA	In early stages of engagement and partnership development.	Same as above.		
Mid-Columbia Housing Resource Center	Familiar with organization and mission; invited to participate in CHA	In early stages of engagement and partnership development.	Same as above.		
Traditional Health Workers (THWs) affiliated with organizations listed in OAR 410-141-3145 (list in this column).					
Asher Community Health Center	Contracted to perform Community Health Worker functions	More transparency about services provided and billing for these services.	Educate partners on CHW billing policy and expand covered services. Survey organizations employing CHWs to evaluate the types of services provided.		
Saint Alphonsus Medical Center Baker City	Same as above	Same as above	Same as above		
Saint Alphonsus Medical Group Fruitland	Same as above	Same as above	Same as above		
High County Health and Wellness	Same as above	Same as above	Same as above		
Yakima Valley Farm Workers Clinic	Same as above	Same as above	Same as above		
Malheur County Health Department	Same as above	Same as above	Same as above		
Stark Medical Group	Same as above	Same as above	Same as above		
Good Shepherd Health Care System/Community Paramedic	Same as above	Same as above	Same as above		

St. Anthony's Hospital	Same as above	Same as above	Same as above		
Warner Mountain Medical Clinic	Same as above	Same as above	Same as above		
St. Anthony's Hospital & Family Clinic	Same as above	Same as above	Same as above		
Valley Family Health Care	Same as above	Same as above	Same as above		
Winding Waters Medical Clinic	Same as above	Same as above	Same as above		
St. Luke's Eastern Oregon Medical Associates	Same as above	Same as above	Same as above		
Community Counseling Solutions	Same as above	Same as above	Same as above		
Elgin Health Center	Same as above	Same as above	Same as above		
Harney District Hospital Family Care	Same as above	Same as above	Same as above		
Grande Ronde Hospital Regional Medical Clinic	Same as above	Same as above	Same as above		
Lake District Wellness Center	Same as above	Same as above	Same as above		

Culturally specific organizations and organizations that work with underserved or at- risk populations (list in this column below).					
EUVALCREE	Provides social capacity building in Hispanic/Latino communities (Malheur and Umatilla)	Early stage of engagement	Strengthen relationships and engagement.		
Other organizations (list in this column below).					
Hospitals	Potential investments in housing and other SDOH areas	Gaps are timing of CHA; early stages of engagement	Continue to strengthen partnerships		
Ford Family Foundation	Health equity work in Hispanic communities	Early stage of engagement; not in every county	Continue to engage and build partnerships		
Oregon Community Foundation	Support parenting and early programs	Early stage of engagement	Continue to engage re: shared goals and investments in early learning		
Office of Rural Health	Provide data for quantitative section of CHA; support rural practice network; help address workforce shortages	No identified gaps	N/A		

Northeast Area Health Education Centers	Workforce partner	No identified gaps	Continue to develop project maturity		
***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.
Transportation	Individual CAC priorities	Continue education on resources for transportation. Have transportation representative attend at least one of all 12 CAC meetings. Health outcome goal is to help improve access to community resources to prevent unnecessary use of ED.
Housing	The RCAC will also have housing as a regional CHP priority	3 CACs working on housing with the goal of identifying what local housing issues are top priorities and what resources are available All CACs will have access to rental assistance information Will work on both health outcome and population goals
Early learning hubs and childhood education	Priority will be a regional outcome for all 12 CACs. Some CACs already have this in their individual CHP	Early childhood education working on outcome goals focusing on kindergarten readiness and improved high school graduation rates.

Frontier Veggie Rx and food insecurity	The source for the CHP priority has come from existing CHPs on the individual CACs. For example, CACs with chronic disease, obesity, and blood pressure priorities selected food projects.	5 CACs are working on food insecurity with the goal of reducing obesity. The Umatilla food program also has an outcome goal of reducing blood pressure.

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.

Timeline: Milestone: Method for Vetting: Planned Actions:

May-October, 2018
21 Focus groups were conducted in the EOCCO service area. The goal was to attain feedback from community members to use for the CHA/CHP. Used predetermined categories from Oregon Medicaid Advisory Committee: Addressing the Social Determinants of Health. Housing and food security were topics discussed in several focus groups as an area of concern. It should be noted that EOCCO has SODH-HE projects already in place during 2018 CHP. For example, in Harney, Sherman, Gilliam, and Umatilla the issue of food insecurity has been supported by CBRI funds from EOCCO. One of the goals is focused on reducing obesity as a health issue.

February 26, 2019:
An online meeting with RCAC members was conducted to share state health plan goals as well as the statewide housing priority. RCAC members selected early learning and food insecurity as regional priority areas. Housing has also been recognized as a regional priority area.

March 25, 2019:
RCAC meeting held to finalize priority areas for CHP goals. Early learning, behavioral health, and obesity are identified as top priority areas. Food security, early childhood, and housing were confirmed in February, 2019 meeting.

March-May, 2019:
Each LCAC will review and prioritize CHP goals at each individual LCAC meeting. All 12 LCAC's are informed of RCAC regional health plan goals and

priorities. Each LCAC will vote and finalize their CHP during the May meetings. CHP priorities will be documented in the meeting minutes of each LCAC.

June 31, 2019:
EOCCO will complete and submit its updated CHA/CHP for each of the 12 LCACs to OHA. In addition, the RCAC CHP will also be submitted to OHA. The RCAC has selected housing as one of its priority areas on the regional plan. Actions moving forward will be to determine specific goals around housing. The actions to do this will involve education and information so members can make informed decisions on the housing issue in their local area.

July-August, 2019:
EOCCO will share housing resources with all 12 CACs to include Rental Assistance, GOBHI seed money to increase housing stock, Yes, In My BackYard (YIMBY) tool kit to assure development of diverse and equitable housing in rural communities. The goal of this work is to educate LCAC members on housing opportunities. LCACs will also partner with local housing authority offices for the purpose of gathering information. In person presentations on housing opportunities will be solicited. The EOCCO has a policy in place for how subsequent year (2021) community social determinants of health spending priorities will occur for all 12 CACs. 60-70 percent of their Community Benefit Reinvestment dollars may be spent on SDOH.

August-December, 2019:
LCACs will focus activities on educating members on local housing issues and potential opportunities to partner with existing housing experts. Some LCACs may choose to form subcommittees around housing to better inform members of the local issues. LCACs will identify and work with public health, hospitals, and other partners on HE-SDOH issues by aligning CHP with this particular issues. EOCCO and public health have been working on identifying potential regional topics that EOCCO and public health could work on together. An action step for this partnership will include jointly reviewing public health equity data to determine if there is some common priority areas for regions to review.

Jan-February 2020:
LCACs will work on fine tuning goals and objectives for housing priority. LCACs may choose to prepare projects for the 2020 CBRI LCAC fund application. Each LCAC will report priorities for housing and this will be documented in the meeting minutes.

March, 2020:
Each LCAC will report housing priorities.

EOCCO Community Engagement Plan

1.0 General Component:

Establishing and maintaining meaningful community partnerships has been the foundation of the Eastern Oregon Coordinated Care Organizations (EOCCO)'s community engagement work since the initiation of the CCO model. Our relationships within the 12 county communities relies on the collaboration and communication of our outreach and understanding of resources and services needed for our Oregon Health Plan (OHP) population by our health providers, local government and authorities, and community organizations. Much of our engagement work is formalized through a Local Community Advisory Council (LCAC) infrastructure in each of our 12 EOCCO counties, allowing the opportunity for each county to identify issues related to health and wellness, develop a collaborative process for change and continue to maintain and address the health challenges towards one of the most vulnerable populations in eastern Oregon.

1.1.a. Identification of Stakeholders (Table 1):

EOCCO continually strives to engage community stakeholders in each of our 12 county regions to represent the health and wellness needs of our OHP consumers. In addition to our LCACs structure, which has OHP consumer member representation and a wide range of community partner involvement, EOCCO also collaborates directly with community-based organizations, healthcare services (physical, behavioral/mental, public health and oral), local government and other local entities representing all aspects of health and wellness in the community. While most of the above mentioned collaborators are engaged with the LCACs in their community, EOCCO also collaborates directly with a multitude of stakeholders providing indirect healthcare services to our most vulnerable populations, including addressing issues related to Social Determinants of Health (housing, food insecurity and transportation), Health Equity and Health Disparities.

Particularly, our EOCCO team focuses on concentrated outreach with 1) *Early Childhood*, by providing parent education and outreach, identification of and training for trauma informed practices in clinical and non-clinical settings, and strong partnerships with the regional Early Learning Hubs (ELHs) to ensure "kindergarten readiness" initiatives in all of our EOCCO counties and 2) *Minority Populations*, through engagement and support of local agencies dedicated to establishing and building social capital (ex: EUVALCREE, https://www.euvalcree.org), support for our Tribal Health Centers through establishment, support and maintenance of Patient Centered Primary Care Home (PCPCH) recognition as well as ensuring a "tribal voice" within our LCACs when reviewing/updating the EOCCO Community Health Plan (CHP), and broadening relationships and outreach around Health Equity through supported programs like the DELTA Program (Developing Equity Leadership through Training and Action) sponsored by the Oregon Health Authority and implemented in Umatilla, Union and Baker Counties.

1.1.b. and 1.2. Stakeholder Maintenance and Evolution (Table 1 and Table 2):

As community partnerships within the EOCCO region continue to evolve in tandem with the dynamic nature of an organization's infrastructure and leadership, so too will our relationship and engagement by our EOCCO team(s). Specifically, in addressing our OHP consumers and Severe and Persistent Mental Illness (SPMI) population, much of our future collaborations will

be focused on meaningful transitions to housing/independent living with mental health residential programs (including our community mental health program, housing authority and peer support services/providers), a strengthened OHP/SPMI consumer caucus in conjunction with mental health services and the Behavioral Health Quality Improvement Committee through GOBHI, and an overall improvement of communication and ability to strengthen the "consumer voice" within the LCACs.

1.3. Member input that will inform CCO decision making (CAC and non CAC):

The EOCCO LCAC process for LCAC and non-LCAC members (healthcare providers, other community partners, broader community) to provide input is standardized based on the LCAC policies and bylaws. All LCAC and LCAC subcommittee meetings are open to the public and all dates/times/location of these meetings and past meeting minutes, current Community Health Assessments (CHA) and Community Health Plan (CHP) are published publically on the EOCCO website (www.eocco.com/members/cac). Additionally, representatives from each of the 12 LCACs within the EOCCO meet quarterly on a Regional Community Advisory Council (RCAC) to discuss more regionally based engagement and concerns. One representative of the RCAC is a member of the EOCCO Board of Directors and represents the "voice" of the 12 LCACs. The RCAC also provides representation and formal input to the EOCCO Board of Directors through an Annual Report (submitted yearly in June), which highlights positive efforts within the EOCCO region as well as areas and recommendations for improvement. The Annual Report is presented by the delegated RCAC member and historically has positively impacted policy changes and adjustments to how OHP resource/services are implemented.

1.4. Member voice

EOCCO understands and strives to embody the concept of *"no care about me, without me"* as a mantra within the CCO model of care. While consumer input is vital to meeting the Triple Aim, engaging and elevating Member voice requires targeted engagement strategies designed to remove participation barriers and increase member understanding of health system transformation. EOCCO plans to add a second RCAC representative who is an OHP Member to serve on the EOCCO Board of Directors. Additionally, any formal complaints and appeals collected from the EOCCO will be regularly summarized and reported annually to the RCAC. This process will ensure that any changes in workflow on the EOCCO end will be effectively communicated to the RCAC, LCAC and ultimately our community partners and OHP consumers.

1.5 Addressing Barriers to community engagement:

EOCCO employs, and will continue to employ, qualified, trusted and local members of the EOCCO team to provide "boots on the ground" engagement within the community on a regular basis. Each LCAC strives to engage community partners by sharing local, regional and statewide health trend data to help inform service needs and barriers to quality care in their community. To maintain consistency and continuity of LCAC membership (including OHP membership) and meetings, each of the 12 counties is allocated $10,000 annually dedicated to an LCAC coordinator that oversees the day to day functioning of the LCAC and recruitment/enrollment of OHP consumers. Additionally, OHP members participating in LCAC meetings are, and will continue to be, offered a monthly $35 stipend, including mileage reimbursement and childcare, as an incentive to reduce the barrier of LCAC attendance and acknowledgement of distance to attend meetings. OHP consumer members serving on the Regional CAC are also compensated at

$200 plus mileage, lodging and childcare. EOCCO values the diversity of its consumer members and understands the importance of equity, therefore all of the meeting spaces are expected to be accessible to individuals with disabilities. People with Limited English Proficiency (LEP) will be accommodated with language needs and CAC orientation sessions have been developed to provide appropriate literacy level information to help consumers understand the organization and operations of the EOCCO.

1.6. Quality Improvement:

The quality improvement process for the EOCCO LCACs is iterative and operates on multiple levels, at the local level through LCACs and at the regional level through the RCAC. Data is shared at the individual, clinic, and CCO level to facilitate improvement. One of the yearly directives tasked by each of the 12 LCACs is to establish and/or review each LCACs Community Health Plan (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 input. EOCCO also assigns Community Benefit Initiative Reinvestment (CBIR) funds to each LCAC 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 LCAC meetings to address OHP consumer concerns. These concerns, if not resolved locally in collaboration with community partners, are brought to the RCAC for review and are included in the Annual Report to the EOCCO Board of Directors.

2.0 CAC Component:

2.1.b. The EOCCO service area includes 12 counties varying in population from 1,440 to 78,340. This vast territory covers almost 50,000 square miles (roughly the size of the state of New York) with a total population of 198,895. Ten of the 12 counties are considered “frontier,” meaning fewer than six people per square mile inhabit the area. Because each of the counties in the EOCCO service area are vastly unique, the EOCCO established 12 LCACs that meet monthly and one Regional CAC (RCAC) which meets at least quarterly. Each LCAC is represented on the RCAC, and the Chair is a voting member. LCACs are intended to represent the diversity of their community, including race/ethnicity, age, gender identity, sexual orientation, socio-economic and geographic location. According to the EOCCO LCAC Charter, which governs the CACs,

“…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.”

2.1.c. The recruitment/retention strategies for the 12 LCACs includes dedicated EOCCO staff that works locally to recruit local healthcare partners (physical, mental and oral), service agencies, early learning partners, OHP members and other community partners who service the OHP population. Each LCAC has devised strategies to incorporate OHP consumer members into the LCAC and to 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 LCAC, 2) development of OHP consumer subcommittees to discuss service/resource issues in each community, 3) alternating

meeting schedules to accommodate all LCAC 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 to allow greater opportunity for LCAC members to contribute and stay engaged in the CHP prioritization process, input of EOCCO services/resources, funding discussions for CBIR funds and other tasks as required by the EOCCO and Oregon Health Authority. Tribal representation has historically been through the two main tribal nations in the region, the Burns Paiute Tribe and the Confederated Tribes of the Umatilla Reservation. While LCAC representation has been varied, there has been representation of tribal needs through public health and PCPCH/PCP representation. While there has been a focus on Health Equity in some of the larger counties within the EOCCO (Umatilla and Morrow), there is a desire to increase tribal representation and re-focus some of the LCAC priorities to include health equity.

2.1.d. Sherman Gilliam and Wheeler Counties share a service area with the EOCCO and the Columbia Gorge CCO in terms of migration of patient care referrals for hospital, specialty and mental health care services. The EOCCO has committed resources to these three counties around PCPCH certification efforts, establishing programs that impact Social Determinants of Health and collaborate with their public health agency. There is CCO collaboration with the EOCCO and Columbia Gorge CCO in terms of data sharing capabilities to provide more accurate information regarding health needs, service gaps, trends and outcomes.

3. Description of CHA/CHP Component:

The EOCCO plans to continue serving the 12 county region and will submit the Community Health Plan to the Oregon Health Authority by the due date (June 30, 2019). The development of the Community Health Plan was based on a mixed method approach of Community Health Assessment data and input from the LCAC and RCACs. The EOCCO conducted 21 qualitative focus groups from each county, in English and Spanish (Umatilla, Malheur and Morrow Counties exclusively) with primary emphasis on Community Health, Health and Healthcare Disparities and Social Determinants of Health in alignment with CCO 2.0. The quantitative data included a meta-analysis of secondary data trends from a variety of different sources, including EOCCO Incentive Measure data, and reviewed with each LCAC and the RCAC. Each LCAC will use its own county specific data to determine priority areas for community-driven improvement initiatives (often in collaboration with CBIR funds) and the RCAC uses the data to produce the EOCCO Community Health Plan.

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

EASTERN OREGON COORDINATED CARE ORGANIZATION

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.*

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EASTERN OREGON
COORDINATED CARE
ORGANIZATION

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.*

EASTERN OREGON COORDINATED CARE ORGANIZATION

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.*

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COORDINATED CARE
ORGANIZATION

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.*

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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.*

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ORGANIZATION

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.*

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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.*

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COORDINATED CARE
ORGANIZATION

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.*

Traditional Health Worker (THW) Integration and Utilization Plan

Background – Building regional capacity

EOCCO 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. EOCCO does not employ THWs or Community Health Workers (CHWs) but instead supports their local employment as needed. This provides for local support and expertise, while creating jobs within the region.

EOCCO saw early success and began dedicating 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.

Because EOCCO's service region is in twelve rural counties, EOCCO needed a plan to ensure a highly skilled and adequate workforce. With this in mind, EOCCO partnered with Oregon State University's College of Public Health and Human Services to provide a State certified Community Health Worker (CHW) program that was local, cost effective, and had training modules designed to suit the needs of Rural Oregon's clinic workforce. Through OSU's extension office, the courses were designed where the first and last class were in person at the local extension office and the remainder were online. The classes were also rotated every quarter throughout the EOCCO region.

Based on the success of the certification program, EOCCO and OSU developed and launched continuing education modules in fall 2017; and then, shortly after, developed a CHW leadership certificate.

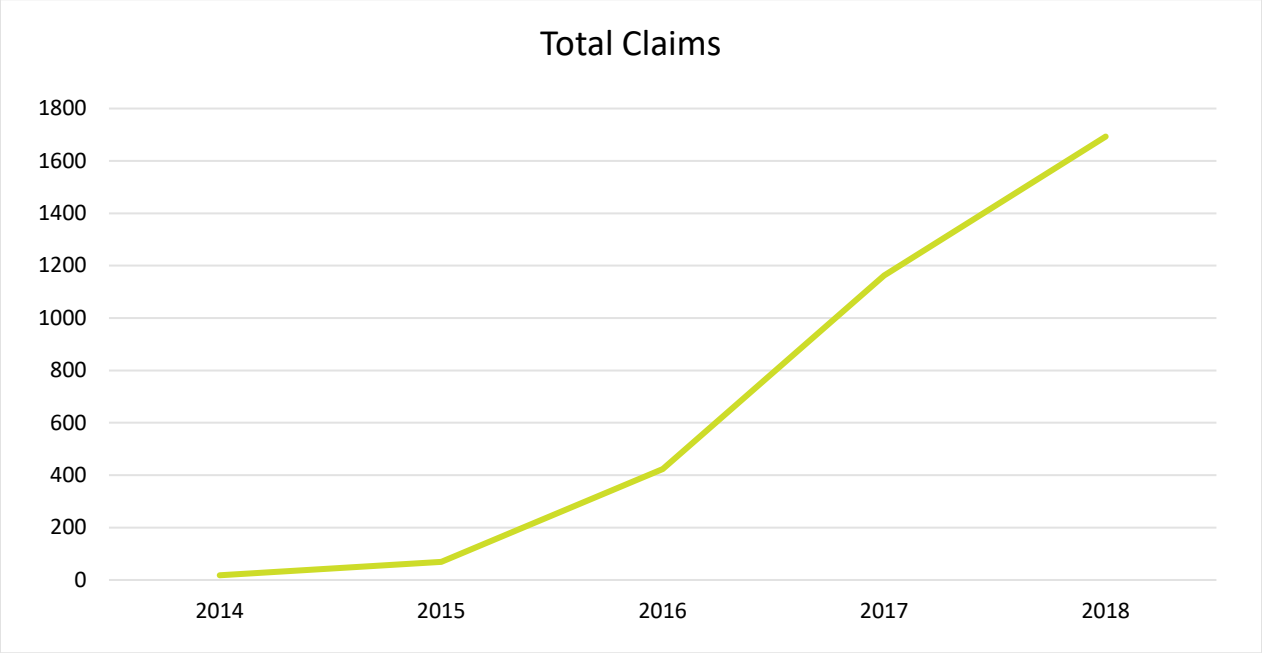
Further expanding the CHW program, EOCCO and its provider partners participated in OHSU's Project ECHO to connect primary care providers to experts and to share best practices, success and areas for opportunity, billing and workflow tips, and discuss the supervision component.

Since THWs are employed locally by community partners, clinics and hospitals, member communication and engagement has been focused at the community level. As many of our providers, systems and health districts employ CHWs and are located within the delivery system, a majority of members have access directly to a CHW. The culture cultivated in Eastern Oregon is one that has integrated THWs into workflows and has added to the workforce count in a way that expands the clinic's community reach.

EOCCO's care coordination team and case management team 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. Below is a table from our 2018 survey, showing the answer to the question: In your organization/agency, where do CHWs work or deliver program services?

Answer choices	% of Responses	Number of responses
Community Events	75.86%	22
Organization's Location	72.41%	21
Client's Home	65.52%	19
Over the Phone	58.62%	17
Schools	41.38%	12
Non-profit Organizations	37.93%	11
Public Places	37.93%	11
Hospitals	34.48%	10
On the Street	27.59%	8
Community Health Centers	24.14%	7
Public Housing Units	24.14%	7
Public Health Clinics	20.69%	6
Private Clinics	20.69%	6
Grocery Stores	17.24%	5
Other	17.24%	5

Please see the chart below regarding CHW utilization for CY 2014-2018.



Calendar Year	Total Claims
2014	18
2015	69
2016	423
2017	1163
2018	1693
Total	**3366**

CCO 2.0 and the future of THWs

THW Integration into the delivery system

EOCCO will continue to build on its successful integration of THWs through continuation of the following:

- Locally employing THWs as needed.
- Hiring a THW Liaison
- THW Liaison will convene THWs across the EOCCO 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

- EOCCO 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.
- EOCCO will publish THWs in the provider directory.
- EOCCO will support the use of THWs through care coordination and case management services available to members.
- The EOCCO THW Liaison will promote the network of THWs in the service area at local Community Advisory Councils, the Regional Community Advisory Councils, as well as health fairs and other community events.

Increase THW Utilization

EOCCO will continue to work one on one with providers that employ CHW's and provide technical assistance to implement CHW billing.

Additionally, EOCCO is working 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.

EOCCO will continue to survey partners to identify utilization trends and to identify clinics with additional support/needs.

Implementation of THW Commission best practices

EOCCO will utilize the THW Liaison to participate in the THW Commission and learn and share best practices along with fellow THW Liaisons.

The EOCCO THW will also share learnings from the THW Commission at Local Community Advisory Councils and the Regional Community Advisory Councils, as well as health fairs and other community events.

EOCCO 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

As part of our Transformation and Quality Strategy (TQS), THWs utilization has been part of the report and EOCCO is currently tracking utilization through claim encounters. In 2020-2024, EOCCO plans to collect the following measurements:

- Track encounter claims and data reported by providers on the THW Minimum Reporting Requirements Template
- Rename the CHW annual survey to the THW survey and conduct annually. 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 into the contracts, 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
- Continue to provide annual reporting to the EOCCO Board related to the THW survey

Utilization of THW Liaison to increase recruitment and retention

EOCCO will hire 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 EOCCO service area to best understand the challenges and success; and to provide support to the THW workforce in Eastern Oregon.

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.

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**					
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

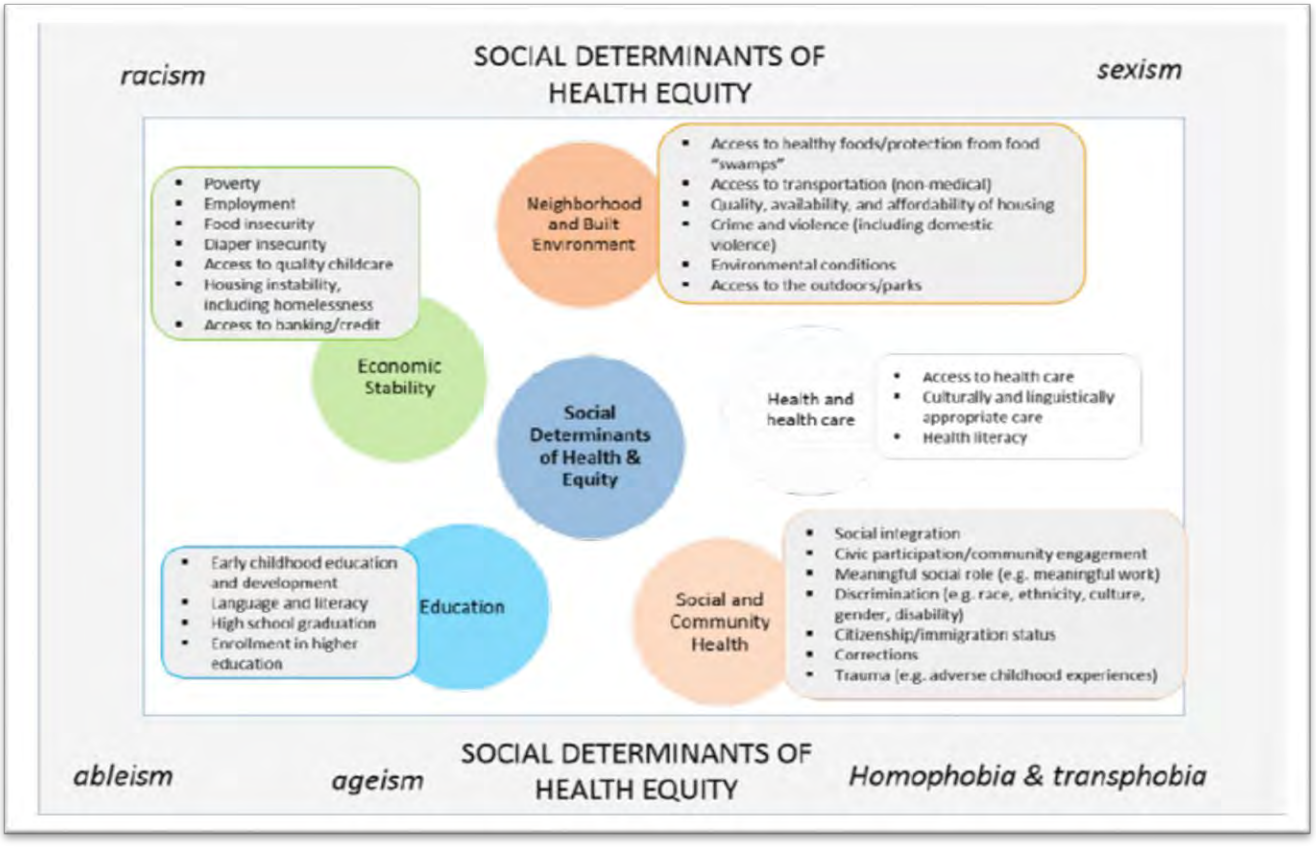
2018 Eastern Oregon Coordinated Care Organization (EOCCO) Community Health Assessment (CHA) Focus Group Report

Analysis Completed by: Jorge Ramirez, PhD and Jill Boyd, MPH, CCRP; Greater Oregon Behavioral Health, Inc.(GOBHI), Eastern Oregon Coordinated Care Organization (EOCCO)

Overview of Data Collection

Between May and September of 2018, field team staff at the Greater Oregon Behavioral Health, Inc. (GOBHI) conducted 21 community health assessment focus groups within the 12 county EOCCO region, at least one per county. 17 focus groups were conducted in English and four in Spanish. The focus groups were recorded for accuracy and lasted about one hour and twenty minutes, including time for group discussion and follow-up questions. All focus group participants from each focus group were provided food and offered a $25 gift card for their participation. Focus Groups are a method of data collection focusing on qualitative information regarding attitudes, perceptions and beliefs of the participants. The focus group protocol covered three community health assessment focus areas: (a) *community health*, (b) *health and healthcare disparities*, and (c) *social determinants of health.* (See Appendix A for Focus Group protocol). Analyses consisted of transcribing the focus group discussion, coding the transcript using qualitative analysis software (MAXQDA) and analyzing content and key quotes that highlight relevant points for future discussion and action (See Appendix B for detailed procedures). Qualitative analysis codes followed the Oregon Health Authority Oregon Medicaid Advisory Committee Report and Recommendations for Oregon's CCO Model (see Image 1).

Image 1: Addressing Social Determinants of Health in the Second Phase of Transformation (2017-2020), MAC Recommendations for Oregon's CCO Model



SUMMARY OF FINDINGS: High Coverage Topics

As part of the data analysis, our analysis team used qualitative analysis software to code and determine the number of times an area of discussion was raised (based on unduplicated number of comments) and/or length of discussion. Highlighted topics that revealed high coverage can be found in the following tables: (A) Economic Stability, (B) Social and Community Context, (C) Health and Healthcare, (D) Neighborhood and Built Environment and (E) Education.

A. Economic Stability-: This section includes Housing Instability, Transportation and Poverty. Participants in the EOCCO region had several comments about issues related to housing, specifically lack of/limited rental housing as well as the inability for people to access housing at all (homelessness). Combined with generational poverty and limited access to transportation in a geographically isolated area, these all serve as major factors that can impact the overall health and well-being of a community, especially in rural Oregon.
B. Social and Community Context: This section includes Social/Community Cohesion, Community Programs, Rural Parity and Community Norming and discusses overall positive aspects of living in eastern Oregon such as having a sense of community. Many examples have been presented in Table B that highlight the positive community programs, outreach and volunteer work done within a community. However, there is mention of the need for rural parity to continue to provide programs and services in the rural areas; community partners cannot sustainably rely on grants and limited funding when the need for community health services is always on the rise.
C. Health and Healthcare Services: This section includes Availability of Healthcare Services, Health Behaviors, Access to Healthcare, Healthcare for Vulnerable Populations, Specialty Care, Healthcare Workforce and Availability and Coverage. The major theme in this section is a need for increasing recruitment and retention of healthcare professional efforts in eastern Oregon. There is no question that rural and outlying areas are always in need of providers, either for specialty services, mental health services or other healthcare workforce to enhance services in the healthcare community (e.g. Community Health Workers [CHWs], care coordination, case management, health educators, application assistors).
D. Neighborhood and Built Environment: This section includes Environmental Conditions and Access to Foods that Support Healthy Eating Patterns and focuses specifically on the natural environment and natural resources that can attribute to healthy lifestyles. Additionally, with several rural, EOCCO communities living in a food desert, accessing healthy fruits and vegetables year round is a continuous challenge. Although many areas are surrounded by farming and ranching, healthy food is not always accessible to all.
E. Education: This section includes Early Childhood Education and Development. Many of the EOCCO region respondents highlighted early childhood education as having a major impact on health and wellness; in Table E much of the conversation highlights the need for health education and interventions beginning at an early age as well as needing the services and resources to prepare children for kindergarten.

Table A: Examples of High Coverage Topics (Economic Stability)

Economic Stability	Direct Quote Example
Housing Instability	*"We have a serious rental housing…shortage… [and the] rental housing we do have is out-priced for our availability…so affordable housing is a big concern."*
	"…a lot of the housing instability and homelessness means that people go inside in to unsafe homes…"
Transportation	*"…you're not going to live in an outlying area if you don't have transportation…there's…seniors in the outlying areas that don't get to come to town. They don't get to [go] grocery shopping because they have no transportation…unless they have a family member to take them shopping."*
	"I think [there is an issue with] transportation to health care. We're getting better at having more specialists available instead of having to tele-commute [for appointments]…"
Poverty	*[Referencing the impact of generational poverty on children] "they're starting from negative five. They're not starting at ground zero."*
	"…if you are struggling to make sure you can pay electricity and your rent and you gotta get your SNAP card and make sure you can have a meal on the table for your kids, you're

	not going to be thinking about your health until you are in crisis because you spent all that time trying to make it to tomorrow."

Table B: Examples of High Coverage Topics (Social and Community Context)

Social and Community Context	Direct Quote Example
Social/Community Cohesion	*"I'd say…I noticed…when someone is in need, whether they had and accident or cancer, we as a community lift them up, we come and fundraise for them or just…wrap [our] arms around them in this community."*
Community Programs	*"…the double-up food bucks program…at the farmer's market which is twice a week, if you have SNAP benefit you can double [your benefits] up to ten dollars…so instead of 10 you now have 20 [dollars] that you can spend on produce at the farmer's market."*
	"…a community thing that happens every summer is the Youth Program that's…put on by Mental Health…it works with…the city, the Summer Program, they do swimming lessons and…all that kind of stuff for youth, so I think that's a good community help thing."
Rural Parity	*"We are stuck in projects. So we can't quite grow up and we can't go back. We can't afford the services that our residents need…there's a big demand [and] we are chronically under serving our residents, but we are doing what we can with the financial means that we have so it's incredibly taxing to try to close those gaps."*
	"We have another issue with regionalization. We [partner with another county and] there's a dozen employees…we have one part-time. We need parity in these counties. Housing, same issue…regionalization to help grow the community, to provide services in each community…there is just no parity."
Community Norming	*"I think…[it]…comes back to the sense of community, and when you have that strong sense of community and you… [have a] …personal investment in your health…you can talk yourself out of it…when you have accountability because of your community, I think that really supports the healthy lifestyle. You have a group of people who are going hiking, or you have these programs that are community based, and there is a group of people expecting you to be there…our sense of community…helps us be healthier."*

Table C: Examples of High Coverage Topics (Health and Healthcare)

Health and Healthcare	Direct Quote Example
Availability of Healthcare Services	*"We offer those living with chronic conditions…powerful tools for caregivers. I think those programs go a long way…something huge, that would benefit…providers and people coming in…[from] foster providers, to the kids at DHS and people caring for their aging parents or spouses."*
Health Behaviors	*"Getting families involved and getting them more active [to] eat… healthier."*
	"*Co-disorders often get the care they need for half of their problems. And that integrative approach in my opinion is needed to help reduce disparities for people with co-diagnoses."*
Access to Healthcare	*[In reference to Medicaid Expansion population] …" [There is] this huge group who never had health care before. They don't know how to access the health care."*
Healthcare for Vulnerable Populations	*"Isolation for the seniors that are out farther than transportation will bring them in…is a big issue that we discovered…if [families] …don't have transportation, it makes it difficult for them to come in for employment. It makes it difficult to come in for doctor appointments, for any kind of care. So, isolation is huge in an outlying area."*
Specialty Care	*"Isolation for the seniors that are out farther than transportation will bring them in…is a big issue that we discovered…if [families] …don't have transportation, it makes it difficult for them to come in for employment. It makes it difficult to come in for doctor appointments, for any kind of care. So, isolation is huge in an outlying area."*

Healthcare Workforce	*"[We need] mental health providers…[the mental health providers in the schools] are grant-funded positions…we can hire three people right now, but will we have…funding…three years from now…even if we had the money it's not forever."*
Affordability and Coverage	*"It's just like anybody else that can't afford their medications and they fall in that 'donut hole'…they can't pay for that insulin. Its $600 and some dollars and so they're going without it."*

Table D: Examples of High Coverage Topics (Neighborhood and Built Environment)

Neighborhood and Built Environment	Direct Quote Example
Environmental Conditions	*[In discussion about water quality] "…Let's deal with water…[the] first time I thought somebody has been in this hotel before me in this room…what would it take to clean up the [water] system? It's the replacement of the pipes…and they do have a plan for that. They will be billing extra, the town, the county."*
	"I think the bike-ability and walk-ability is pretty good, coming from bigger places. But I think it would be awesome to have bike paths…"
Access to Foods that Support Healthy Eating Patterns	*"[People] are existing on food bank donations and the snack program or the Oregon Trail Card. You can get a whole lot of top ramen cheap, grains, that kind of stuff for a whole lot less than fresh meat, fresh fruits, vegetables, and so they really are at a disadvantage. They may be overweight and overfed but they are way under nourished with rich nutrients. I think that there is a real disparity there."*
	…. *"It's sad to me that we are living in the middle of wheat and fruit country and we have people that can't get access to fresh fruit and vegetables. It seems so ironic that we are goring food for the rest of the world and our own people are hungry and can't access high quality food."*

Table E: Examples of High Coverage Topics (Education)

Education	Direct Quote Example
Early Childhood Education and Development	*"I do see a stronger…public education [system] out here, and services [that educate]…on nutrition and how it interacts with the brain and body and people in general."*
	"…well there are a lot of issues involved…we see students coming to school at age five, already two and three years behind where they should be at that age. Because they don't have early learning experiences, early literacy experiences, any type of growth enrichment at all…so… by age five they are halfway behind where they should be..."

QUALITATIVE RESULT COMPARISON: High Coverage Topics (English vs. Spanish) Focus Groups

In addition to reviewing high coverage topic areas across the 21 focus groups, our team of analysts also provided direct quote examples of comparison topics between the English and Spanish focus groups. This highest ranked sections for both English and Spanish included (a) Health and Healthcare (Availability of Healthcare Services, Health Behaviors, Affordability and Coverage, Healthcare for Vulnerable Populations and Access), (b) Social and Community Context (Social Cohesion and Community Programs) and (c) Neighborhood and Built Environment (Environmental Programs). Examples can be found in Table F below.

Table F: High Coverage Topic Comparison (English vs. Spanish Focus Groups)

Health Topic (English)	Health Topic (Spanish)	Direct Quote Examples
Health and Healthcare – ***Availability of Healthcare Services***	Health and Healthcare – ***Health Behaviors***	(Availability of Healthcare Services-English) *"I'm…passionate about the Children's Community Nursery and the Boys and Girls Club for what they do…they are overall for young children to [be able to] …start thinking positively about themselves and…raising kids to be…healthy physically and mentally. They take care of food needs, medical care, whatever they need… two year olds to*

		16-17 year olds are taken care of in this community just through those two agencies."
		(Health Behaviors-Spanish) "*Pues yo diría que el estilo de vida porque hoy en día a ver cuántos niños ves jugando en el parque. La tecnología juega un papel importante porque muchos niños prefieren quedarse a jugar al XBOX, el WII, el Play, hay que salir a jugar o a correr después de la escuela. Entonces este tipo de falta de actividad hace que los jóvenes y los niños tengan sedentarismo entonces van a sufrir de actividades. Corren el riesgo de sobrepeso y con el sobrepeso y obesidad y con la obesidad problemas cardíacos y respiratorios diabetes entonces es como una cadenita la falta de actividad y luego comer mucha comida alta en calorías."* **[Translation]** "*I would say that it's lifestyle; in today's world there are not many children out playing in the park. Technology plays an important role because many children prefer to stay in and play in the XBOX, Wii… when they should be going outside to play after school. This type of lack of physical activity makes youth and children more sedentary … they run the risk of becoming overweight and with being overweight and obesity there are cardiac and respiratory health issues, diabetes... so it is like a small chain beginning with lack of activity, followed by eating highly caloric food..."*
Health and Healthcare – ***<u>Health Behaviors</u>***	Health and Healthcare – ***<u>Affordability and Coverage</u>***	(Health Behaviors-English) *"I worry about…[having] an active lifestyle to do some of that proactive and preventative stuff for the elderly... We don't have a mall to walk, and we don't have an indoor wellness center. So some of those preventative things that are going to be critical for their ongoing health we're going to be in active mode with pain medications and therapy after a problem has happened; because there's… nothing enticing for a 70-80-year-old to go out walking in February on snowy streets. Some do it, but most hunker down, so I think that's going to become a long-term problem for us. How do we keep or promote an active lifestyle for that demographic?"*
		(Affordability and Coverage-Spanish) *"Si en realidad sí, muchas de las veces nos quedamos mejor en la casa enfermos, con alergias a curarnos uno mismo porque no tenemos esos recursos y hay en lugares donde va uno y quieren que al momento pague uno y sin tener uno el dinero si no pagan no te atienden."* **[Translation]** *"The reality is that many times we stay sick at home with allergies to get better by ourselves because we don't have those resources and there are places where we go to look for care and they want you to pay right here and without the money upfront, they won't provide you the health care."*
Social and Community Context – ***<u>Social Cohesion</u>***	Health and Healthcare – ***<u>Healthcare for Vulnerable Populations</u>***	(Social Cohesion-English) *"…the community coming together to participate in programs from a variety of health organizations…for example, free screen week in May…or a health fair. From April to October and just the Health Fairs. I think the community reacts positively to that. And they get to go around and see the resources that are available to them and opportunity to learn more and just participate."*
		(Healthcare for Vulnerable Populations-Spanish) "*También cuando uno tiene que llevar los niños al dentista y te dicen que les tienen que sacar estos dientes, pero solamente cubre tanto. También te limitan o te dicen que te tengo que referir haya, pero ya no te puedes regresar para acá, así que chiste. Te traen para ya y para acá como globo y pues así no.*"

		[Translation] *"Also when we take children to the dentist and they have to extract teeth, but they only cover so much, there's a limit, or they refer you and you can't go back to them. You end up going back and forth [between providers]."*
Health and Healthcare – ***Access to Healthcare***	Health and Healthcare – ***Availability of Healthcare Services***	(Access to Healthcare-English) *"… you go and you may or may not see the person you were hoping to see…Or you end up in the ER, you're not going to see the same person…If you want to be seen quickly you're not going to see your primary care provider…And we can get seen really quickly, you can get…x-rays and CTs and some other things quicker than a lot of areas…so there is a lot of good stuff…as far as continuity."*
		(Availability of Healthcare Services-Spanish) "*Yo pienso que también estoy orgullosa de los servicios que tenemos en nuestra comunidad. En el tiempo que nos ayudan, Como los hospitales y clínicas, eso es algo que depende mucho aquí en nuestra comunidad necesitamos todas las personas en una emergencia. Yo me siento orgullosa que en mi comunidad tengamos ese tipo de ayuda*." **[Translation]:** *"I also think that I am proud of the services we have in our community. In those times that we get help, like the hospitals and clinics, this is something that we depend on here in our community all of the people may need in an emergency. I feel proud that in our community we have this type of help/services."*
Social and Community Context - ***Community Programs***	Neighborhood and Built Environment - ***Environmental Conditions***	(Community Programs-English) *"Something that just says 'open door.' So you can just…show up and hang out for a while and come and go…I think sports involves everything. It could be mental. If you have good people in place, good coaches…a coach is a teacher and a teacher is a coach. So it goes both ways. If you have those good people, you have that extension for anything for the mental…help… you have this small town, you know togetherness..."*
		(Environmental Conditions-Spanish) "*El ambiente, mantener tu lugar, para que no haiga tanta contaminación, como … Como aquí tranquilo y limpio. Te puedes mover a otro condado donde está bien sucio y tiene basura en las yardas y todo eso. Y aquí no. Se me hace un ambiente bien limpio, saludable*." **[Translation]** *"The environment counts, we need to keep it up so there's no contamination like in other places… this is a calm and clean place. People can end up in dirty places with trash in yards. Not here. This is a clean and healthy environment."*

ADDITIONAL SUMMARY FINDINGS: Health and Healthcare Disparities and Social Determinants of Health

There were topics that did not receive the highest levels of coverage but remain important for community health planning. These include Health and Healthcare Disparities (Table G) and Social Determinants of Health (Table H). Below are additional direct quote examples from highlighted sections of several county-specific reports in the EOCCO region.

Table G: Health and Healthcare Disparity (Examples in EOCCO Region)

Health Topic	Direct Quote Examples
Social and Community Context - ***Civic Participation and Pride***	*"…Hermiston was very friendly, for its ranking…I'd say it's a pretty tight community…every time there has been a tragedy...the community steps up."* (Umatilla County)
Social and Community Context - ***Poverty***	*"People who don't have the money, people who don't have, I don't know how to say, the poor people, they absolutely do not have the same as people who work…. So you have people who are sicker or have chronic diseases [that] are the poorer population."* (Malheur County)

Social and Community Context – ***Stigma/Discrimination***	"*Se sigue viendo discriminación eso me pasó hace 3 años y tenía seguro me mandaron con un especialista por un derrame en un oído el especialista me mandó para atrás con mi médico la recepcionista sabiendo que está en un medicamento muy estricto no me quiso dar en dos meses cita con mi doctor ahí tuve que moverme de doctor"* **[Translation]:** *"You continue to see discrimination, it happened three months ago and I had insurance when they referred me to a specialist for an ear infection with spillage and the specialist referred me back to the doctor (general practitioner) and the receptionist - knowing that I was prescribed a strict medication - did not give me an appointment with my doctor for two months, and I had to change doctors."* (Malheur County)
Social and Community Context - ***Family Involvement***	*"I think that's a major building block…how strong a community is, how strong our families are, that's how strong the community is. If you've got weak families, you've got weak communities. If you have strong families, you have strong communities. You've got a really strong family; you've got a really strong community."* (Morrow County)
Social and Community Context – ***Community Outreach***	*"[We have] limited media sources. We have some really good newspapers, but… we still struggle to… put posters up, and let people know what's going on and a lot of people just don't know what's going on. Because they don't go look at those things. Just in general in terms of programs, events, and resources. So reaching out to those outlying communities or those folks that live outside of town that may not come to know what's going on."* (Wheeler County)
Neighborhood and Built Environment – ***Quality of Housing***	[In referencing the local market value on housing] *"…out in the remote communities, there just flat out are not habitable dwellings…and that's largely market value. People would build if they didn't end upside down by $30,000. Take some of the equity out of the negative equation. And our hope is people who have capital and credit will start hunting. They are squatting on rentals that could be available to individuals with a lower income bracket…"* (Grant County)
Neighborhood and Built Environment – ***Natural Resources***	*"…safe places to walk and get exercise…going to parks and playing with kids. So…people can get natural exercise."* (Wheeler County)
Health and Healthcare ***– Health Integration***	[Discussing new integrated care facility] … *"…that has been a great way of two organizations going to integrate before the building gets built. We are already talking about team trainings together…the possibility of…more and more people…[thinking]… it's great how our health care community is thinking holistically and bigger and they're excited. They're just excited for their own health care to see what happens."* (Wallowa County)
Health and Healthcare - ***Health Literacy/Education***	*"There are still people who have the Oregon Health Plan that don't even know what their coverage is."* (Baker County) *"I think a lot of people ignore symptoms and they don't go seek help. I think people on the Oregon Health Plan don't know what they are offered could do…"* (Malheur County)
Education - ***Generic***	*"I think the Extension Service has a 'Puente's Program'…it's another program that works with the students to keep them in school. And it also works with families and uh, educating them about resources and to better support their children so they keep them safe…I think they work with high schools."* (Morrow County)
Economic Stability - ***Employment***	[Discussion of a visiting family looking for employment in the area] … *"she is a wellness coach and she was looking to move out here but her partner is a teacher…finding both of them some sort of positions and come out here [is difficult]…"* (Wheeler County)

Table H: Social Determinants of Health (Examples in EOCCO Region)

Health Topic	Direct Quote Examples

Education – ***Skills Training/Vocational Education***	*"I would like to see more training in Union County that prepares [students] for jobs that are available in Union County. Not so that I can go get my fine arts literature degree so I can go work at Walmart."* (Union County)
Economic Stability - ***Food Insecurity***	*"…pero por ejemplo como el banco de comida. Ese es un muy buen ejemplo. ¿Ay un banco de comida aquí? Ay un banco de comida, pero a mi ver, no sé ustedes una ocasión yo fui y la verdad lo que a mí me dieron fue puro pan y ya caducado a mí me toco como otras personas que no se vendieron un montón de aguacates pero que todos fueron al bote de la basura y cobrando ya ni me acuerdo cuanto se me hace que fue como $18 o $20."* **[Translation]** *"…for example the food bank….in my mind, [the food bank is] …not a very good one. I went and…what was given to me was pure bread [that had] already expired, like others that did not sell… a lot of avocados…and it all went to the garbage and… [I] remember they charged me like $18 or $20."* (Morrow County)
Economic Stability - ***Economic Development***	*"Financially viable…Growing businesses…[ability] to provide all the services that are needed"* (Harney County)
Neighborhood and Built Environment- ***Public Safety***	"*Pero si estas en la zona de la escuela y vives a menos de 10 cuadras o lo que sea menos de 2 millas de distancia debes ir caminando. Pero los niños de 5 años que apenas van a entrar al kínder y que uno no puede... donde está la seguridad."* **[Translation]** *"…if you are in the school zone and you live less than 10 blocks away or less than 2 miles, you must walk. But kids who are five who are just entering kindergarten… …where is the security."* (Morrow County)
Social and Community Context - ***Sense of Belonging***	*"…moving here I feel a unity in the city. Everybody seems to know everybody and… pull(s) together…I think local businesses are pretty supportive financially."* (Umatilla County)
Social and Community Context - ***Trauma***	*"…adverse childhood events. I think children are impacted by something and by the time they enter the school system, teachers and our administrators are seeing those problems…it's a component of family life and the dynamic [of] mental and behavioral health."* (Morrow County)

For more information about the EOCCO CHA analysis process, or to request transcripts , please email Jill Boyd at jill.boyd@gobhi.net.

APPENDIX A: Focus Group Protocol

Eastern Oregon Coordinated Care Organization:
Community Health Assessment Focus Group
(Version 4/4/2018)

OPENING REMARKS AND INTRUCTIONS/GUIDELINES

[Read] Thank you for taking the time to speak with us today! My name is _____ and I work for the Greater Oregon Behavioral Health, Inc. (GOBHI) as part of the Eastern Oregon Coordinated Care Organization (EOCCO) [we are the organizing body that oversee Medicaid or OHP services in the eastern Oregon region] and we are here to talk with you today about the health in your community. The purpose of this focus group is to learn more about your experiences and perspectives about the overall health and well-being in your community, specifically around the healthcare in your area, what is working well, where there are barriers to services/resources for members on the Oregon Health Plan (OHP) and what we can do to work together to make sure everyone in the EOCCO region stays healthy and happy. The information you are sharing with us today will help the EOCCO with a Community Health Plan, a guidance document that will help us develop strategies, strengthen community partnerships and potentially enhance services/resources to improve the overall health and well-being of eastern Oregon.

[GROUND RULES] This focus group will last about one-and-a half hours (90 minutes) and there is a lot of material to cover, so let's set some ground rules for today:

1. We will be covering various topics related to health in your community and we would like to hear from everyone, so please let's respect one another's opinions
2. If I interrupt, I am not trying to be rude, but making sure everyone can participate and that we stay on time
3. Only one person may speak at a time and try not to talk over one another
4. Please silence your phones for the next 90 minutes
5. The questions I will ask provide a semi-structured guide for discussion. I may need to ask follow-up questions for clarification and to make certain we understand your answer

[CONFIDENTIALITY] We really appreciate you participating in our focus group today and value your time, comments and privacy. For the purposes of confidentiality, your names will remain anonymous to audiences who will hear / learn about the results. This means that we will not connect your comments to your name, when we summarize results. This conversation will be recorded and transcribed for accuracy. Do you have any questions about confidentiality that I can answer at this time?

We are going to record this focus group session, but before I do, do you have any other questions?
[pause and wait for verbal and non-verbal responses before moving forward]

First we are going to briefly go around the room and have you introduce yourself and what part of the community you represent.

----------START OF FOCUS GROUP ----------

[PART I: COMMUNITY HEALTH] First we are going to talk about your community. A community can be defined in many different ways, for some people a community means having a group of people living in the same location or having particular characteristics in common; for others it means having a sense of fellowship with others, having common attitudes, interests and goals.

1. Give me an example of a time where you felt proud to be part of your community?
    a. ***Prompt if necessary****: In thinking about how you define a "community" tell me what makes you the proudest of your community?*
2. What do you believe are the 2-3 most important characteristics of a healthy community?
    a. ***Prompt if necessary****: What community characteristics help people stay healthy? Be healthy?*
3. Share with me a time when your community came together to improve a specific health issue.

   a. ***Prompt if necessary:*** *Give me some examples of people or groups working together to improve the health and quality of life in your community.*
4. Tell me about some concerns you have about the health/well-being in your community
   a. ***Prompt if necessary****: What do you believe are the* ***most important issues*** *that need to be addressed to improve the health and quality of life in your community?*
5. Give me an example of a specific challenges in your community that gets on the way of people having healthy lives.
   a. **Prompt if necessary**: What do you believe **is keeping your community** from doing what needs to be done to improve the health and quality of life?
6. Give me an example of a program or policy change that would help make the community healthier (policy example: laws about tobacco and alcohol use).
   a. **Prompt if necessary**: What actions, policies or funding priorities would you support to build a healthier community?
7. Give me an example of a health-related program or model that you are passionate about or that you currently participating in.
   a. **Prompt if necessary**: What would excite you to become involved (or more involved) in improving your community?

PART II: DISPARITIES] Now we are going to talk a little bit about health disparities, which is often defined as the difference in illness, injury, disability or mortality experienced by one population group relative to another. Healthcare disparities typically refer to differences between groups in health insurance coverage, access to and quality of care.

8. In thinking about neighborhoods and groups in your community, do some people in your community have more health issues than others? If yes, why?
   a. ***Prompt if necessary****: What are some of the reasons why some people have more health problems and poorer health than other areas in your community?*
9. Now think of the reverse, in neighborhood and groups of people in your community, why do some people in your community have **less** health issues than others [better health]?
   a. ***Prompt if necessary****: What are some reasons why some people have fewer health problems and better health than other areas in your community?*

[PART IV: SOCIAL DETERMINANTS OF HEALTH] Finally, we are going to talk Social Determinants of Health and how they impact the overall health of an individual or community. We define social determinants of health as the settings/places where people live, learn, work and play that can shape the overall health of an individual or community. Some examples of social determinants include education (or lack of education), food insecurity, housing, employment, social stressors (hostility, sexism, racism), working conditions and transportation (or lack of transportation).

10. What are examples of social determinants of health, that may impact the overall health in your community
   a. ***Prompt if necessary: Tell*** *me how the settings/places where people live, learn, work and play impact the health in your community.*
   b. ***Prompt if necessary****: Tell me how social stressors, such as hostility, racism and sexism impact the health in your community.*
   c. ***Prompt if necessary****: Tell me how employment, education and skills training opportunities impact the health in your community*.
   d. ***Prompt if necessary****: Tell me how social resources (transportation, housing, food) or a lack of social resources impact the health in your community.*

[CLOSING REMARKS, FINAL COMMENTS] We are close to wrapping up our focus group but before we do I want to ask a few final questions…

11. Is there anything else that we haven't already discussed that you would like to add?
12. Do you have any questions for me?

[Provide at least three strengths of the conversation]

Thank you again for your time today, specifically in sharing the challenges in your community. We have come away with several strengths in your community such as:

1. _____
2. _____
3. _____

Our next steps are to summarize the information and share this back with you. Again the purpose of this focus group is to help develop a Community Health Assessment in which we can work with your community to identify areas of improvement. We really appreciate your time in speaking with us today and as a token or our appreciation we have gift cards for each of you.

APPENDIX B: Focus Group Analyses Procedure

Recordings of focus group discussions were transcribed; the typical transcript was 20 single-line spaced pages and 850 or more lines of text. A team of data analysts drew largely from the Healthy People 2020's Social Determinants of Health Framework[1] that includes Health and Healthcare, five major social domains, and Health Disparities to develop a scheme to classify and summarize the information offered. The scheme's 56 unique codes organized into five major domains was used to examine and summarize the focus group transcript.

[1]U.S. Department of Health and Human Services. (2015). Healthy People 2020: An opportunity to address social determinants of health in the United States. Author. Retrieved from: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

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?

Yes, the community was involved in the development of the community engagement plan for EOCCO. The Regional Community Advisory Committee (RCAC) reviewed and shared input on the Community Engagement Plan at its March 26, 2019 meeting. In addition, two major community engagement processes were used to identify strengths, needs and gaps as we look toward the future. First, between May and September of 2018 we conducted 21 community health assessment focus groups within the 12 counties comprising the EOCCO region (8 in English and 4 in Spanish) with three community health assessment areas: community health, health and healthcare disparities, and social determinants of health. Second, interviews with over 80 early childhood community partners and stakeholders were conducted between March and December of 2018 to identify strengths, gaps and needs in parenting (including pregnant women) and early childhood behavioral health. Our over-arching aim for our plan is to prevent and mitigate the impact of adverse childhood experiences (ACEs) through behavioral health promotion.

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.

EOCCO supports 12 Local CACs (LCACs) and one RCAC, each representing a broad set of stakeholders including local government, public health, OHP members, and health and human service focused non-profit organizations dedicated to meeting the social, educational, and cultural needs for people of all ages and backgrounds in the region. We support a process for developing the Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) that includes all LCACs and the RCAC. Please refer to the Community Engagement Plan and required tables for details.

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)

Please see EOCCO Community Engagement plan and required tables 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.

Housing: We administer a Rental Assistance Program (RAP) in Eastern Oregon through contract agreement with Community Counseling Solutions and with dedicated funding from OHA. RAP services assist adults with Severe and Persistent Mental Illness (SPMI), as defined in OAR 309-032-0311. RAP Services include funding for a residential specialist and peer support specialist, responsible for facilitating program and service components. This includes: the housing application process; finding a rental unit; payments to landlords; household budgeting; community navigation; and maintaining healthy relationships, which supports individuals as they live as independently as possible in the community.

Early Learning: We participate in all early learning hub governance boards in the region. Contract agreements are in place with both Relief Nurseries (Ontario and Pendleton) in the region to strengthen capacity for high-quality, culturally and developmentally appropriate parenting and infant/toddler care. We are a partner with the Baker Early Learning Collaborative, a partnership involving educational entities, early learning, DHS, healthcare, Eastern Oregon University, and others aimed at improving early learning outcomes, Kindergarten readiness and school success for all Baker families. Contract agreements are in place with the Four Rivers Early Learning Hub for staff augmentation through a three-way partnership including the local public health authority. We are engaged in a partnership with OSU, Hallie Ford Center for Healthy Children and Families and the Oregon Community Foundation aimed at strengthening workforce capacity to deliver high-quality child development and parenting education services. We also hold an agreement to financially support mental health consultation coupled with home visits with Eastern Oregon Healthy Living Alliance.

Educational Supports and Partnerships: We support capacity for school-based prevention/promotion and behavioral/mental health services aimed at increasing school performance and retention for students with behavioral health needs: Community Counseling Solutions Behavioral Therapy Classroom; Lost & Found Youth Outreach

Alternative/Charter School prevention and promotion; Milton-Freewater Friends of the Library-Ready2Learn; Intermountain Education Service District Wellness Hub CARE Coordination; New Directions Northwest Trauma-Informed Therapeutic Classroom; North-Central ESD Early Education Community Coordinator; Umatilla County RISE Program School-Based Mental Health Services.

Food Insecurity: We began managing Frontier Veggie Rx in three Eastern Oregon counties on July 1, 2018, supporting the program's launch in Gilliam and Harney counties, and its continuation in Sherman County, where Gorge Grown Food Network previously operated the service. During the first year, the program ran out of booklets in all three counties due to demand. The voucher program combats food insecurity in rural areas by connecting eligible low-income individuals and their families with prescriptions to buy fresh, healthy produce. LCACs affiliated with EOCCO identified the need for Frontier Veggie Rx and provide funding for prescriptions.

Transportation: We are the transportation broker for Non-Emergency Medical Transportation in the region and have agreements with transportation providers. We support an advisory committee that provides input and feedback about how this system operates and provide training, technical assistance, perform safety audits, and other activities to ensure transportation needs are met for our members.

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.

EOCCO's 12 counties have highly varied SDOH-HE needs. While one county may have a strong transportation infrastructure, another may list transportation as its biggest SDOH-HE barrier. EOCCO's approach to addressing this variation has been to support locally-identified initiatives. This means that each county identifies its most pressing issues and EOCCO funds projects to address them. Additionally, EOCCO supports regional SDOH-HE issues to address transportation, housing, early learning and food insecurity. There are two distinct processes in place to establish metrics related for locally and regionally identified initiatives:

1) Partner projects and programs begin in March, use performance metrics created at the local level and must submit three progress reports each year, including a final report;

2) EOCCO SDOH-HE regional activities begin in January of each year, are measured by RCAC performance metrics, and reviewed at the June RCAC meeting to ensure enough time has passed to collect adequate data.

Because performance metrics for partner programs are created at the project level, we work collaboratively with partners to establish performance expectations and then review the results together quarterly. For example, our Frontier Veggie Rx project was initially funded for one county (see section 2.B.a.). We worked with the county to created metrics for taking a count of the number of patients who were screened for food insecurity; the number who received 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. Projects that are not successful and do not meet measurement objectives are reengineered or discontinued.

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.

EOCCO is in the fifth year of its Community Benefits Initiative Reinvestments (CBIR) program. CBIR is a policy approved by the EOCCO Board to allocate 6% of each year's quality pool funding to LCACs. This policy requires that 60-70% of allotted LCAC funds be spent on SDOH-HE needs (see LCAC CBIR Application included with our submission). LCAC's are responsible for tracking, reviewing and determining SDOH-HE spending of these funds. The LCACs are then responsible for determining how to use these funds for SDOH-HE and transformation projects that connect to their CHIPs, and how much of their funding allotment to spend on each project. LCACs are then required to write up a summary plan which is submitted for feedback and approval. We have included the EOCCO policy documents defining the process and the role of the LCACs including: 1) LCAC CBIR Application; 2) the CBIR Review Template; and 3) the CBIR Final Report Template.

The amounts allocated to the LCACs are calculated by adding a base funding amount plus an amount per member residing in the county. For example, in 2019 Umatilla County is receiving a total of $185,567 for their projects of which $24,211 is base funding that all counties receive and the remainder of $161,356 is based on their EOCCO membership. EOCCO has a robust policy and practice for working with our LCACS in each county first to identify SDOH-HE needs; and then the RCAC 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 and provide feedback as well as Technical Assistance (TA) to LCACs and additional applicants. TA often includes how to select appropriate interventions, evaluation metrics, and methods to measure impact. ORPRN then tracks these metrics as the LCACs report on their projects on a quarterly basis. This enables EOCCO 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 EOCCO leadership to develop and review RFPs for LCAC and Transformation Grants (see LCAC CBIR Application attached). EOCCO continuously works to improve the process and increase the program's impact. For example, in the 2019 grant cycle EOCCO incorporated performance-based awards for certain incentive measure projects, thus moving the program more towards paying for value.

d. Please describe how Applicant intends to award funding for SDOH-HE projects, including:

(1) How Applicant will guard against potential conflicts of interest;

EOCCO plans to continue using an outside agency that uses set guidelines for the application and funding process of the SDOH-HE projects. Through an established review process, qualified personnel read and score each proposal using an established rubric. The current rubric 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 be free of conflicts of interest with EOCCO, Eastern Oregon, 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 submitting final scores to the CBIR Subcommittee. At the beginning of each EOCCO CBIR scoring sub-committee 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 EOCCO Board which votes on approval or denial of funding.

(2) How Applicant will ensure a transparent and equitable process;

EOCCO will continue to ensure a transparent process for funding SDOH-HE projects through the RFP and review processes (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. EOCCO provides reviewer feedback to applicants, regardless of the outcome of their proposals. Reviewers of diverse backgrounds are then 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 grants are published on the EOCCO website along with paragraphs 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, EOCCO uses 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 are 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, EOCCO provides each LCAC a $10,000 award for LCAC Coordination. Part of the role of the LCAC Coordinator is to ensure that underrepresented or marginalized groups have representation on the LCACs. This diverse membership helps to ensure a more equitable process of decision making regarding which projects to propose each year for funding through LCAC dollars.

(3) How Applicant will demonstrate the outcome of funded projects to Members, SDOH-HE partners, and other key stakeholders in the Community.

Applicants are required to propose appropriate process and/or outcome metrics and report on metrics through two interim reports aimed at identifying and helping to address issues and a final report. After the award, ORPRN works with grantees to

provide feedback on their metrics, sometimes suggesting metrics that are more directly attributable to grantee projects or more impactful for assessing project results. In addition to the selected project-specific metrics, grantees are required to report on overall project activities, how activities aligned with goals, number of EOCCO and non-EOCCO 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 are shared in a variety of ways with members, SDOH-HE partners and other key stakeholders. EOCCO LCACs share the results of their projects with Members, SDOH-HE organizations, and other key stakeholders at monthly meetings, and minutes of these meetings are published online. Results of funded projects are also shared across communities through quarterly RCAC meetings, which allows for learning and best practices to be spread. Many projects are also highlighted in the media which reaches a greater audience than the LCACs. The EOCCO Board of Directors, including an EOCCO Member, LCAC and community partner representatives, also receives presentations on the outcomes of funded projects delivered by staff and grantees at their meetings. Other presentations of project outcomes are provided at EOCCO-sponsored meetings in participating communities. EOCCO piloted a brief annual report of the outcomes of funded projects with the Board of Directors and plans 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.

EOCCO 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.

2. Evaluation Questions

a. Please describe the criteria Applicant will apply when selecting SDOH-HE partners.

EOCCO will select SDOH-HE partners by identifying community-based entities who effectively deliver services and impact systems change related to SDOH-HE. EOCCO

has a vast service area comprised of 12 counties. The LCACs will serve as subject matter experts in identifying organizations within their appropriate counties 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 tribes will also be identified as potential SDOH-HE partners. EOCCO has nine public health entities and five Early Learning Hubs with whom we currently partner. All are influential in addressing SDOH-HE and will be potential partners for new initiatives.

When determining which new or existing SDOH-HE partners to invest resources in, EOCCO will follow a similar approach to that of its CBIR program by engaging Members, LCACs, 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, EOCCO 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 EOCCO; Organizational capacity; and Interest and willingness to work with EOCCO 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.

EOCCO 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 LCACs and community partners. We will continue to publish these priorities in RFPs released on the EOCCO website and through our email lists which, in the future, will include SDOH-HE organizations identified through the 211info inventory of community-based organizations plus any others identified by LCACs. 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.

Currently, we 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. We will explore using PreManage as a tool for community communication regarding SDOH-HE.

EOCCO 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 has demographic data. Once matched, the data can then be used for general analytics and reporting purposes, in combination with any other existing EOCCO data. Specifically, EOCCO plans to administer an annual survey to all members. The survey tool will include validated questions regarding SDOH-HE needs. Once EOCCO receives outcome data we will incorporate it into our Analytics Data Warehouse (ADW). The ADW generates our monthly provider progress reports which are disseminated to all EOCCO 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 EOCCO 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.

EOCCO will track SDOH-HE spending using quarterly cost and utilization reports. These reports are shared bi-annually with the EOCCO 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 ORPRN.

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.

Please see the EOCCO's Community Engagement Plan for our response.

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.), EOCCO uses HRS funding for needs that are unique to each community as identified through the CHP process. Apart from the CHP process, needs are identified by primary care clinics and other entities. EOCCO utilizes these funds for adolescent well care incentives including backpacks for children and gift cards for adolescents who complete a wellness visit. Primary care clinics and other entities within our service area frequently submit requests for health related services for which they need funding. This is then approved by EOCCO and administered by EOCCO. EOCCO also utilizes the HRS funding for a Cribs for Kids program that all counties are eligible for. EOCCO staff have presented the Cribs for Kids program at multiple LCAC meetings so that community members and local healthcare organizations are aware of the program. EOCCO QI staff discuss this resource with contracted primary

care clinics as well. Additionally, this information can be found on the EOCCO website.

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 utilize demographic information from the 834 enrollment files. We also use the Portland State University (PSU), Center for Population Research as our base for defining the population. For Medicaid members, we collect information on age, gender, zip code (geography) and preferred language as provided by OHA.

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 EOCCO Community Engagement Plan included with our submission for information on the 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.

Between the physical, dental, and behavioral health organizations that comprise EOCCO's current service area, we have the capacity and ability to successfully execute health equity strategies and meet future health equity metrics.

Our partner dental care organizations 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 EOCCO team members who are EOCCO member interfacing receive the training on an annual basis.

EOCCO's partner, GOBHI has also implemented health equity employee trainings for all staff. This training is a three-part series that includes interactive online courses on cultural competence, implicit bias, and working in an inclusive environment.

In addition to including diversity and equity training as part of the mandatory onboarding training for all new employees, EOCCO's partner, Moda, 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.

We are also currently assessing cultural competency and health equity trainings delivered among our behavioral health provider network based on a commonly used, web-based training tool to ascertain whether or not they match Oregon's Criteria for Cultural Competence Continuing Education training. If so, EOCCO and our behavioral health providers will be updating the Health Equity Plan and add this as a tool for lower level cognitive domain learnings. In that matter, it can also be used to help track a portion of employee training and compliance with the Health Equity Plan.

We conduct an annual provider training across the service area for 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 hold an annual clinician summit with contracted providers and partner organizations.

b. Please describe Applicant's capacity to collect and analyze REAL+D data.

EOCCO collects the REAL+D data provided via 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. In April 2019, EOCCO will start reporting REAL+D data on our monthly provider rosters to ensure 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.

EOCCO is committed to eliminating health disparities and providing the highest quality of care to all EOCCO members, regardless of race, ethnicity or primary language. To provide culturally and linguistically appropriate services to EOCCO members, we stratify data from multiple sources including the member eligibility files from the state, internal data, and CAHPS survey data. EOCCO's monthly provider progress reports contain information on incentive measure rates as well as demographic information on EOCCO members. This includes both race and ethnicity data. This allows clinics to minimize gaps in care while also outreaching and delivering services in a culturally competent manner. EOCCO analyzes this data to reveal health disparities among certain

cultural and ethnic groups. In 2018, EOCCO's data analyst revealed three disparity populations within three different areas of care including adolescent well care, effective contraceptive use, and emergency department utilization. EOCCO plans to implement strategies in response to the identified health disparities and gaps in care. EOCCO will continue to analyze claims data and compare OHA race and ethnicity data to identify trends in underutilized services. Assets within the EOCCO 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.

EOCCO always seeks 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. We will continue to promote a culture of inclusiveness. We recruit from the communities where services are provided. We advertise positions through media, publications and web sites based on the diversity of populations consuming these various media. To help us with this, we utilize Portland State University, Center for Population Research as our base strategy for defining the population of the twelve rural counties that make-up EOCCO, and our effort for effective and diverse recruitment and operation of each Local CACs (LCACs), one in each county. We also support a Regional CAC which meets at least quarterly for which we also seek diversity based on the unique population demographics and socio-economics in each of EOCCO's twelve counties. Additionally, the EOCCO Charter for LCACs requires the CACs to be reflective of the local community and community partners that they serve.

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.

EOCCO recognizes that providing linguistically appropriate healthcare in both verbal and written forms plays a crucial role in effectively delivering healthcare services. Quarterly, EOCCO verifies the languages of the substantial population from the declared languages reported on the 834 eligibility files. As needed, EOCCO adjusts translated member materials for significant new languages in the EOCCO membership. Our EOCCO member informational materials are 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 are sent to the member through the mail. Member handbooks include a tag line on the first page that offers the handbook in alternate languages and formats. The handbooks can also be found on the EOCCO website in both English and Spanish. EOCCO also implemented a monthly employee training course on how to write in plain language. EOCCO provides multilingual customer service at no charge to the member through respective translation vendors. EOCCO is prepared to meet the special health care needs of members who are hearing

and visually impaired. Of EOCCO's contracted clinics, 994 providers are able to deliver services in languages other than English. This is inclusive of 15 languages including American Sign Language. EOCCO also arranges for interpreter services at members' medical provider appointments when clinics lack bilingual services. EOCCO member handbooks and participating provider manuals include instructions on how to request these services. This information can also be found on the EOCCO website. In 2018, EOCCO arranged for interpreters at 588 medical office visits. EOCCO intends to continue 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.

EOCCO notifies members in the member handbook of the availability of auxiliary aids. For example, EOCCO provides the member handbook and other letters in other languages, large print, a computer disk, audio tape, spoken presentation or Braille. EOCCO also ensures all communication providing toll free customer service number also encourages TTY users to dial 711. EOCCO monitors the availability of these services through the grievance and appeal process for both internal and provider concerns. Additionally, monitoring is 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.

Please refer to the EOCCO Interpreter Services Policy & Procedure included with our submission.

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.

EOCCO has supported the use of Traditional Health Workers (THWs) in the service area since 2014. 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 Community Health Worker (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 believe 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.

EOCCO utilizes THWs within the Wraparound Process as well as ISA (IOSS). Performance is measured and evaluated utilizing encounter data, CANS scores and Peer Support Competencies Assessment Tool. There are seven (7) Family Peer Support Specialists – specialty code (606) and seven (7) Youth Support Specialists – specialty code (607). In addition, some EOCCO communities are beginning to utilize Family and Youth Support Specialists when youth are in the Emergency Department. EOCCO also has CHWs placed in 19 clinics throughout the region (see RFA Community Engagement Plan Tables: Table 4).

EOCCO will build additional THW workforce capacity in the coming years. These investments include the development of OHA-approved CHW continuing education training programs in partnership with Oregon State University and continued improvement to the billing and payment policy for certified CHWs. CHWs can be reimbursed for time spent with EOCCO 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. Please see 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.

EOCCO has grant funded positions for personal heath navigators and community health workers. We also reimburse THWs on a fee-for-service basis. By the end of 2020, we plan to implement a reimbursement model that provides qualified providers 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 included with our submission.

3. **Requested Documents**

   Completed THW Integration and Utilization Plan (page limit: 5 pages)

   Please see the THW Integration and Utilization Plan included with our submission.

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.

Attachment 11 - Behavioral Health Questionnaire

A. Behavioral Health Benefit (recommended page limit 8 pages)

Applicant must be fully accountable for the Behavioral Health benefit to ensure Members have access to an adequate Provider Network, receive timely access to the full continuum of care, and access effective treatment. Full accountability of the Behavioral Health benefit should result in integration of the benefit at the CCO level. Applicant may enter into Value-Based Payment arrangements; however, the arrangement does not eliminate the Applicant's responsibility to meet the contractual and individual Member need. Applicant must have sufficient oversight of the arrangement and intervene when a Member's need is not met or the network of services is not sufficient to meet Members' needs.

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?**

   Members are provided an integrated EOCCO handbook versus separate handbooks for physical, oral and behavioral health. Members are also provided an EOCCO customer service phone line where the greeting notifies the member they are calling EOCCO customer service and can inquire about behavioral, physical and dental health services. External member communications only have the EOCCO branding and EOCCO customer service number. EOCCO has an integrated website, including a combined behavioral, physical and dental provider search.

   In the new contract period, EOCCO will work to further integrate behavioral, oral and physical health services as follows:

   - Further enhance the EOCCO website to provide a more robust page related to behavioral health services.
   - Evaluate and edit all external member materials that make reference to any differences in how the benefits are managed.
   - At community events, project a unified approach under the EOCCO branding.
   - Engage the Community Advisory Councils for community feedback related to opportunities to improve behavioral and physical health integration.

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?**

   EOCCO is structured as a limited liability company (LLC) with eight equity partners that assume ultimate financial risk for the organization. The equity partners take full responsibility for the entire benefit package, including behavioral health in primary care settings and primary care in behavioral health settings. None of the services (physical,

behavioral health, dental, transportation, etc.) have a pre-defined cap, and the partners are responsible for covering any over-spend, regardless of what types of services contributed to the deficit.

Under this governance structure, the equity partners share the risks and rewards that result from EOCCO's performance in relation to the Global Budget. On an annual basis EOCCO's financial and actuarial teams develop a global budget which is then approved by the EOCCO Board. The global budget is developed using a ground-up approach to ensure adequate funding is available to cover all services we are required to provide to the EOCCO population. EOCCO produces 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 EOCCO's annual global budget to ensure the appropriate allocation of funding for all covered services.

EOCCO's equity partner GOBHI, a NCQA Accredited Managed Behavioral Health Care Organization, administers the behavioral health benefit and non-emergency medical transportation (NEMT) benefit on behalf of EOCCO. GOBHI's administrative responsibilities include, but are not limited to, utilization management, contracting with an adequate behavioral health provider network and development and implementation of various forms of value based payment (VBP) models with their network of providers. GOBHI also works with PCPCH's and School Based clinics that have employed behavioral health providers and requires coordinating care of patients with behavioral health needs through a collaborative care model. Under this model GOBHI reimburses for behavioral health treatment as part of primary care while ensuring members that need a higher level of care receive treatment in the appropriate setting.

EOCCO 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 fund, etc.) and support, are provided for those clinics that deliver co-located and integrated services.

EOCCO also provides behavioral health expertise through the Collaborative Care Model (CCM). The CCM model is designed to support integrated behavioral and mental health care services to primary care practices that are certified as a Patient Centered Primary Care Home (PCPCH) Tier 3 or higher. The collaborative care model is a systematic approach to the treatment of depression and anxiety in primary care settings that involves the integration of care managers and consultant psychiatrists, with primary care physician oversight, to more proactively manage mental disorders as chronic diseases, rather than treating acute symptoms. The CCM model in place today provides PCPCH's with:

- Financial stipend, as outlined in the Behavioral Health Integration Contract provided by EOCCO, of $4 per member/month (PMPM) for adult Medicaid (EOCCO) patients (population stratified through CCM process)
- Facilitation of a Professional Learning Community for Behavioral Health Consultants to exchange ideas, provide support, and share information/education

- Technical assistance (TA) for CCM implementation, patient tracking, screening tools, and recommended targets

EOCCO provides GOBHI a capitated premium for providing Behavioral Health services. The premium is determined on an annual basis as part of EOCCO's global budget to ensure adequate funding of the behavioral health benefit. The process for determining the annual capitated premium is similar to how EOCCO determines adequate capitated premium for primary care services. As part of EOCCO's shared savings model, GOBHI and their contracted providers share in savings produced as a result of EOCCO's overall performance keeping medical costs below budget and also takes downside risk for costs that exceed GOBHI's capitated premium. Medical providers participating in EOCCO's shared savings model share in any savings produced when costs come in below the GOBHI's capitated premium and also share in the downside risk if costs exceed GOBHI's capitated premium.

Moving forward into CCO 2.0 EOCCO intends to fully fund behavioral health provided in a primary care setting and will provide funding for primary care delivered in a behavioral health setting using a collaborative care model. Enhanced funding for behavioral health will be tied to close coordination and integration across physical and behavioral health providers. Additionally, as EOCCO works to implement its 70% VBP goals by 2024 we will work closely with all providers to drive payments to the highest LAN categories while at the same time retaining full responsibility for the entire benefit package.

3. How will Applicant fund Behavioral Health for its Service Area in compliance with the Mental Health Parity and Addiction Equity Act of 2008?

EOCCO will assure that the parity requirements established in 42 CFR 438.910 are addressed by utilizing evaluation standards that ensure funding to mental health/substance use disorder (MH/SUD) is at a minimum comparable to funding for medical/surgical (M/S) benefit in the same classification.

In 2018, Mercer (on behalf of OHA) vetted EOCCO's MH/SUD and medical/surgical (M/S) policies against these requirements and found them to be in full compliance. These same policies are delegated down to independent practitioners and organizational providers to ensure that access and funding standards required under parity are met.

The EOCCO biennially evaluates the financial requirements and qualitative treatment limitations (QTL) in all six classifications using the principles of "substantially all" and "predominant." This ensures that membership restrictions are not in place that limit access to appropriate services based on medical necessity for either MH/SUD or M/S. In accordance with CMS rule CMS 2333-F § 438.900, EOCCO will also biennially evaluate Non-qualitative Treatment Limitations (NQTL) to ensure no imposition of limitation to the MH/SUD benefit in any classification. The only exception is when other factors in the classification are comparable to, and are applied no more stringently, than the requirements used with respect to M/S benefit in the classification.

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 of Behavioral Health care needs is 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

   The majority of outpatient behavioral health services are funded on a base PMPM plus quality focused value-based purchasing model for the CMHPs throughout the EOCCO region. Other services, including specialty services, acute care, crisis/respite, day treatment, intensive services, out-of-network, etc. are paid based on the DMAP Fee-for-Service schedule. Providers also receive additional payments for increased services such as ACT, Mobile Crisis and Wraparound. Monthly reviews of the base PMPM payments against encounter data are tracked to assure funds are being utilized to deliver services. Costs are tracked and reviewed retrospectively to analyze per member, per provider, per level of care, per service provided, per diagnosis, etc. to determine any areas for improvement.

   On an annual basis EOCCO's financial and actuarial teams utilize this data to help develop a global budget which is approved by the EOCCO Board. The global budget is developed using a ground up approach to ensure adequate funding is available to cover all services we are required to provide to the EOCCO population.

   Prevalence and utilization information is also regularly reviewed by the Utilization Management Committee, Network Management Committee and Quality Improvement Committee (QIC). Annually, a Population Assessment, Utilization Management Summary and Provider Availability report are prepared employing NCQA standards. A root cause analysis is completed for any areas not meeting expectations, and based on this information quality improvement action plans are developed with the input of our providers.

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?**

   EOCCO currently uses an enhanced PMPM payment for clinics that employ behavioral health providers to provide brief behavioral health interventions, enhanced screening, and bridges to higher levels of care if indicated. The region is moving toward 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.

The Certified Community Behavioral Health Clinic (CCBHC) model is being piloted in three Community Mental Health Centers (CMHCs) in our region to integrate physical health in behavioral health care clinics. This model of care was created through Section 223 of the Protecting Access to Medicare Act (PAMA) which established a demonstration program based on the Excellence in Mental Health Act. EOCCO transformation grants help with staffing and start-up expenses for this innovative model. EOCCO staff, and the EOCCO HIE provide data to help track progress on quality measures. In smaller communities where the population does not support providing primary care within the CMHC, we utilize contracting expectations to ensure that care is coordinated between the CMHC and the PCPCH, to ensure that whole person care is provided in a coordinated manner.

Moving forward into CCO 2.0 EOCCO intends to fully fund behavioral health provided in a primary care setting and will provide funding for primary care delivered in a behavioral health setting.

6. How will Applicant ensure the full Behavioral Health benefit is available to all Members in Applicant's Service Area?

We consider the following data and information in establishing and maintaining our behavioral health network, and work through GOBHI's EOCCO Network Management Committee to look for additional providers to fulfil unmet needs and assure Members have access to all services:

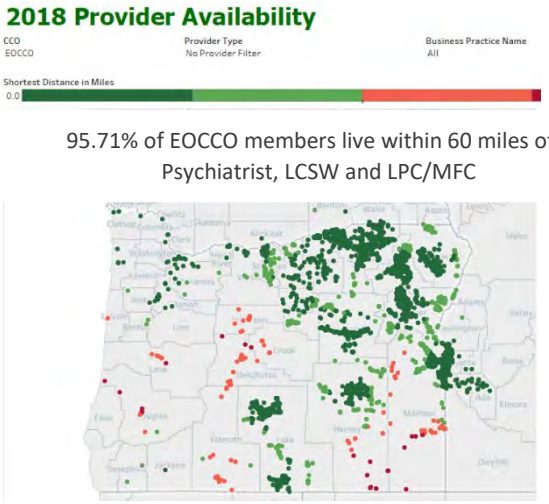
- Anticipated Medicaid enrollment and anticipated enrollment of Fully Dual Eligible individuals
- Appropriate range of preventive and specialty services for the population enrolled or expected to enroll
- Expected utilization of services, the characteristics and healthcare needs of enrollees
- Numbers and types (training, experience, specialization) of providers required to furnish the contracted Medicaid services

Practitioner Type	Practitioners in Network	Ratio	Goal
Psychiatrist	50	1,990:1	2,000:1
LCSW	100	995:1	1,000:1
LPC/MFC	85	1,170:1	3,000:1

- Identified clinical, cultural, linguistic, demographic, risk characteristics and expressed special or cultural needs or preferences of individuals and communities being served.

- Recognized clinical risks including physical or developmental disabilities, serious mental illness, multiple chronic conditions and severe injuries that need to be cared for.

- Number of network providers not accepting new Medicaid patients



- 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)
- 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...)
- Complaints and grievance trends related to access or quality of care
- Data on accessibility (wait times) of appointments
- Reports from Member Services, Care Management or other areas indicating that the needs of an identified Member or members are unable to be met.
- Requests for out-of-network Practitioners (for those members who have out of network benefits).

Note: If a Member needs a service that is not immediately available, EOCCO works through single-case agreements and out-of-network providers to assure services are provided.

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. As part of the 2019 CMHP VBP program, all CMHPs must meet the goal of 90% of members receiving access to routine care (both MH and SUD) within 10-days. CMHPs failing to meet the standards are placed on a Performance Improvement Plan, that may be escalated per policy, up to and including termination.

EOCCO collects wait times from contracted providers to monitor timely access to behavioral health services. An annual Member survey is also utilized to obtain feedback regarding access to services. EOCCO collects quarterly access standards for contracted providers. Data is separated between Youth (0-17) and adult (18+), and Mental Health and

Substance Use Disorder services. The total number of members who were seen for requested service within specified timeframes is divided by total number of members requesting the service, with a goal of 90% receiving services within the goal timeframes: Emergency care members shall be seen within 24-hours or as indicated in initial screening; Urgent Care shall be seen within 48 hours or as indicated in initial screening; Non-Urgent Care needs shall be seen for an intake assessment within two weeks from date of request. Other data collected includes: average number of days after initial visit to scheduled routine follow-up; average time from LMP (prescriber) appointment request to date of first available appointment; and average time between initial crisis call and start of crisis assessment. Data (claims-based) submitted by providers is also analyzed for average timelines from assessment to service plan, and from service plan to first delivered follow-up appointment.

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?**

   As noted above, if a Member needs a service that is not immediately available, EOCCO works through single-case agreements and out-of-network providers to assure services are provided.

   EOCCO Members have access to all medically appropriate, behavioral health services that are covered under the Oregon Health Plan or EOCCO's behavioral health benefit. EOCCO coordinates timely and adequate access to the benefit. If an in network provider is unavailable, or there is a need for the Member to utilize an out-of-network provider, EOCCO works with the Member to find those services. Out-of-network services that are medically appropriate, delivered by a qualified professional and billed with codes that are consistent with the behavioral health fee schedule published by OHA) are paid for by EOCCO. EOCCO assures that services for Members traveling outside EOCCO service area will be paid for if they are medically necessary, urgent, or emergent.

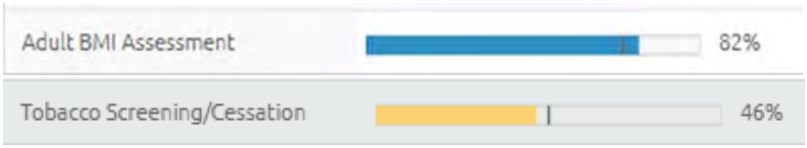
9. **How will Applicant ensure Applicant's physical, oral and Behavioral Health Providers are completing comprehensive screening of physical and Behavioral Health care using evidence- based screening tools?**

   Contracted providers are required to complete comprehensive screening tools during the intake/admission process. Some of the screening tools include:

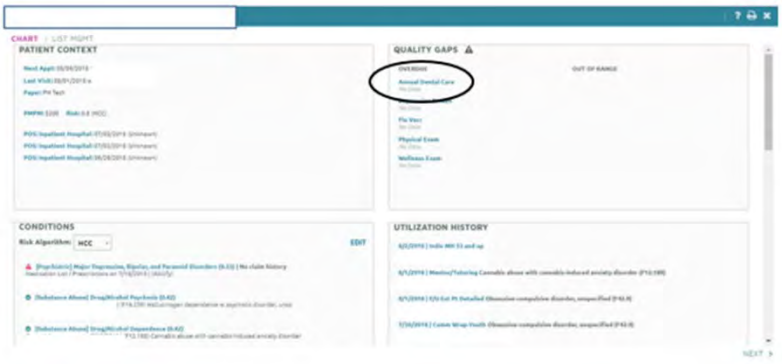
   - SBIRT
   - BMI
   - DAST
   - Cervical
   - Cancer
   - Depression
   - PROMIS
   - Tobacco Use
   - Colorectal Cancer

- GAD-7
- Infectious Disease Risk Screening
- Unhealthy Alcohol Use Screenings
- Diabetes

EOCCO utilizes an HIE (Arcadia) and other data analytics tools to collect near real time information on the completion of comprehensive screenings.



The HIE and provider specific reports provide information on upcoming screening opportunities. All EOCCO providers connected to the HIE have access to this information on an individual and clinic wide basis.



EOCCO is currently working with local CMHPs to streamline and standardize intake packets. This review is designed to assure compliance with OARs and standardize screening tools to assure adequate and useful data collection.

EOCCO also reviews clinical charts from all providers at least once every three years for contracted providers, and annually for CMHPS. Charts are chosen at random from encounter data based on encounters for assessments and services rendered. All contracted providers are required to sign an EOCCO attestation at least once every three years ensuring that they are completing screenings upon intake and throughout a member's care.

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?

EOCCO will contractually require each provider to utilize Mobile Crisis Service as their 24/7 crisis standard. This will be a continuation of the current standard of care within each of the regions to be covered by Applicant.

EOCCO will require each contracted provider to respond to behavioral health crises at the location within the community where the crisis arises. The contracted provider will be

monitored on how they assist the member in resolving the crisis: were services provided in the most integrated setting possible; and did the intervention avoid unnecessary hospitalizations inpatient treatment, civil commitment, and/or arrest or incarceration? The later objectives will be monitored to ensure higher levels of care or arrest/incarceration were clinically and legally appropriate and necessary.

Contracted risk bearing providers will also be monitored for delivering care in a timely fashion, as evidenced by the amount of time required to deliver a face-to-face contact after a professional decision is made that an intervention is required. Response time should be either 1, 2, or 3 hours based on the region and/or locations designation as either urban, rural, or frontier. Contracted providers will be required to ensure all requests for crisis screening are completed in a timely manner, whether face-to-face or over the phone, but must be initiated within 15 minutes of the request.

EOCCO will require all providers to show evidence of compliance with the regulatory requirements associated with documentation, clinical staffing, utilization of interpreter services, and training standards for the delivery of emergency and mobile crisis services. Including the utilization of ACT team resources for members enrolled in that level of care.

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

EOCCO believes in the power of peer services in assisting people with behavioral health conditions to achieve recovery and build resilience. EOCCO's behavioral health program has overseen a peer delivery system that has provided services to 318 mental health enrollees and 99 substance use disorder enrollees. We utilize certified peers in the delivery of care for both adolescents and adults. There are currently 36 peers supporting Members in MH, SUD and Wraparound programs throughout EOCCO. Peer services are available in-person through local CMHPs and through direct to Member, HIPAA compliant, tele-behavioral health software.

Information about access to PDS will be available and communicated to members in a variety of ways such as the Member Handbook, our web site, and directly through providers. The utilization of peer delivered services (PDS) will be arranged on a per contracted provider basis depending on demographics, population, and the community health assessment and/or community health integration plan.

PDS will be incorporated into assisting members with community engagement needs, getting to appointments, negotiating public benefits, and assurances of person-centered planning. The full array, will include certified peers engaged with ACT, crisis services, and warm handoffs from inpatient levels of care. The objective is to integrate PDS into the community's service array in a meaningful and organized manner, based on the inherent limitations of both rural and frontier regions.

EOCCO's Consumer Caucus provides support and training for Members who wish to become Peer Specialists. Two Members from this group sit on the Behavioral Health Board of Directors and one Member sits on the Behavioral Health Quality Improvement Committee.

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

EOCCO's Governing Board has given oversight responsibility for the utilization of Social Determinates of Health (SDOH) to the Local Community Advisory Councils (LCAC's). The LCAC's authorize, based on Governing Boards allocation, reimbursement processes for SDOH entities within their communities. This includes using Traditional Health Workers (THW) and Certified Peer Specialists (CPS) for connecting members to needed SDOH entities or services that exist within the member's community. Both THW and CPS workers are authorized to connect members to educational, employment, health care, housing, transportation, social supports, and other identified SDOH targeted within their communities. These workers support members with integrating, mitigating, and overcoming identified limitations within their communities for a period of time determined by the member. Currently EOCCO contracts with Health Integrated for the provision of behavioral health telephone support to high risk members. Health Integrated also connects these members to SDOH services and/or THW or CPS workers as requested. EOCCO contracts with Community Counseling Solutions (CCS) for telephonic "warm-line" services provided across the region. This service provides a peer connection to anyone with SPMI diagnosis. We recently expanded capacity to include older adult specific peer supports provided by CCS. We also hope to identify funding and expand capacity within the warm line to include SUD specific peers in the future.

B. Billing System and Policy Barriers to Integration (recommended page limit 2 pages)

Applicant must identify and address billing system and policy barriers to integration that prevent Behavioral Health Provider billing from a physical health setting. Applicant will develop payment methodologies to reimburse for Warm Handoffs, impromptu consultations, integrated care management services and all services for evidence-based treatments (for example, Wraparound, ACT, PCIT, EASA, Peer Delivered Services). Applicant will examine equity in Behavioral Health and physical health reimbursement.

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.

EOCCO providers strive to assure there are warm handoffs across our provider network and with other CCO's when members relocate to other areas. To accomplish this:

- EOCCO provides HIE access to both behavioral and physical health providers, with plans to expand to public and oral health providers in the near future. The HIE allows providers to see where their patients are receiving care, any upcoming appointments, current diagnosis, medications, and care gaps. This information helps assure that each Members care team has the information they need to care for the whole patient, regardless of care setting. This information helps to facilitate warm handoffs and ongoing communication.

- EOCCO also provides and supports PreManage, a software platform, to document care plans and recommendations so that each of the Member's caregivers has a way to communicate with others on the care team.

- Within the network, members age 0-5 are referred from pediatricians, family practice physician, early intervention, DHS, and Head Start. We have provided funding to Oregon Pediatric Improvement Partnership (OPIP is housed within the department of pediatrics at OHSU), to create referral tools and feedback forms for the above referral sources in order to address the barrier that this population experiences when trying to obtain mental health services.

- The *Follow-up and Referral Pathways for Children at Risk for Developmental, Behavioral and Social Delays* program, aims to develop and pilot implementation of specific tools and strategies meant to increase the number of young children and their families (target population) who receive behavioral health and specialty infant and early childhood supports.

- For youth eligible for Wraparound and that decline to participate, there is a Warm Handoff to Intensive Care Coordination services, so that they are aware that services can be accessed at any time. If youth are currently receiving Wraparound services, there is a Wraparound Transfer Protocol that details documentation requirements of both the sending and receiving counties.

- The EOCCO EASA program also encourages flexibility for clinicians that allow clients to receive warm handoffs with immediate access. EASA teams coordinate services and conduct warm handoffs through consultation calls, and are actively participating in the EASA center for excellence. EOCCO honors automatic acceptance when members transfer into EOCCO from another CCO.

- Mend is a telehealth platform used to connect providers and members with services, such as psychotherapy, case coordination, and medication management. This platform can be utilized by members through an APP or low bandwidth web browser, which is extremely important to our members in rural areas who often do not have adequate

bandwidth. Through this pilot project, if a member does not have internet access, we are able to provide this access to assist them with appointments. EOCCO is expanding tele-health capabilities and currently have used it successfully with warm handoffs. EOCCO is hoping to pilot a program utilizing tele-health to help facilitate discharge planning and Warm Handoff's for Members at the Oregon State Hospital.

- EOCCO provides a $4.00 PMPM for qualified PCPCH's. In order to receive the increased reimbursement the clinic must provide for BH Consultation, including Warm Handoffs, brief assessment and interventions for patients, consultations to primary care clinicians and participation in pre-visit planning and/or daily huddles. In addition, Primary Care clinics are paid additional levels of PMPM for various tier levels of PCPCH certification. EOCCO provides start up dollars for Behavioral Health Consultants for the first year**.**

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?

EOCCO provides a variety of in-home behavioral health care services.

- Through an HRSA supported grant: we supply direct-to-Member, HIPAA complaint, tele-health software to all EOCCO CMHPs. The software allows Members to receive behavioral health and SUD services in their homes. Services currently provided via tele-health include assessments, therapy, Warm Handoffs with PCPCH patients, medication management and psychiatrist appointments. Group therapy appointments will be trialed in Spring 2019. Future tele-behavioral health services to be implemented include Peer Delivered Services and Intake visits.

- EOCCO has developed a reimbursement structure for Traditional Healthcare Workers (THWs), such as state certified Community Health Workers (CHW) that can provide in-home behavioral health services. Examples of CHW in-home service offerings include: tobacco cessation counseling, weight management and nutrition counseling and linkages to other social service needs. EOCCO contracts with the Oregon State University College of Public Health & Human Sciences to support state certified CHWs and THWs. Examples of CHW in-home service offerings include: tobacco cessation counseling, weight management and nutrition counseling and linkages to other social service needs.

- In-home Applied Behavioral Analysis (ABA) services for EOCCO members in Therapeutic Foster Care and/or with Wraparound supports are available to members in their home. Services allow for direct assessment, therapy, parent training, and other services all within a location and schedule that is flexible to meet the needs of the family. Staff receive extensive training on therapy techniques and strategy on working in the home with children, with emphasis on social and integration settings.

- EOCCO is partnering with local public health departments to implement a universal screening and nurse home visiting program for providing in home services for infant and maternal health.

- Additionally, EOCCO provides case management funding for primary care practices certified as a Patient Centered Primary Care Home (PCPCH) Tier 3 or higher, who offer a level of integrated behavioral health care services, including same day consults, Warm Handoffs and in-home visits (as needed). PCPCH's at Tier 3 (or higher) are eligible for a per-member/per month contract for behavioral health services delivered to EOCCO members.

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.**

   EOCCO requires our provider network to initiate discharge planning at the beginning of an episode of care. In Wraparound, the team creates 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 uses a Wraparound Transition Checklist to assist members in their discharge planning. From the beginning of services through the transition, Youth Partner and Family Partners are engaged and supporting members through the process.

   EASA starts the discharge planning 3- 6 months prior to the client completing the 2 year EASA program. The clinician meets with the client and family 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.

   EOCCO collaborates with Community Mental Health Programs (CMHP) in discharge planning involving all members moving between levels of care and Episodes of Care. EOCCO Utilization Management (UM) monitors Premanage daily and notifies the CMHP the same day of an admission. The Intensive Care Coordinator (ICC) immediately begins the discharge planning process and communicates the plan with EOCCO 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 among the CMHP, EOCCO UM and EOCCO CM to ensure a timely and successful discharge.

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.**

   EOCCO has established practices and policies, such as Medicare by-pass allowances and out-of-network policies, to allow all members, including the fully dual eligible (In 2018 this was 1,348 members), to receive all benefits covered under the Oregon Health Plan.

EOCCO has established processes that ensure all enrolled fully dual eligible members are properly cared for and services are properly billed. 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 provider or member.

C. MOU with Community Mental Health Program (CMHP) (recommended page limit 6 pages)

Applicant will enter a MOU with Local Mental Health Authority that will be enforced and honored. Improved health outcomes and increased access to services through coordination of safety net services and Medicaid services.

EOCCO has executed MOUs under CCO 1.0 with both the Local Mental Health Authorities and the local Community Mental Health Programs in each county served. MOUs are in place with the following CMHPs: Wallowa Valley Center for Wellness serving Wallowa County; Center for Human Development serving Union County; Lifeways serving Umatilla and Malheur Counties; Community Counseling Solutions serving Grant, Gilliam, Morrow and Wheeler Counties; The Center for Living serving Sherman County; Symmetry Care serving Harney County; New Directions Northwest serving Baker County and, Lake Health District serving Lake County.

In order to facilitate the local Behavioral Health Plan, and outline shared goals commensurate with CCO 2.0, MOUs will be reviewed and amended after initiation of the new contract to be effective by January 1, 2020 per the contract template provided in the RFA.

1. **Describe how Applicant plans to develop a comprehensive Behavioral Health plan for Applicant's Service Area. Please include dates, milestones, and Community partners.**

   Our "Applicant Service Area" is comprised of twelve counties in eastern Oregon. EOCCO is structured to recognize the uniqueness of such a diverse set of counties. Therefore, EOCCO has established 12 Local Community Advisory Councils (LCAC) which focus on the needs of each local county. To address the entire service area, the EOCCO has also created a Regional Community Advisory Council (RCAC).

   The RCAC membership is comprised of a representative from county government and the LCAC Chair from each of the twelve counties. Each LCAC creates a Community Health Plan (CHP) and the RCAC has a Regional CHP. The comprehensive Behavioral Health plan will be embedded in the Regional CHP. The Regional CHP was created in 2014 and updated in 2016. Work is under way to produce another set of twelve local CHPs and the Regional CHP by June 30, 2019. Mental Health is currently the priority area for the Regional CHP. The overarching goal in this plan area is to improve health literacy and reduce stigma among EOCCO members so they are more likely to recognize and seek treatment (or encourage others) for mental health issues. One objective in the plan includes Mental Health First Aid trainings for adults, children, veterans and seniors. Another

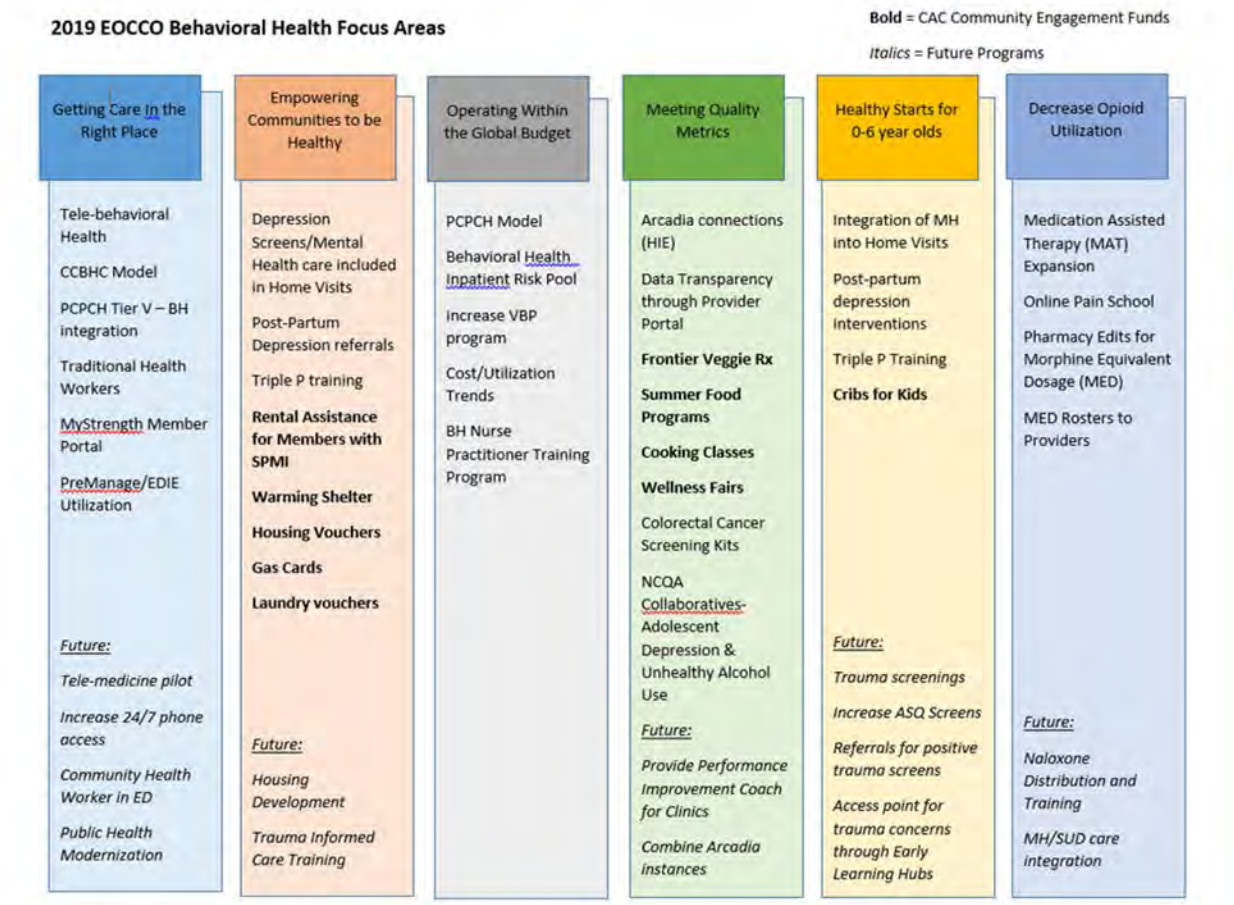
objective is the encouragement of integration of mental/behavioral health and physical health through incentives paid to Patient Centered Primary Care Homes.

Under CCO 2.0 we will be expected to deliver a new comprehensive Behavioral Health Plan by June 30, 2021. We have set the following milestones to meet this date:

- Kessler's Practice Integration Profile model; and an evaluation of each primary care practice and community mental health program to determine how much behavioral and mental health is being delivered in primary care and the number of referrals to the community mental health program. This includes involvement of Certified Community Behavioral Health Clinics (CCBHC) and Patient Centered Primary Care Homes (PCPCH). **Completion: June 30, 2020**

- Review of the results of the assessment across all twelve counties to include clarity on common strength and weakness. Development of appropriate strategies across the entire Applicant Service area and within individual counties. **Completion: December 31, 2020**

- The Regional CAC will approve the Behavioral Health plan and forward to the EOCCO Board of Directors. **Completion: March 31, 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.**

   EOCCO collaborates with Local Mental Health Authorities (LMHA) through regular meetings of the LCACs and the RCAC. County Government represents the LMHA on all of the LCACs and on the RCAC; and LCACS also include Community Mental Health Programs. The CHP results from the broad assessment of community health including health status, health behaviors, vital records, social determinants of health measures, demographics, socioeconomics, health system needs and qualitative input. In late 2018 and early 2019 EOCCO worked with the LCACs and RCAC to develop a series of focus groups designed to collect information, stories, and input from the local communities. This information, along with research and data collection by EOCCO analysts will form the basis of the EOCCO Community Needs Assessment. A timeline including dates and milestones is provided below in question 3.

   Because we support CACs in each county within our service area, a representative from each LMHA has the opportunity and direct responsibility for examining the qualitative and quantitative data prepared as part of the CHP process. Data represent population health indicators as well as aggregated, de-identified data from claims and encounters. Progress measurement on CCO metrics are also examined as part of this process.

   Where possible the CHP assessments provide results over multiple years to demonstrate trends and compare local data to the State of Oregon results. Comprehensive Community Health Assessments will be prepared by the applicant and presented to the LCACs by October 2020. In order to ensure that each LMHA has the opportunity to review and provide comment on the CHP, we will offer assigned staff to share information and updates, as requested, by the LMHA.

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.**

   EOCCO will meaningfully engage in collaboration and coordination with local mental health authorities (LMHA), acting through Community Mental Health Programs, in the development of a comprehensive local plan as adopted under ORS 430.630. These plans, as requested by OHA, provide the service and funding framework for a continuum of non-Medicaid service elements (including services for individuals with serious and persistent mental illness who are under Civil Commitment, Aid and Assist/.370, and Psychiatric Security Review Board) supported by State General Funds, block grants, and Other Funds to be implemented during the biennium beginning July 1st of odd numbered years. The following milestones reflect work that EOCCO will do related to this effort beginning January 2020 (dates subject to revision once guidance is provided by OHA):

   - January-March 2020: Collect and review local plans currently in effect.
   - March-April 2020: Provide a primer on local plans including statutory references and sample plan information from a local plan to all LCACs. Invite representative from LMHA and/or CMHP to share information with LCAC.

- April/May 2020: Review guidance on local plan development, if available, from OHA.
- May/June 2020: Ensure at least one representative from each LCAC is assigned to participate in the local planning process.
- June 2020 (or soon after OHA guidance is released): Develop a summary of aggregate, de-identified data, owned by EOCCO, for each LMHA region that would be helpful to individuals working on the local plan. Develop a process for sharing this data as described in the revised MOUs with each LMHA.
- July 2020 and through Local Plan submission: Include local plan development on the agendas for each LCAC and the RCAC. This includes presentations by representatives from each LMHA or CMHP acting on behalf of the LMHA about the needs, gaps, opportunities for better coordination, shared goals toward the advancement of the triple aim, and ultimately the final plan as approved by the LMHAs.

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.**

   EOCCO has strong relationships with Local Mental Health Authorities (County Government) and Community Mental Health Programs. These organizations are well represented at the LCAC and RCAC. We do not expect any challenges or barriers to executing the plan or MOUs.

D. Provision of Covered Services (recommended page limit 6 pages)

Applicant must monitor its Provider Network to ensure mental health parity for their Members.

1. **Please provide a report on the Behavioral Health needs in Applicant's Service Area.**

   Through our close coordination with the LCACs, CMHPs, Early Learning Hubs, educational services districts, local justice partners, hospitals, primary care clinics and data analysis strategy, we maintain constant pulse on the behavioral health needs in the region. EOCCO's capacity to monitor its behavioral health service provider network has grown and become increasingly rigorous. EOCCO adheres to the standards required by the Managed Behavioral Health Care Organization (MBHO) by the National Committee on Quality Assurance (NCQA). These standards require that organizations regularly conduct: (a) Membership Profiles that examine demographics, behavioral and physical healthcare needs, as well as cost and service utilization patterns through the integration of OHP enrollment, behavioral health claims, and health plan data; (b) Community Health Assessments that cover behavioral and physical health needs as well as health risks such as Social Determinants of Health (SDOH); (c) Provider Network analyses and Directory updates; and (d) Provider to Population Ratios.

Strategies to continuously strengthen our workforce include: (a) supporting providers in recruiting other providers through a central recruiting and hiring hub; (b) maintaining partnerships with the State's higher education and research institutions that include traineeship programs; (c) implementing and disseminating programs that increase the reach of evidenced-based behavioral services; and (d) training to update and increase the breadth of skills of its existing behavioral provider workforce.

Behavioral Health Needs in EOCCO's 12-County Service Area

EOCCO's Membership Profile reports stratify its population by demographic, clinical and utilization patterns in detail and with special attention to vulnerable populations. For the purpose of this section on behavioral health service coverage, we briefly report on the EOCCO Membership by County, demographics, linguistic/cultural background and its SPMI sub-population. We largely use OHP enrollment and behavioral claims data for ***January 1, 2017 to December 31, 2017*** because they have been verified across data sources.

	Total Enrollees	**% of Total EOCCO**	**% BH users by county** **OHP enrollees**
Baker	5,117	7.9	15.1
Gilliam	529	0.8	10.2
Grant	2,019	3.1	16.0
Harney	2,570	4.0	12.1
Lake	2,386	3.7	12.5
Malheur	12,553	19.4	9.8
Morrow	3,880	6.0	9.1
Sherman	482	0.7	10.2
Umatilla	24,329	37.7	11.5
Union	8,104	12.5	15.0
Wallowa	2,233	3.5	15.0
Wheeler	384	0.6	12.3

Table 1. Total Annual EOCCO Enrollment and Percent of users of behavioral health services by county

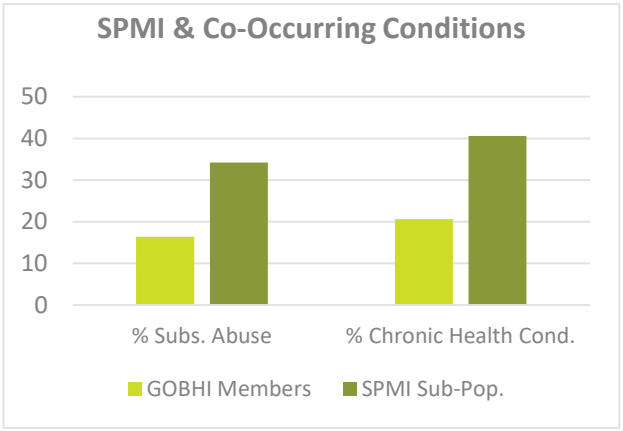
Throughout 2017 there were 64,586 OHP Members enrolled across the 12 EOCCO counties. Over one-third live in Umatilla and nearly one-fifth in Malheur. Three counties had 6 to 12.5% of enrollees in each: Baker, Morrow, and Union. Seven counties had 0.6% (less than 1%) to 4% of enrollees in each: Sherman, Gilliam, Wheeler, Grant, Lake, Wallowa, and Harney.

Following encounter-claims data: **unduplicated individuals' usage of behavioral health services among OHP enrollees per county ranged** between 9.1% - 16%.

Analyses of demographics for the entire EOCCO region reveal that **gender** is evenly divided—52% are female and 48% male. Regarding age - only a minor fraction were in the 65 years plus bracket (4%). The Children / Youth 18 years or younger bracket and the adult age bracket between 19 and 64 years were evenly represented in the Membership with 48% of the total Members each. The Ethnic background of EOCCO enrollees was led by individuals with a European-White (Non-Hispanic) background 60%. Among ethnic minorities, 22% were Hispanic/ Latinx, 3% Native American, 0.8% Asian American or Pacific Islander, and 0.8% African American (13% of enrollees had an "undetermined"

ethnic membership and 1% “other”). The large majority of Members (84%) report that English is their preferred language**,** 10% reported Spanish, and 0.4% “other” (for 5.9% language was undetermined).

In analyses carried out with integrated health plan data, we found that among adults with behavioral health conditions, Serious and Persistent Mental Illness (SPMI) is the highest category: among adult individuals eligible for SPMI, 53% (1,874 total) had an SPMI diagnosis for all EOCCO counties as a set (Range 41% to 59% within counties). In recent analyses with the EOCCO SPMI population, we have found that 41% had a chronic health condition and 34% had a Substance Abuse disorder. Notably the likelihood of having either of these two conditions was higher compared to the rest of EOCCO Members by a factor of 2 or more.



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.

EOCCO conducts regular analytics on provider type and availability to membership. The current analysis shows that EOCCO has one (1) psychiatrist for every 1,990 enrolled members, with a best practice ratio of 1: 2,000. This pattern exists for LCSW’s, current ratio of 1: 995, with best practice ratio of 1: 1,000, and for MFC/LPC’s current ratio of 1: 1,170, with a best practice ratio of 1: 3,000. EOCCO utilizes industry establish practitioner to member ratios in determining workforce shortage areas and hiring practices.

The same analytics are conducted on the location of practitioner types (psychiatrist, LCSW, MFC/LPC) to members within the geographic coverage area. EOCCO currently has over 99% of all practitioner types within 60 miles of each known member. With approximately 80% of all enrollees being within ten (10) miles of each of these practitioner types. These reviews are done at least quarterly to ensure adequate access to covered benefits by all enrolled members.

Practitioner Type	EOCCO
ABA Behavioral Analyst Interventionist	7
ABA Board Certified Behavioral Analyst (BCBA)	0
Behavior Analysis Practitioners:	**7**
Certified Alcohol Drug Counselor (CADC) I	71
Certified Alcohol Drug Counselor (CADC) II	42
Certified Alcohol Drug Counselor (CADC) III	4
LPC Master Addiction Counselor (MAC) CADC I	0
Addictions Counselors (non-MH services):	**117**
Certified Recovery Mentor	6
Community Health Worker	2
Community Health Worker QMHA	1
Traditional Healthcare Worker	4
Health Workers:	**13**
Clinical Social Work Associate (CSWA)	5
CSWA CADC I	0
CSWA CADC III	1
Licensed Clinical Social Worker (LCSW)	57
LCSW CADC I	4
LCSW CADC II	1
LCSW CADC III	2
LCSW RN	0
Licensed Master of Social Work (LMSW)	5
LSW CADC I	1
Licensed Social Worker (unspecified)	2
Social Workers:	**78**
Licensed Marriage and Family Therapist (LMFT)	3
LMFT CADC I	1
Licensed Professional Counselor (LPC)	52
LPC CADC I	2
LPC CADC II	2
LPC CADC III	2
LPC LMFT	0
Licensed Professional Counselors and Therapists:	**62**
Doctor of Osteopathy (DO)	1
DO Psychiatrist	1
MD Addiction Medicine	5

Practitioner Type	EOCCO
MD Child Psychiatrist	1
MD Emergency Med Practitioner	1
MD Family Practitioner	3
MD Internist	14
MD Neurologist	1
MD Pediatrics	0
MD Preventative Medicine	1
MD Psychiatrist	18
MD Psychologist - Neuropsychologist	1
Nurse Practitioner Family	6
Psychiatric Mental Health Nurse Practitioner (PMHNP)	19
Physician Assistant (PA)	8
Licensed Medical Professional (prescribers):	**80**
Peer Support Specialist	35
Peer Support Specialist QMHA	0
Peer Wellness Specialist	1
Peer Support Specialists:	36
Qualified Mental Health Associate (QMHA)	167
QMHA CADC I	7
QMHA CADC II	3
QMHA RN	1
Certified Recovery Mentor QMHA	2
QMHA:	**180**
Qualified Mental Health Professional (QMHP)	114
QMHP - Psychologist	1
QMHP CADC I	13
QMHP CADC II	5
QMHP CADC III	1
QMHP RN	2
MSW QMHP	21
QMHP:	**157**
Registered Nurse (RN)	19
RN:	**19**
Total EOCCO:	**749**

EOCCO has a feedback loop with our network providers as we rely on these providers to share with us on a daily and/or weekly basis what their recruiting needs are. As will be mentioned in questions #3 & #5 of this section, EOCCO coordinates recruitment with network providers to maximize range of recruitment and qualifications of candidates. EOCCO then relies on network providers to be responsive to our requests to address shortages within their coverage areas. This will require them to develop capacity to either reduce the ratio of practitioner type to enrolled members to meet our standards and/or to locate practitioner types in specific areas to ease access for members.

EOCCO also relies on network management to assist in finding contractors to fill positions on an interim basis in order to ensure service delivery needs are being met. This can include contracting with practitioners for the delivery of care if underperformance in meeting ratio or proximity requirements is chronic and cannot or has not been remedied.

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?**

   EOCCO will continue to refine its' current efforts to ensure our workforce is prepared to meet the covered services appropriate to our membership. The following represents both formal and informal action plan agreements between EOCCO network providers, and community partners.

   - Ongoing recruitment in service areas: In 2018 EOCCO staff assisted Providers to hire twelve people to fill a range of positions including: from peer support positions, housing coordinator, BH clinicians, to a DD program manager. EOCCO works in a complementary role with the Provider Organization, in that we assist with advertising, salary surveys, candidate searches, screening, and establishing interviews, but not in interviewing or selecting candidates.

   - Training: Training is the largest part of EOCCO efforts. EOCCO sponsors two annual state wide conferences, the GOBHI Spring Conference in Bend which has featured speakers such as Rep. Patrick Kennedy, Dr. Bruce Perry, and Dr. Gabor Mate, and the Behavioral Health & Education Summit in Pendleton that is targeted for educators, early learning providers, and all who work with young children and families. Both of these events draw from 350 to 500 participants each year from around the State.

   - EOCCO sponsors or conducts trainings including but not limited to: Cultural Diversity, Child Parent Psychotherapy, Trauma Informed Care (with and without Law Enforcement), Medication Assisted Treatment, and Mental Health First Aid.

   - Consultation: EOCCO makes available consulting psychiatrists to network providers for challenging clinical cases. These services are offered to both in and out of network providers serving EOCCO members. Psychiatrist provide numerous trainings and technical assistance on areas ranging from medication management, warm handoffs back into the community, and medication assisted therapy, if appropriately credentialed.

   - Collaboration with higher education: EOCCO collaborates with state educational resources including with Northeast Oregon Area Health Education Center in the submission of and subsequent awarding of a one million dollar Oregon Health & Science University (OHSU) grant entitled Healthy Oregon Workforce Training Opportunity. The grant's purpose is to increase mental health workforce in Eastern Oregon. EOCCO is also collaborating with OHSU in admitting qualified nurses in the Nurse Practitioner distance education program and embedding/retaining graduates as licensed PMHNP in Eastern Oregon clinical practices.

   - Supporting for Practice Exposure: EOCCO contracts with Northeastern Oregon Area Health Education Center and the Rural Health students as they conduct their

Inter-Professional Practice and Education (IPE) community project through the duration of their rural rotation in Union and Wallowa counties.

4. What is Applicant's strategy to ensure workforce capacity meets the needs of Applicant's Members and Potential Members?

EOCCO providers are required to send quarterly practitioner lists, access reports and chart audits. These reports combined with complaints and grievance trends provide a quick snapshot into the availability and quality member care.

Network providers are required to submit all reports quarterly. EOCCO reviews them for compliance with EOCCO's established threshold standards, like routine visits scheduled within ten (10) business days of initial request and the percentage of care delivered within these time frames. There are numerous areas that are evaluated based on regulatory requirements and other standards developed by EOCCO in conjunction with internal quality improvement committees. Acceptable threshold limits are usually established at between 90-95% depending on contracted area.

One result of these continuous evaluations of our network providers' performance is EOCCO's ability to determine the underlying cause of poor outcomes. If EOCCO notices trends of underperformance in the same areas regularly, EOCCO will, based on their progressive corrective action policy, conduct an investigation to determine the root cause. The outcome of the investigation will direct the required next steps as stipulated in the same policy.

In circumstances that involve limited workforce capacity, the network provider will be required to rectify the deficiency within an appropriate period of time, as outlined in a corrective action plan.

EOCCO recognizes that due to the rural nature of our service areas that there are there are workforce shortages in all 12 counties. We are pro-actively providing the necessary support and technical assistance to remedy workforce shortages once identified. We have outlined in section D questions 2, 3, and 5 the processes in place to prevent such an occurrence. However, in circumstances in which there is a repeated failure to meet minimum performance measures, we recognize that increasing network provider participation and capacity, delivering services, and/or increasing candidate incentives may be the only means of mitigation.

5. What strategies does Applicant plan to use to support the workforce pipeline in Applicant's area?

In addition to efforts described in response to D.3, EOCCO has ongoing human resources (HR) collaborative meetings with network providers. These quarterly meetings are designed to strategically assess workforce capacity with regards to recruitment, retention, and development. In addition to these collaborative efforts, staff are also assigned to work with statewide resources/entities such as Mental Health & Addictions Certifications Board of Oregon (MHACBO), Childrens System Advisory Council, the National Association for Health Care Recruitment (NAHCR), and Eastern Oregon Workforce board. These efforts

are to ensure our workforce have the most current information, possess the highest qualifications, and utilize the best practices.

We places 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. These and other benefits are offered to entice highly qualified and competent professionals to the EOCCO region.

Examples of additional benefits provided include scholarships/furthering education cost reimbursement, signing bonus/loyalty bonus/quarterly bonus, Federal student loan forgiveness programs for rural Oregon, HRSA SUD loan forgiveness programs for rural Oregon, Oregon Healthcare Provider Loan repayment programs, licensure assistance, support of a remote work environment for candidate flexibility, support of strong work/life balance, and relocation reimbursement offered by some network providers. The intent is to maximize rural and frontier community's attractiveness, to encourage youth from this region to return after they finished their educational aspirations, and to retain those who are skilled and experienced to remain.

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. We also work to encourage word of mouth recruitment by offering Employee Referral Bonus' if a referred candidate is offered employment. Additionally, we work to offer Internship opportunities to students at any of Oregon, Washington, and Idaho's universities. These efforts reflect EOCCO'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?

All data collected is analyzed with a focus on opportunities for improvement. Aligning these opportunities with the needs of our most vulnerable populations, including SPMI, children, and pregnant women, is a focus.

In addition to the workforce data, demographics and co-occurring data mentioned in Section D.1, EOCCO collects data on utilization trends (over, under, specific services, readmissions, Emergency Department, Inpatient…), access, crisis response times, completion of recommended screenings, screening results, quality metrics, costs trends, complaints and grievances, member safety, transportation usage, provider experience, member experience and patient reported outcomes. Improvement projects are prioritized and tracked, with regular reporting to the Quality Improvement Committee, Peer and Provider Advisory Council, and Board of Directors (all of which contain consumer representatives). Annually, the information is used to generate a number of reports according to NCQA standards that detail improvement efforts and progress toward goals. Data collected is also made available to practitioners and providers as part of this annual

process improvement evaluation. This evaluation assists EOCCO and our network practitioners and providers in recognizing areas that require improvement and where services are being delivered successfully so that these best practices can be mirrored across our health network.

EOCCO also uses the collected data to build reports that identify members who may benefit from further coordination of services. Staff then conduct outreach based on results of the report or provide a list of identified eligible individuals to ACT teams that are the geographic proximity to the client and require ACT providers to do the outreach.

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?**

   Collaboration with the Confederated Tribes of the Umatilla Indian Reservation and the Burns Paiute Tribe have been, and continues to be ongoing in the area of systems and services for tribal members with SPMI who need effective transitions from institutions, including jail, or transitions back to community from hospital levels of care. Representatives from both tribes are involved in helping determine and develop strategies regarding needs and gaps related to early learning and parenting education.

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?**

      We will continue to provide a full array of SUD services, focusing more attention to 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. Data will be utilized 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 as well as a customer service and trauma-informed approach to all who come for care. CCO staff are trained to either connect members to staff who speak their language or to utilize language lines for translation. The CCO maintains data on member preferred languages to identify need for staff and printed materials to reflect the

members' preferred languages. Contracted providers are required to similarly employ bilingual staff and utilize language lines.

Members have access to culturally responsive and linguistically appropriate SUD services through their local providers, any other EOCCO provider (with transportation provided if needed), and through HIPAA compliant, tele-health software. Members can utilize the EOCCO provider directory (on-line or hard copy) to find the best provider match to meet their needs. This information is 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?

Local communities and tribes employ SUD prevention specialists to provide education and preventative programming appropriate to the local cultural and community needs. EOCCO coordinates with communities via the LCACs and with local prevention and public health workers to support these efforts. Trainings can be provided through bilingual staff or utilizing translators to accommodate language needs. EOCCO supports the implementation ofSUD screening utilizing SBIRT and other appropriate tools through financial incentives. Intervention for lower level use disorders or high risk behaviors is supported within the primary care clinics utilizing training for staff on motivational interviewing, scripts for tobacco cessation counseling, and integration of behavioral health consultants. We also administer grant programs providing funding from the incentive pool for innovative and targeted prevention activities for youth and families.

EOCCO, through an NCQA collaboration, is working with four other health plans scattered throughout the United States to develop best practices related to unhealthy alcohol usage. As part of this work, EOCCO CMHPs are implementing pilot programs to support it.

EOCCO also provides access for all Members and Providers to myStrenths, a self-help software platform designed to "empower users with individualized pathways incorporating multiple programs to help manage and overcome co-occurring challenges."

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?

Many of our communities have collaboration between SUD providers and referral sources via multi-disciplinary teams to ensure the local community and culturally specific needs are being addressed. The EOCCO provider directory is available to find an SUD provider that best matches needs. The member handbook is available in English and Spanish, with information on how to access it in 15 additional languages. EOCCO also disseminates information to community members and referral sources via a number of venues including LCACs, the CAP, and the Regional Opioid Prescribing Group (ROPG).

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.

Since 2015, EOCCO has been actively working to lead the efforts in opioid reduction in Eastern Oregon. The work has been clinician and data driven to ensure the highest level of clinical efficacy and outcomes based interventions.

Beginning in 2016, EOCCO has been providing ongoing Waiver X trainings for providers at zero cost. As well as working with clinic opioid champions to do a series of train the trainers to outreach to as many clinicians as possible. In July of 2017, EOCCO removed access barriers by placing OUD treatment options, such as naloxone and buprenorphine, on the pharmacy formulary without any prior authorizations. As of 2018 Eastern Oregon has also been working on strategies to bulk buy naloxone to increase access for areas of the community who are unable to receive it through a pharmacy benefit, i.e. law enforcement.

EOCCO, through separate OHA funding mechanisms, will purchase an initial supply of Naloxone. Goals include: all behavioral health crisis teams are trained and carry Naloxone; each individual that is involved in MAT services will be provided with Naloxone; and training on how to utilize the medication is provided throughout the communities. In addition, through community partnerships and the Oregon Center of Behavioral Health and Justice Integration, strategic outreach to the law enforcement community will be facilitated to introduce the concept of Naloxone distribution and use by first responders. Referral pathways to appropriate medical and rehabilitative services will be developed and documented in order to sustain this effort.

There has been ongoing support since the publication of the CDC guidelines, for physicians on how to apply the guidelines in clinical practice. On the EOCCO website, there is a taper plan template that allows physicians to build customized taper plans for each of their patients. The EOCCO Regional Opioid Prescribers Group (ROPG), also provides support through a peer to peer engagement strategy for the Eastern Oregon clinicians who may have concerns about specific members or need help taking the first step of broaching the conversation with their members.

EOCCO has also been a strong proponent of alternative treatments and therapies for patients struggling with opioid use. Ongoing sessions of in-person as well as online pain schools have been established for members of the community. And alternative payment models have been created to increase access to movement therapy for these members.

At the core of all the various interventions has been data and utilizing data to drive change. From a population level, EOCCO uses claims data to evaluate utilization patterns and identify areas of opportunity. For example, identifying certain cohorts of individuals who would be considered long term opioid utilizers and work with their PCPs to determine if a pain school would be appropriate. EOCCO uses data at a clinic level to monitor taper success and high risk opioid prescribing. EOCCO provides the clinic their results benchmarked against the CCO's goal rate on a monthly basis. And EOCCO uses

data at a PCP to member level, to help identify members who need a taper and where they are getting their opioids from. EOCCO also strongly encourages all providers to check the PDMP prior to any visit with the patient who has been identified as utilizing an opioid.

EOCCO will continue to provide a full spectrum of SUD services including OUD specific services. We are focused on meeting members where they are in terms of stage of readiness, location, culture, and socioeconomic circumstances, and improving coordination and connection with members transitioning between levels of care. We are in the early stages of an OUD workforce expansion initiative to develop more MAT capacity in Eastern Oregon through separate funding from OHA. We will coordinate with other entities who have received this funding by initiating the Eastern Oregon Learning Collaborative with OHA in order to take advantage of opportunities for shared learning and building upon the continuum of care. This effort will increase OUD capacity among our contracted providers and create additional capacity for MAT for OUD in all forms: Buprenorphine, Naltrexone (oral and injectable) and Methadone. This effort will result in increased MAT capacity in at least five EOCCO counties.

e. Coordinate with Providers to have as many eligible Providers as possible be DATA Waived so they can prescribe MAT drugs.

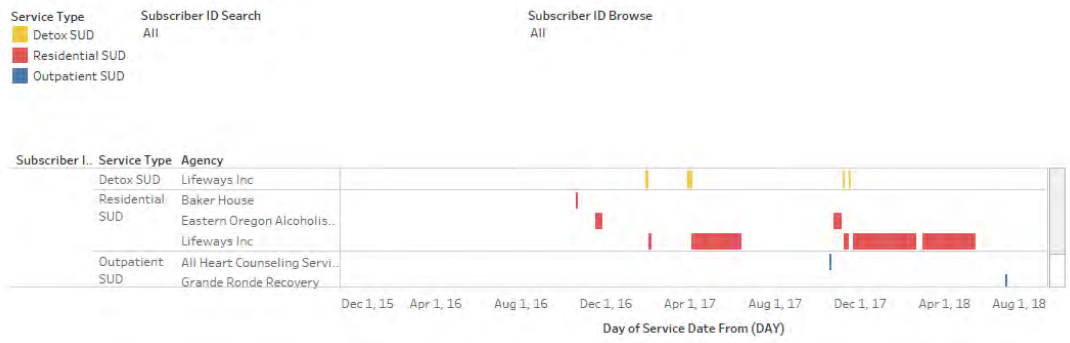
In addition to the strategies outlined in section d, in spring 2019 a planning committee will convene to expand access to MAT and opioid-specific outpatient services. The planning committee will include members of EOCCO's provider network to identify the most effective locations to create new capacity in our region. EOCCO expects to expand MAT capacity and enhance the continuum in at least five counties throughout the region and support efforts in two additional counties who are also receiving funding from OHA. We established a multi-disciplinary team to provide technical support and consultation for MAT programs, to include opiate treatment specialists to further assist MAT providers in caring for members. Also, EOCCO will develop financial contracts with selected providers, and provide recruitment support for hiring new staff. We have successful experience developing MAT capacity in other parts of the state and will use that experience to support this effort.

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.

As mentioned above in E. 1. d., we are embarking on a major systems initiative to strengthen capacity in all areas for individuals and families in need of OUD treatment and recovery services. This effort will help us tie together the coordination that we have done so far related to OUD, which has been focused on prescribers, law enforcement, EDs, local public health authorities, our provider network and other stakeholders. We are currently setting up a team to own this work and coordinate with all of the stakeholders

mentioned in this question. (Please also see this work reflected in our Community Engagement Plan, Table 2.)

EOCCO is utilizing data and software systems to look for gaps in care. In the example provided, EOCCO "found" a member with multiple trips to Residential SUD and Detox programs who did not appear to be receiving outpatient treatment. EOCCO was able to assign a care coordinator to work with this member to connect them to local community supports and to encourage outpatient treatment with the hopes of preventing the need for higher levels of care.



The EOCCO supports an annual conference with partners including law enforcement to discuss current challenges, available resources, and coordination of efforts in prevention, treatment, and supporting recovery. Crisis workers are utilized to assist with assessment and referrals within Emergency Departments and in communities, and for non-urgent outreach, recovery mentors are utilized. EOCCO also supports housing efforts for members affected by SUD, with a priority emphasized for pregnant women and families with young children.

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**

  - PCPs are sent a monthly roster that identifies of all members that are on an opioid product and specifically calls 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. Since the deployment of the rosters, we have seen an additional increase of 32% of high risk patients being successfully tapered off of their opioid products.

  - Morphine Equivalent Doses (MED) Point of Sale Edits are being 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 EOCCO before the prescription is filled. Since implementation in July 2018, there has been a significant reduction of products filled at 200 MED or greater.

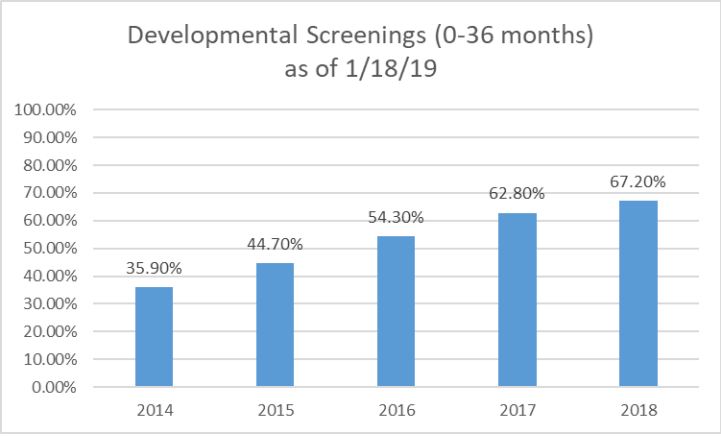
- EOCCO has an online pain school designed to provide Members with alternative options to pain management. Members enrolled in the program report a decrease in depression, anxiety, and pain interference, as well as an increase in self-confidence related to managing pain.
- The ROPG created a list of all of the current contracted EOCCO alternative care providers in order to increase access and use of alternative therapies.
- In partnership with Oregon State University, Community Health Worker advanced training modules were developed. One of these modules focuses on Chronic Health Conditions with a subcomponent around chronic pain and the role of CHWs in the management of these conditions.
- With the help of a new grant received from OHA, EOCCO will be working to expand access to Medication Assisted Treatment for Members living in our region (see above for more information).

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?

EOCCO ASQ Incentive Measure continues to improve due to primary care providers becoming PCPCH certified, therefore increasing tier level reimbursement rates and clinics recognizing the value of using one developmental screen to measure young children's development being used over a period of time. ASQ materials, workflow training and education were provided to Eastern Oregon clinics through the PE 30 grant and by Oct. of 2018, the measure met the target.



EOCCO plans to expand our pilot project with Oregon Pediatric Improvement Partnership to address when social-emotional screenings reveal concerns. The "Follow-up Pathways for Young Children Identified in Primary Care at-risk for Social-Emotional Delays" project is developing pathways for young children identified in primary care through assessments to the referral and follow up process. This effort will develop a Primary Care Decision Tree to support primary care providers in identifying children and families who should be connected to internal behavioral health supports, referred to specialty mental health, or both. Indicators will be developed across primary care sites with enhancements and customization based on child and family risk factor screening that each primary care will be utilizing. Standardized and child-specific referral forms will be used to refer children 0-5 and their caregivers from primary care to mental health agencies.

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?

Currently, when serving young children and their caregivers using a dyadic model, two screening and assessment tools are being used to assess ACE's and trauma: Parenting Stress Index 4 Short Form (PSI4-SF) and Eyberg Early Childhood Behavioral Inventory (ECBI). Moving forward, EOCCO will also be using the Devereaux Early Childhood Assessment for Infant & Toddlers, DECA I/T.

These tools, approved and monitored by the OHA, contain pre/post scores that are submitted to the Early Childhood Mental Health Policy Specialist in our quarterly reports for data collections and evaluation purposes.

We are currently examining practice workflows, barriers and opportunities with regard to screening for ACEs and resiliency among primary care providers serving parents and children as part of our parenting and early childhood initiative. Training on ACEs and trauma-informed practices has been delivered to these practices, but they are not yet screening for ACEs or resiliency factors. We will be identifying and reviewing tools and their effectiveness with providers in the coming months.

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?

As part of our parenting and early childhood initiative, we evaluated PRAMS data from OHA, noting that 48.1% of women in our region reported depression during or after pregnancy in 2017. We are planning for a roll out of the Family Connects model from North Carolina to create universal screening for all pregnant members. EOCCO currently utilizes the PHQ-9 to screen for behavioral health needs in primary care for all pregnant members both during pregnancy and post-partum. EOCCO will continue to partner with local Public Health Departments and other home visiting programs to build an

infrastructure with the ability to provide screening and subsequent visits to every pregnant member. Additional EOCCO efforts include:

- Apply to be a pilot site for SB 526 (OHA shall study home visiting by licensed health care providers in this state) in 2020, with a goal to implement region wide within 3 years.

- Continue support for using 5 P's to screen for substance use concerns in pregnant members: Did any of your Parents have problems with alcohol or drug use, Do any of your friends (Peers) have problems with alcohol or drug use, Does your Partner have a problem with alcohol or drug use, Before you were pregnant did you have problems with alcohol or drug use (Past), In the past month, did you drink beer, wine or use other drugs (Pregnancy).

- Support infants/toddlers and caregivers identified as needing it

- Financial support for the Integrated Nurse Home Visiting Program (INHV) in several counties in collaboration with public heath home-visiting nurses and mental health clinician's to provide PHQ-9 screenings to mothers and offer additional mental health support in the home. The aim is to support early childhood health and strengthen the parent-child relationship by addressing maternal and caregiver depression and integrating behavioral/mental health services within existing home visiting programs. This pilot project is partnered in four eastern Oregon counties (Grant, Morrow, Umatilla, Malheur), by four public health departments, and two community mental health providers.

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?

EOCCO supports the Oregon Pediatric Improvement Partnership (OPIP) in a pilot to develop pathways throughout the entire catchment area for young children identified in primary care through assessments to the referral and follow up process. This effort will result in a Primary Care Decision Tree to support primary care providers in identifying children and families who should be connected to internal behavioral health supports, referred to specialty mental health, or both. Indicators will be developed across primary care sites with enhancements and customization based on child and family risk factor screening that each primary care will be utilizing. Standardized and child-specific referral forms will be used to refer children 0-5 and their caregivers from primary care to mental health agencies.

EOCCO is developing additional integrated clinics to increase access to behavioral health resources for members within the primary care setting. This will help remove existing stigma associated with established mental health stand-alone sites, support the Warm handoffs and in-house referral process with connection to support services such as Children and Recovering Mothers (CHARM) and smoking cessation resources.

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?

GOBHI on behalf of EOCCO is the only CCO in Oregon that is a Licensed Child Caring Agency providing Therapeutic Foster Care services. Our Planned and Crisis Respite program also provides opportunity for short term interventions to support parent education and skill development for children while remaining a family unit. This additional service provides members an opportunity to address needs of children and families immediately, preventing higher levels of care, and keeping families together.

EOCCO intends 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 these children and their parents reduces the likelihood of out of home placement, and encourages healthy parenting skills, child development, and attachment.

GOBHI on behalf of EOCCO financially supports the two Relief Nursery's that are located in eastern Oregon. Therapeutic classrooms provide evidence based treatments to babies, very young children and their parents or guardians. Relief Nursery's work is a partnership with DHS to provide parent education and respite, which has proven to keep children living in their homes with their primary parent(s) or guardians. Relief Nurseries also reduce the risk of child abuse and neglect.

GOBHI on behalf of EOCCO recently supported Eastern Oregon providers to expand evidence based dyadic treatments by obtaining available funding for Parent-Child Interaction Therapy. In 2018, Oregon Health Authority (OHA) introduced flexibility in their fidelity model to assist and encourage rural counties to apply. As a result, five new sites were awarded funding for start-up and training expenses, two of which will be housed inside Relief Nurseries. This will increase EOCCO's capacity to serve our youngest members and their caregivers in rural Eastern Oregon.

For children who have an autism diagnosis, EOCCO provides intensive (up to 30 hours a week) Applied Behavioral Analysis in the home. Due to the fidelity requirements and intensive service benefit to members who qualify for this service, we decided not to delegate this program to another agency. We hire, train and provide staff to work with rural communities to best meet the needs of our members.

The Applied Behavioral Analysis (ABA) program in Eastern Oregon provides additional services:

- Merging our ABA program with the Eastern Oregon Developmental Disabilities program allows us to work in the home using family advocates who create specific plans that assist parents and children with other behavioral and social concerns, especially decreasing medical emergencies. These family advocates also provide

parent and Behavior Intervention Training and education. Family Advocates also provide in-home Behavioral Consultation and connection to resources and county networks to families that are on the waitlist for ABA services.

- Board Certified Behavior Analysts (BCBAs) prepare Behavior Intervention Plans (BIPs) for clients who display maladaptive behaviors (i.e., aggression and self-injurious behavior) to support both child and parents with coping strategies, and complete Functional Behavior Assessments to determine ways to support children with home and academic skill learning.

- Training to siblings to teach about triggers and how to avoid escalating their brother/sister

- Family Advocates provide in-home Behavioral Consultation and connection to resources and county networks for families that are on the waitlist for ABA services.

- For the past six years, GOBHI on behalf of EOCCO has supplemented OHA funding for Child parent Psychotherapy (CPP) in order to provide this training and consultation to a new group of clinicians, not just in EOCCO, but throughout the state. To date, we have trained over 125 clinicians.

- CPP is an evidenced based treatment model that treats children who have experienced at least one traumatic event (death, domestic violence, maltreatment, sexual abuse), and as a result are experiencing attachment, behavior and/or mental health problems. Treatment uses the parent-child relationship to help reestablish a sense of safety and security, and is a treatment model that can be made available to families through in-home visiting, thus reducing further stress on the family to receive services in a clinic setting.

- A Positive Parenting Program (Triple P) Program Coordinator is financially supported by GOBHI on behalf of EOCCO to provide services in Umatilla County. It also plans to continue financial support and extend the program into other counties beyond the grant completion in June 2019. We are currently the first program in the nation implementing a new Triple P model, Positive Early Childhood Education Program (PACE), for early learning settings in the Umatilla County to enhance early childhood educator skills and reinforce consistency in approach from home to school. Triple P has multiple delivery options; including individual sessions, group classes, online courses, and home visits. With a vast reach at a community level and increasing intensity, Triple P has the ability to support parents with multiple existing barriers. Triple P partners with DHS to provide parent education to at risk families including parents who are currently living with their children and those seeking reunification. Parent education coordinator works with local agencies, including pediatric/primary care offices. Parenting concerns are often initiated in pediatric/primary care setting. This promotes a direct referral to quick intervention and support, increasing the number of children remaining in the home with their primary parent.

- EOCCO will continue to support research, training, and implementation of several Dyadic Treatments that allow children to remain living with their parents. We are encouraged by the research that claims the earlier we provide support and interventions, the greater possibility of early success, keeping families together and consequently lowering cost.

- EOCCO is in conversation with the Oregon Infant Mental Health Association (ORIMHA) and plans to partner with them to create a larger impact statewide. The second phase of this initiative is to build on the evidence based Dyadic Treatments that exists in our region by defining them as available supports.

- EOCCO plans to support and assist in the implementation of the Attachment & Bio behavioral Catch-up Model (ABC) by partnering with home visiting and/or early childhood providers. ABC is a model is used for treating young children 6-24 months who have been exposed to trauma. Based in attachment theory, ABC intervention consists of 10 manualized sessions that addresses nurturance, synchrony, and frightening and intrusive behavior. The sessions are provided through guided discussion by a "coach", which can be care extenders, family support workers, and/or Traditional Health Workers.

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)?

The Positive Parenting Program (Triple P) Program Coordinator in Umatilla is financially supported by the GOBHI on behalf of EOCCO. It plans to continue financial support and extend Triple P into other counties beyond completion of the grant, which ends, June 2019. Triple P parenting education can be provided in the home allowing the practitioner to identity family needs of supports and services. Triple P is currently able to provide incentives that include necessities such as diapers, formula, gas cards, home safety supplies, etc. Triple P collaborates with the CARE program, a wraparound service helping family's access resources with the purpose of strengthening families to deliver the material to parents they already serve.

GOBHI on behalf of EOCCO contributes financial support to expand staffing in the two eastern Oregon Relief Nursery's that are located in Umatilla and Malheur Counties. Relief Nursery's offer in-home family support, provide transportation, connect community supportive services, meet immediate needs such as diapers, food, safety equipment, clothing and much more. Therapeutic classrooms for babies and young children, parenting education, and respite care, are provided through relief nursery staff and services. Relief Nursery's provide support to families and work closely with DHS to keep children at home with their primary parent or guardian.

Many counties in Eastern Oregon have provided care coordination services to children and families through the CARE Program, which has serve over 1,000 youth and 500

families/year with substantial support via EOCCO. A major component of this service provided to parents is to assess for issues related to social determinants of health. The CARE program staff goes to the child and family in their environment, which decreases stress and stigma form families.

EOCCO plans to implement the findings from the Integrative Nurse Home Visiting pilot project and expand to other counties. This project is in collaboration with public heath home-visiting nurses and mental health clinician's working together to provide PHQ-9 screenings to mothers and offer additional mental health support in the home. When a referral is made, the mother/caregiver is not required to go to another agency, instead, the additional support is provided in the home and introduced by their home visiting nurse who they have already establish a relationship with. This pilot project is partnered in four eastern Oregon counties (Grant, Morrow, Umatilla, Malheur), by four public health departments, and two community mental health providers.

ABA and Family Advocates Program provide support in the homes of Members. This allows site observations of family living conditions and safety assessments for the welfare of the child. Additionally, specific parent/guardian interviewing occurs frequently to discuss other challenges the family may be facing beyond the child's diagnosis. Funding support for home fumigation, the Veggie RX program, fuel stipends, etc. are made to support local families in Eastern Oregon. The ABA team also offers in-person consultation, telemedicine, phone calls and email that allow parents to directly engage, participate or observe the techniques used by the clinical team regularly as the child progresses through therapy. EOCCO recently made two clinic locations available to parents and primary caregivers, where they can bring their child to interact in a therapeutic setting. These clinic locations are designed for increased social engagement, community involvement, recreation activities and to support integrated peer-supported therapy with both parents and interventionists of two or more families involved.

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.

EOCCO will utilize the Health Complexity Data provided by OHA in partnership with the Oregon Pediatric Improvement Partnership (OPIP). Given that this data identifies children with medical and social complexity in EOCCO's population, we plan to further aggregate the data into specific counties to assist with further identification. 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, EOCCO will use technical assistance from OPIP.

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?

EOCCO does 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 are automatically eligible for and offered fidelity Wraparound. Regardless of the interest in the Wraparound process, the youth is provided ICC services and supports. If a child is placed into a facility based residential treatment program, EOCCO contracts with service providers who are equipped with both video conferencing and other reasonable accommodations to continue treatment while in out of home placement. Once youth are enrolled in these highest levels of care, EOCCO utilizes the Wraparound model to maintain parents' participation in their child plan of care.

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.

EOCCO has several opportunities for employees and providers to attend trainings related to trauma-informed approaches and ACEs on an annual basis, including:

- The GOBHI Spring Conference holds an agenda that includes evidence-based and emerging best practices as a training opportunity for not only staff members but providers and other community members. The last three conferences focused on trauma informed approaches.

- GOBHI on behalf of EOCCO is also a host and funding source for the Child Parent Psychotherapy (CPP) Training and Learning Collaborative. The collaborative spans an 18-month period and trains clinicians to address trauma though the dyadic relationship. Clinicians are also taught how to heal those who have had traumatic experiences by increasing the caregiver's attachment, knowledge of typical children's developmental milestones, and ensuring the use of trauma-informed responses when symptoms arise.

- EOCCO is also a strong proponent of suicide prevention and awareness in Oregon communities, and has several Mental Health First Aid trainers on staff. Youth and adult focused trainings are held annually in a variety of locations. GOBHI on behalf of EOCCO also has certified Applied Suicide Intervention Skills Training (ASIST) trainers who train staff in addition to community members and the EOCCO provider network.

- EOCCO ensures that all therapeutic foster parents receive training in the evidence-based practice - Collaborative Problem Solving. It is a recognized trauma-informed approach to working with youth with significant behavioral issues and multiple traumas. All therapeutic foster care staff are Tier 1 trained, at a minimum, with content refresher training occurring on a minimum of a quarterly basis. Our trainers also coordinate with other CPS trainers in the state to ensure Tier 1 trainings are brought to remote places in Oregon so that providers, community members, and staff

who otherwise may have a distance barrier have an opportunity to attend. CPS Parent Group Trainings are provided to parents and legal guardians of youth involved with Wraparound and ICC to help build skills in parents and legal guardians of children in need of additional support.

- Crisis Prevention Institute, Non-Violent Crisis Intervention training is also a training provided through the Therapeutic Foster Care (TFC) program to foster parents and staff of the TFC program, Applied Behavioral Analysis staff, and members of the EOCCO provider network. This training equips individuals with skills, confidence, and an effective framework to safely manage and prevent difficult behavior. It is proven effective to support multiple populations across the lifespan, from children to older adults with dementia.

- GOBHI on behalf of EOCCO co-sponsors the Behavioral Health and Education Summit offered in Eastern Oregon. Through partnering with the Blue Mountain Early Learning Hub, and Intermountain Education District, this event is held in Umatilla County each year in October. The training is targeted towards educators, early learning providers, and all who work with young children and families. Noteworthy topics have included ACEs, resiliency, brain development and growth, and Trauma Informed Care. In the last 6 years, this summit has provided training to over 2000 individuals who serve young children and their families in Eastern Oregon.

- ABA and I/DD programs provide specialized and uniquely designed training programs for employees to become registered and licensed as Behavior Interventionists within the state of Oregon. Many of the trainings are focused on techniques involved for providing individualized ABA therapy for children with ASD, mental health and developmental disabilities. Specific trainings for ABA Behavior Interventionists and Developmental Disabilities Coordinators include: Oregon Intervention System Training (OIS), Trauma, Identity Disturbance, and Borderline Personality Disorder in Persons with I/DD, Health Care Decision Making Training, Beneath the Surface; Understanding Challenging Behavior, Overview of Autism, Ethics of Touch, Crisis Intervention Training and Getting to the Heart of Intimacy. These trainings are specifically selected to compliment the complexity of rural Oregon to support families within the home.

3. **Care Coordination (recommended page limit 12 pages)**

Applicant is required to ensure a Care Coordinator is identified for individuals with severe and persistent mental illness (SPMI), children with serious emotional disorders (SED), individuals in medication assisted treatment for substance use disorder (SUD), and Members of a Prioritized Populations. Applicant must develop standards for Care Coordination that reflect principles that are trauma informed, linguistically appropriate and Culturally Responsive. Applicant must ensure Care Coordination is provided for all children in Child Welfare and state custody and for other prioritized populations (e.g., intellectual/developmental disabilities). Applicant must establish outcome measure tools for Care Coordination.

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): EOCCO provides 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 is provided to local Community Mental Health Programs (CMHPS) for all youth entering Child Welfare and state custody. EOCCO utilizes our partnerships with local Child Welfare and other State agencies to facilitate engagement from legal guardians for successful Care Coordination.

Youth with SED: EOCCO qualifies for Wraparound all youth identified with a serious emotional disorder (SED) and that is 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). EOCCO is guided by the Wraparound principles when working with all youth at this level of care, and provides these services in a trauma informed, culturally response, and linguistically appropriate way.

EOCCO: SPMI population: Members with an SPMI diagnosis 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 are identified and enrolled in the Choice Model program for Care Coordination services at the local CMHP. Intensive Care Coordinators (ICC) also provide care coordination for those who are in higher level of care (acute/residential) and/or needing assistance with stepping down into a lower level of care. EOCCO identifies monthly high risk individuals with an SPMI diagnosis using an objective, data-driven process through an HIE data analytics platform. These individuals are invited to engage in care coordination services. In addition, referrals for care coordination services are received from across all EOCCO counties from a variety of sources, including providers, members, caregivers and discharge planners; including those needing care coordination through the regional 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, EOCCO 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 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): EOCCO will ensure youth in state custody have access to care coordination services by providing access information and initiating conversation with their legal guardian. We generate weekly reports to identify youth in state custody and provide to contractors to initiate Care Coordination services. Access standards (Policy 1200.10) require that individuals are seen within two weeks from date of request for an intake assessment, and within 24 hours if in an emergency situation. Children in Child Welfare custody receive two assessments within the first 60 days: 1) mental health; 2) Child & Adolescent Needs and Strengths (CANS), and offered care coordination once the assessments are complete.

Youth with SED: Youth identified with a serious emotional disorder receive individualized outreach to assess their needs, and also offered the opportunity to participate in Wraparound services. 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 EOCCO members getting MAT services receive care coordination as part of the basic services provided by the MAT team.

SPMI population: 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. EOCCO staff provide daily support, as required, to CMHPs staff in meeting care coordination needs of these individuals. For individuals identified through data driven alerts the EOCCO Complex Care Management Team begins outreach telephonically. If an individual indicates they need a phone in order to engage in services, EOCCO provides the individual a mobile phone with attendant minutes. Individuals referred to the twice monthly MDTs are outreached by telephone or, if needed, in-person by CMHP staff. In addition, GOBHI on behalf of EOCCO is participating in a HRSA grant which provides a telehealth platform, MEND, that allows members to receive mental health services in their home and access care coordination services as needed.

(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?

EOCCO analyzes data for inpatient, outpatient, professional, mental health, pharmacy, and dental utilization on a quarterly basis. Based on this information each PCPCH will receive a list, as part of their monthly provider progress reports, of their Members who have not utilized services since their enrollment. The PCPCH clinics will be responsible for reaching out to those identified Members to encourage them to engage in services. (Current analysis showed that 36.6% of members haven't had a primary care visit in the past 12 months). Quarterly reports will be tracked to assure that Member engagement is occurring.

Children and Adolescents (Child Welfare): We run a week utilization report using PERC codes to identify children in Child Welfare and state custody that will address lack of utilization if there is not utilization within the first month of care. Through the CANs process, all children in Child Welfare custody should be seen within their first month of care.

SPMI Population: EOCCO will continue to use an established coordinated process to welcome new members to the plan. All newly enrolled members receive a detailed welcome letter from EOCCO that explains enrollment, coverage, services and benefits. EOCCO also distributes the member rights and responsibilities statement in the welcome letter.

EOCCO CMHPs are responsible for completing Care Recommendations in PreManage for each Member with an SPMI diagnosis. When a Member shows up on the CMHPs PreManage list, their utilization data is reviewed in both PreManage and the HIE. The CMHP then develops a Care Recommendation to help assure Member is engaged with the appropriate care providers and that communication is occurring across care settings.

Transition Age Youth: EOCCO sends 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 and a care plan will be entered into PreManage.

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).

EOCCO through GOBHI adheres to NCQA standards for timelines for screening and assessment of those individuals who have been identified as needing intensive care coordination. The ICC initial assessment is initiated within 30 days of the date a member is identified for ICC and completed within 60 days of that date. EOCCO assigns a care coordinator to engage each member newly identified for ICC. The care coordinator initiates telephonic contact with the member within ten business days of case assignment. The care coordinator makes two telephonic attempts on different days and times of day; and one attempt by mail.

c. Please describe Applicant's proposed process for developing, monitoring the implementation of and for updating Intensive Care Coordination plans.

EOCCO monitors its providers' behavioral health care plan development, completeness and updates through quarterly provider chart audits. They are annually validated by EOCCO staff to assure accuracy. If a pattern of issues is identified, EOCCO utilizes performance improvement plans and progressive corrective action to work with the provider until the expected quality of care plans are achieved.

Children and Adolescents: Eligible children who require ICC participate in monthly meetings to update their plans of care.

SPMI population: EOCCO through GOBHI 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. The ICC plan is updated at least annually with regular evaluation of the effectiveness of the plan by clinical staff.

MAT services: MAT team care coordinator stays in regular contact with CCM in order to coordinate with all involved staff. Communication will be scheduled with a frequency determined by the needs of the member.

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 reducing costs. EOCCO takes 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. Care coordinators offer Member support through a variety of programs:

- 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: In 2017, NEMT services were provided to 3,346 unique Members who travel 3,079,559 miles. Note: EOCCO would like to expand these services to beyond medical covered services and is looking at how this fits within current rules.

- The Frontier Veggie Rx Program works with EOCCO providers to "prescribe" fresh produce that the Member can than access for free at local stores.

- 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: 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 of a set of five additional criteria. The EOCCO region currently has 30 slots maximum per month to utilize. Participants are usually housed for 8 to 16 months before they are able to be placed in HUD Section 8 permanent 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 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?

Care coordination assessments assess the cultural and linguistic needs of the individual. EOCCO values culturally responsive care and policy states that staff are to "be aware of, and are sensitive to, the cultural and demographic diversity of the populations served and of colleagues and stakeholders" in providing care coordination services. We provide

regular staff training in cultural responsiveness as well as in the principles of trauma-informed care. EOCCO utilizes the 10 principles of Wraparound for children who receive Intensive Care Coordination which includes culturally responsive and trauma informed practices.

Our policy (bulleted below) requires that employees as well as contractors and subcontractors adhere to trauma informed principles including "the need for respect, information, connection, and hope for individuals, recognition of the adaptive function of any symptoms that are present; and working collaboratively and in a person-directed empowering manner with individuals who have experienced trauma." Our policy also requires that development and implementation of trauma informed services follow OARs 309-018-0100, 309-019-0100, and 309-022-0100.

- Contractors and subcontractors shall provide a clearly defined process by following the Local Implementation Plan Guidelines, and examine existing practices, environment and treatment approaches to ensure trauma specific services (see definitions) are readily available to all individuals and that such services are individualized.

- Contractors and sub-contractors will provide services in a collaborative, person-centered process, and ensure that the person receiving services and their designated support person(s) will be partners in the treatment planning process.

- Contractors and subcontractors will utilize the educational resources, toolkits and other technical assistance provided by OHA Health Systems Division to facilitate the implementation of trauma informed services.

- Contractors and subcontractors shall follow OARs 309-018-0100, 309-019-0100, and 309-022-0100 when developing and implementing trauma informed services.

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?

Care coordination is provided at a variety of levels throughout the EOCCO delivery service network, depending on the complexity of the Member's needs. For care coordination delegate to the local provider, CMHP contracts include care coordination requirements. EOCCO enforces contract requirements by conducting annual reviews of all high capacity behavioral health providers. Reviews can be peer-based (review of charts that the agency have themselves reviewed) or based on randomized member selection based on encounter data. 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) and Quality (care coordination during treatment and transitional processes and documented follow up on coordinated care). Feedback on reviews is given to providers with potential for corrective action plans (CAPs), technical

assistance, or additional monitoring. EOCCO utilizes a progressive corrective action if a provider is unable to deliver the expected level of care coordination.

g. For Fully Dual Eligibles, describe any specific Care Coordination partnerships with your Affiliated Medicare Advantage plan for Behavioral Health issues.

Bi-weekly regional MDTs provide opportunity to coordinate care for those members who are dually eligible. All EOCCO 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. EOCCO Case Management staff work within the same department, in the same location, as the case managers that work on the affiliated Medicare Advantage plan. When an EOCCO 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.

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: EOCCO incorporates family partners and youth partners into our delivery model to engage members in specialized populations. Many members in these populations have historically had negative experience with behavioral health service providers. In an effort to engage in a culturally responsive and trauma informed way, EOCCO utilizes the Wraparound principles of outreach and engagement to break down barriers or resistance to accepting services from behavioral health organizations.

WrapServices for Mother & Child: EOCCO intends to launch a new program offering wrap 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. Often the child is born with developmental issues secondary to mom's substance use and needs specialized supports and services. EOCCO believes that providing wrap services for the mom and child as a unit could directly impact the health of both.

SPMI population: EOCCO through GOBHI adheres to NCQA standards in efforts to engage the SPMI ICC population. Outreach occurs telephonically and through letters. As needed, outreach occurs in-person through CMHP staff. Explaining how EOCCO and CMHPs can assist in helping an individual meet stated needs and achieve desired goals is foundational in engaging an individual in care coordination. EOCCO also identifies members with SUD diagnoses and reaches out to engage these individuals that were in higher levels of care but have no documented follow-up.

Addressing engagement barriers with the ICC population: EOCCO is committed to outreach to members, especially those who have difficulty coming to a clinic. ACT outreach services at the local level 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. EOCCO's Complex Care Management Team reaches out to contact individuals telephonically to engage them in needed care coordination services. Care coordinators make use of techniques, such as 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, EOCCO provides Non-Emergent Medical Transportation (NEMT) services.

MAT Services: MAT team care coordinators 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, then 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: EOCCO 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.

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): EOCCO works to 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. If this is an initial identification of SED, Wraparound services are offered and ICC services initiated. In addition, the Wraparound Transfer Protocol ensures that Wraparound will transfer with them if they transfer counties or outside of EOCCO service area. EOCCO uses Pre-manage to track acute episodes of care. This allows for quick follow up with Providers and engagement of child and family teams after discharge from a hospitalization stay. EOCCO works to notify our provider network of these episodes and to ensure the member is seen with seven-day post-acute hospitalization stay.

SPMI population: EOCCO oversees 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 involved in different levels of care is assigned to a CMHP ICC as determined by County of Record (COR). The ICC coordinates the care of the member, including outside the COR. 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. EOCCO monitors these members through Choice Model reports. Staff are available daily to assist ICCs in care coordination. We achieve continuity of care because each member has one care coordinator throughout episodes of care and at different levels of care.

MAT services: MAT provides care coordination to Members involved in the program with any other needed services. When necessary, the MAT care coordinator can coordinate with the CCM team or the ICC's at the local CMHP.

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: Because EOCCO monitors Premanage software daily for members, immediately upon identification of a member as being admitted to an acute care facility, we can notify the local CMHP staff. Discharge planning begins as soon as a member is known to be admitted to a facility. EOCCO monitors discharge planning progress and provides support for challenging discharge planning situations. Cases are reviewed weekly in EOCCO UM/CM rounds to ensure that discharge planning is progressing as needed. Once an individual is discharged the CMHP staff ensure that a 7-day visit follow-up occurs. EOCCO monitors 7-day follow-up visits and, when necessary, provides CMHP staff support in successfully making the 7-day follow-up visit. (In 2018 78.51% of Members received a Follow-up with 7-days of Hospitalization for a Mental Illness, surpassing the goal of 66%.)

MAT Services: Discharge discussion begins at the first team meeting and in the first conversation with the member. Identification of and planning for needed long term recovery supports is a 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 works 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)?

EOCCO Utilization Management, Care Management and CMHP ICCs are notified through Pre-manage for all Members that enter the hospital, subacute, and PRTS. More detailed Member information (admissions, providers, diagnosis, medications, upcoming appointments, screening gaps, and clinical information) is also available near real time in the EOCCO HIE. Increasing access to PreManage and the HIE for EOCCO Providers not yet connected will be a priority focus area going into the new CCO contracting period.

Children and Adolescents: System of Care Manager and Director of Therapeutic Foster Care attend the UM meetings to ensure appropriate transition and care coordination is occurring. SOC Manager relays treatment information to the youth's local care coordinator and monitors coordination activities throughout the youth's stay.

As evidenced in Policy #300.20.13 (3.3)-Intensive Treatment Services: Care Coordination During Treatment: While a child/adolescent is in a PRTS and/or Sub-Acute facility, the Care Coordinator, or the designated primary clinician for the child/adolescent and family, will be responsible for consistent collaboration with and support to the PRTS and/or Sub Acute facility.

- Ongoing CFT meetings will occur to support proactive preparation for the child/adolescent's transition to the community.

- A utilization review meeting (or teleconference), involving the PRTS facility, GOBHI's Utilization Management Team, the WCC, the child/adolescent's parent and/or legal guardian, and other involve parties, will occur every 30 days to ensure

that the child/adolescent is receiving services at the most clinically appropriate and least restrictive environment possible.

- After residing in PRTS for 90 days, the Care Coordinator will contact GOBHI's Chief Medical Officer for a utilization review update.

- The transition of the child back to community will be coordinated by the Care Coordinator and Child & Family Team. Attention will be given to needed supports such as medication management, therapy, school and parent support to avoid gaps in care during the process. Attention to the family/caregiver's ability to successfully receive the child back into the home should be an ongoing process that began when the child entered the PRTS facility.

SPMI population: Each member involved in different levels of care is assigned to a CMHP ICC in their county of record. The ICC coordinates the care of the member across all levels of care, including outside the COR. The ICC conducts in-reach activities in the hospital and subacute settings as needed. ACT staff may provide in-reach in a criminal justice facility as needed. The ICC takes primary responsibility for the care coordination of the individual across all levels of care.

m. Describe how Applicant will ensure ICC Care Coordinators will maintain the 15:1 caseload requirement.

EOCCO through GOBHI requires that all behavioral health care ICC Care Coordinators remain at a 15:1 caseload or lower. Also, contract requirements are enforced by conducting annual reviews of all 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?

Children and Adolescents:
We are currently exploring evidence-based tools for use with our infant/child/adolescent populations. For consistency, we are first analyzing the PROMIS 10 pediatric version against our needs. In addition, we are consulting the AHRQ Care Coordination Measures Atlas and the National Quality Forum endorsed practices in care coordination and corresponding performance measures.

For Youth and Family: EOCCO plans to extend the two Wraparound measures that are currently approved by the State of Oregon to ICC clients. We plan to utilize the Wraparound Fidelity Index Short Version (WFI-EZ), administered 6 months after enrollment, and the Team Observation Measure (TOM), conducted on each care coordinator to ensure twelve facilitation components. Beginning in 2019, we will participate in a pilot program with OHA to purchase rights to the Team Observation Metric System (TOMS) so that is can be captured electronically. The Child & Adolescent Needs and Strengths Comprehensive Screening (CANS) will also be utilized as an

outcome measure since it is required at enrollment and every 90- days following enrollment.

SPMI population:

- Members in the Complex Care Management program: the PROMIS 10 survey is conducted during initial assessment, every three months while engaged in CCM and at closure. Comparisons are made between baseline scores and scores overtime.
- Other general ways of measuring: An experience survey is conducted every three months while engaged in CCM and at closure. In addition, EOCCO analyzes complaints to identify opportunities to improve satisfaction with its ICC program. EOCCO measures ED incidents per 1000 members and Inpatient incidents per 1000 members for this population.

Note: All EOCCO CMHPs implemented the PROMIS Global Health Assessment (adult and pediatric) in 2018 to provide a standardized patient-reported outcome metric that can be utilized at an individual, organizational, and plan level to determine progress toward Member and Population health. Value-based payment incentives will be utilized during 2019 to assure that assessments are being completed. (http://www.healthmeasures.net/administrator/components/com_instruments/uploads/Global%20Health%20Scale%20v1.2%2008.22.2016.pdf)

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?

Children and Adolescents: Our network providers secure consent for release of information from youth and families to facilitate sharing care plans with child and family team members. If a child and family have excluded specific partners from their child and family team, EOCCO encourages the use of Motivational Interviewing when appropriate to encourage the benefit of sharing of information for the coordination of their care.

MAT Services: The MAT team has, at minimum, a weekly huddle where client status is reviewed. Notes and summaries are required to be shared among involved clinicians on a regular basis.

SPMI population. All member information related to care coordination is recorded in a medical case management system. In accordance with HIPAA law, this information is shared with appropriate providers/parties that need access in order to provide services and assist with care coordination. In addition, EOCCO maintains an HIE with member information that is shared as appropriate with other providers based on current HIPAA regulations. EOCCO has also implemented Premanage in all EOCCO CMHP and Primary Care providers. To coordinate care, CMHP staff enter Premanage care plans on members meeting the ED Disparity metric in order to provide the ED physician of key information when the member visits the ED. (Note: As part of the EOCCO's CMHP 2018 VBP program over 500 members now have active behavioral health care plans in Pre-Manage.)

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?

Building relationships with a broad set of community providers and allied service networks is an area is strength and focus for us. We will expand our partnerships with components justice system to improve access and services at all intercept points. Over the past two years, we have layed the groundwork by facilitating Sequential Intercept Mapping, Crisis Intervention Training and other specialized technical assistance through the efforts of the Oregon Center on Behavioral Health and Justice Integration, housed at GOBHI and funded by OHA through a separate agreement. The Center provides specialized training and technical assistance for behavioral health and justice partners to enhance knowledge and improve practices aimed at a treating people who, primarily due to symptoms of serious behavioral health conditions, are at risk of becoming incarcerated or are already within the criminal justice system.

We will make concentrated efforts to build strong partnerships with housing authorities and community action organizations over the next few years. We will work to ensure that housing needs for individuals with SPMI are known and understood by these partners and expand our network capacity to work with housing partners in developing options that promote independent living. Other areas of improvement for this population are highlighted below. EOCCO will continue to look for additional partnership opportunities to further improve the care provided for Members with SPMI.

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. EOCCO is fully cognizant of the need to allow people to get better and to move out of highly structured care settings. GOBHI on behalf of EOCCO works 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.

EOCCO continues 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. Knowledgeable and experienced Residential Care Management staff continue to promote flexible clinical programs, designed to adapt to the specific needs of individuals at risk for higher levels of care.

EOCCO will continue managing 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. EOCCO uses a Utilization Management program to work rapidly on these situations, day and night, every day. ***Note:*** *We are ready to work with OHA on accepting risk for managing residential care.*

EOCCO approaches 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 move through various level of care. EOCCO provides 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?

EOCCO through GOBHI funds Exceptional Needs Care Coordinator (ENCC) positions at each of our EOCCO CMHPs. These are highly trained and well supported clinicians who are in constant contact with EOCCO's CCM staff. We also 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 are 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. Further, EOCCO's years of co-location within each of our communities has placed us on a first name basis with all of our housing providers and housing related agencies. EOCCO has always understood 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, we utilize 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 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.

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. EOCCO includes a new bed and bedding for each recipient.

To assure the housing is appropriate and adequate, the residential specialist annually inspects housing units, rented in this project, pass the criteria outlined in the OHA approved Housing Condition Checklist located on the OHA website. Very positive relationships have been established with landlords and many will now call the residential specialist about improvements to the rental units to assure they will meet the standards.

Currently thirty rental slots are available for each month. Many participants stay for multiple months or as long as two years but there is no limit, as it is difficult to find any housing for those who are registered sex abusers. There is a waiting list of at least fifteen at any one time. In 2019, EOCCO started utilizing its own funds to back an additional 5 to 6 EOCCO members per month to receive the same level of services. Question J, below, provides greater detail on work with housing providers and how EOCCO through GOBHI is setting up a parallel program for OHP members only. While approximately 90% of the participants in RAP are OHP, this will help to increase the capacity of this RAP to respond to the needs of those who are not under the Oregon Health Plan.

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?

We will continue to address infrastructure needs for each CMHP so that ACT services are available in each county. There are currently 10 fidelity ACT teams in the EOCCO region (see oceact.org). We will make sure that for each ACT referral from OSH, the CMHP covering that region is aware. ICCs are the single point of contact for all ACT referrals. Referrals to ACT who meet eligibility are comprehensive assessed for enrollment in ACT. We will comply with OAR 309-019-0248. Our ultimate aim is that there be fidelity ACT services in all counties through CMHPs.

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?

We will set up a process to receive information from all ACT teams regarding admission and denials. A licensed clinician (QMHP or higher) 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. Individuals will be served through alternative evidence-based services while we wait for placements to be opened up or developed. We will amend 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, our consumer caucus 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?

EOCCO hopes to work together with the OHA to expand our existing capacity to use SRTF beds for short term placements. We will work with regional and then state wide systems of care to develop SRTF beds for patients who cannot be directly discharged to the community after commitment hearings and for whom hospital placement is either unavailable in the short term or unnecessary. These people often end up going back to emergency rooms or jails while awaiting hospital placement which is often traumatizing and clinically inappropriate. To accomplish this EOCCO will work with secure residential providers on creating the clinical capacity to admit and discharge people more rapidly than current practices. This would mean an expansion of the secure respite bed capacities EOCCO currently operates in compliance with Level I statutes and rules. The clinical program for short stay SRTF beds would be different from that typically associated with longer term residential treatment programs. Short stay clinical models and rates would first need to be designed in collaboration with EOCCO's SRTF providers and the OHA. EOCCO proposes to require our providers to adapt their treatments to the short terms clinical needs of newly committed people, rather than building new beds for this purpose.

In order to free up beds for this capacity, long term SRTF residents who no longer need that level of care will have to be transitioned to unlocked programs. Many care providers and their residents have come to regard SRTF placement as indefinite, typically because past attempts to transition some people failed. These residents and their providers cannot suddenly be told there is no longer eligibility because of a rigid new UM system, or another round of destabilization and hospitalization will result.

The clinical method by which EOCCO approaches the population with an established residential treatment history will focus on identifying transitional issues, critically examining past attempts at discharge and then mitigating risk factors while adding protective factors. Again the most important protective factor, the key to resiliency in recovery is the construction of durable relationships outside the SRTF and that means using our robust organizational connections to community based systems of support.

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?

As described in response to questions c and d, above, EOCCO participates in the Oregon Rental Assistant Program. The residential specialist in that program has been working to

establish positive relationships with both housing providers and the housing authorities (Housing and Urban Development or HUD programs within the EOCCO region). Currently, any person who has been successful in working with the RAP residential specialist for at least nine months is accepted for a HUD voucher without having to go through a waiting list. Within the past six months 20 HUD vouchers have been made available for successful participants in RAP through the Northeast Oregon Housing Authority for Baker, Grant, Union and Wallowa counties.

We are currently planning to augment the State of Oregon RAP program with an EOCCO program to start in January 2020. This will provide an additional residential specialist position and an additional peer support specialist position for every 45 Members served. The program will probably start with 45 Members and, based upon the success in placing Members, potentially expand to 90.

The intent is to shift as many OHP members as qualify from the state funded RAP program to the EOCCO funded program to open up more slots for those who are not on OHP. The EOCCO RAP will also include broader criteria. While using the same criteria for homelessness or near homelessness as the state RAP, the EOCCO program will expand rental assistance vouchers for temporary housing to EOCCO members who are pregnant and homeless (or soon to be); a family who is homeless (or soon to be); an individual with at least one chronic disease or complex medical and/or behavioral health problems; Members with disabilities; veteran's with complex medical needs. Currently we are seeking consultation on establishing a priority system to encompass these complex needs. Additionally, there is still consideration for how long temporary housing might need to last until people can be shifted into HUD housing to assure consistent supportive and Supported Housing services. Likely that will vary depending on housing availability within the community where the Member resides.

EOCCO RAP staff are also to be responsible for coordinating the 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. The intent is to also have both the specialist and the peer support staff visit each participant on a monthly basis for the purpose of assuring compliance with their lease and assessing the need for additional support services. These staff will also work in coordination and regular communication with whatever care coordinator or Traditional Health Worker is also serving the member. Measurements will be kept for new Members placed each month, the number of staff contacts and the support services provided by the EOCCO RAP staff.

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.

EOCCO, through its Utilization Management and Care Management teams closely works with acute psychiatric care providers to assure that Members with SPMI are receiving

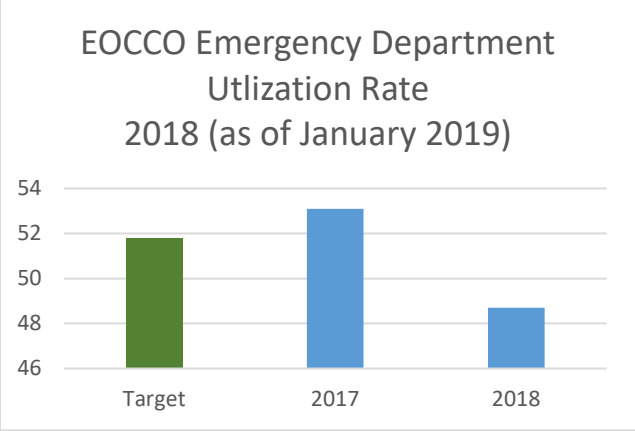
appropriate care in the least restrictive environment possible. These teams also work closely with local CMHPs on discharge planning and smooth transitions between levels of care. EOCCO, also requires local CMHPs to submit copies of their MOUs with local Emergency Departments that outline how post-stabilization and post-emergency department care will be coordinated. In addition, EOCCO is continuing to look for innovative and effective ways to utilize peer services, especially as part of the transitions between levels of care. As a baseline, 2018 claims showed that behavioral health peer services reached .54% (318) members and SUD focused peer services reached 0.17% (99) members. The work involves training peer specialist, and the creation of a Consumer Caucus. This nine member group provides insight on how to engage people in the peer process, as well as acts as a sounding board for any proposed improvement projects.

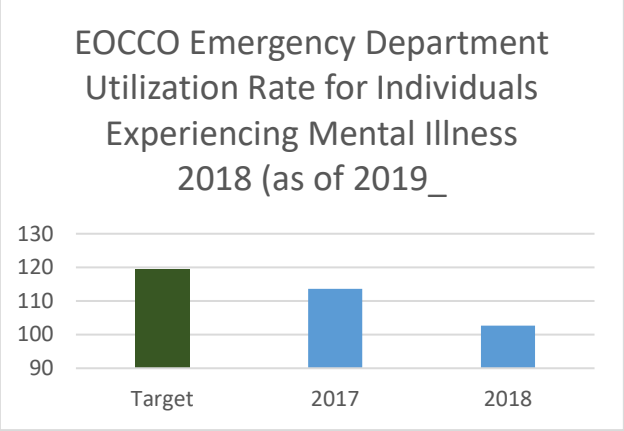
EOCCO's Network Management process continually evaluates the delivery network to assure contracts are in place for all needed services at all levels of care. Quality of care is reviewed and monitored through documentation reviews as part of the authorization process, as well as through complaints and grievances.

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.

EOCCO has a multi-pronged approach to reducing ED utilization.





- EOCCO CMHPs are required to have mobile crisis services that can respond to Members in crisis out in the community, without requiring a trip to the local Emergency Department. Pilot projects will be developed to "medically clear" a Member if necessary through alternative arrangements outside of the ED.

- Pilot programs are underway with Crisis workers “riding along” with local law enforcement to help facilitate getting Members to the appropriate care immediately.

- EOCCO along with Community Mental Health Programs (CMHPs) and some Primary Care Clinics (PCPs) are notified each time a member is admitted to an Emergency Department. Along with these notifications monthly reports will be reviewed to determine members with more than 2 or more ED visits who need to be contacted and assisted in connecting to appropriate services.

- Alternates to Emergency Department services are being developed to provide Members suffering from mental illness with easily accessible options for care. Utilization of direct to Member tele-behavioral health services allow Members to utilize technology to connection to psychiatrists, therapists, care managers and peer support without the Member needing to leave their home or any other location. EOCCO is working to extend these services so that they are available 24-hours per day, utilizing shared services across the EOCCO region. This work is being supported by a three year HRSA grant that provides funding for the direct to patient software platform. Funds are also available to provide Members with cell phones, iPads, cellular data or internet access as needed.

- EOCCO CMHPs have worked to extend office hours to provide easier access to their Members. Many CMHPs now have evening or weekend hours. EOCCO will continue to provide incentives to expand these services.

- For children and adolescents, EOCCO uses Therapeutic Foster Care (TFC) to establish a Planned and Crisis Respite program across the EOCCO service area. Community Mental Health Program staff are able to refer to and access Crisis Respite services from highly trained foster parents, with 24/7 on call crisis support from the TFC team.

- Given that most youth are brought to the emergency room in the evening or on weekends, EOCCO is in the process of partnering with a local DHS branch to share a hired home support position that would work in the evenings and on weekends to be available for support and skill buildings to youth and families.

- EOCCO is currently working to develop and implement a Regional Crisis Center (RCC) in Wasco, Oregon for Oregon DHS Youth to defer from hospitalization and out of state placement. The proposed facility will be a temporary residential placement for DHS identified youth. The RCC will complete an evaluation of individual needs and provide treatment services. The RCC will use an array of clinical methods to stabilize the behavior of youth in crisis.

- EOCCO CMHPs, as part of the 2019 CMHP VBP program are required to enter a care recommendation into PreManage for every member with an SPMI. This program will expand in 2020 to ensure that every member with 2 or more ED visits

in a 6 month period has a care recommendation (including contact information for the local CMHP) entered into PreManage. Outreach to the EOCCO ED and primary care clinics will occur in 2019 to help facilitate the use of these care recommendations throughout the care continuum.

- EOCCO partners including PCPs and CMHP will have weekly sharing meetings to discuss care plans for members. This weekly meeting will identify barrier(s), determine main point of contact for members and discuss potential solutions. Care plans will be monitored monthly by EOCCO clinicians and support staff to ensure care plan in appropriate and make recommended changes as necessary. CMHP will send EOCCO 3 day follow up note and care plan within 7 days to be shared with PCP.

- For members who continue to utilize the ED despite the above mentioned efforts, EOCCO psychiatrists will be assigned to work with local providers to brainstorm alternative care recommendations and treatment options.

EOCCO has implemented processes to reduce Members length of stay in the Emergency Department. These include:

- Planned and Crisis respite through TFC program to coordinate efforts to deliberately transition kids to Respite from ED.

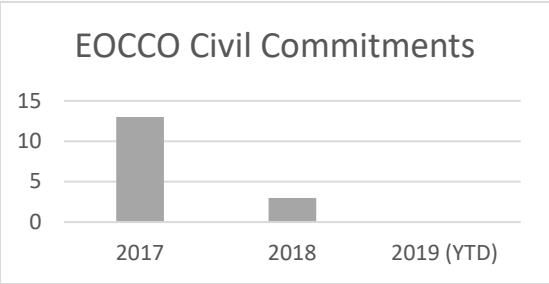
- Pilot programs to move Members directly from the Emergency Department, or ideally, prior to being taken to the Emergency Department, to appropriate levels of care, such as Crisis/Respite facilities.

- EOCCO monitors regularly to assure timely assessments and care planning with local CMHPs is occurring.

6. Oregon State Hospital (recommended page limit 1 page)

EOCCO has fully committed itself to the State's goal of reducing the use of the Oregon State Hospital (OSH) for all but those with no other treatment option. We have been reducing the overall number of persons going to the OSH under civil commitment as well as reducing their lengths of stay.

As for transition out of the hospital, EOCCO was in compliance with the recently implemented Ready to Transition metrics at 33% in FY 2016-17. For FY 2017-18 EOCCO achieved 100% compliance and has remained at 100% to the present.



a. How will Applicant coordinate with system partners as needed regarding Oregon State Hospital discharges for all adult Members with SPMI?

Prior to OSH admission, EOCCO 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, EOCCO monitors the members closely. The CMHP 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. An EOCCO clinician, EOCCO 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), EOCCO focuses predominately on civilly committed members ensuring that they are discharged in a timely fashion. EOCCO supports the ICCs in working with system partners such as OSH SW, Kepro, residential facilities and housing supports. EOCCO facilities 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?

The ICC begins developing discharge plans within seven days of OSH admission. The discharge plan evolves and is 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. EOCCO oversees this care coordination and assists the ICC when needed.

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?

EOCCO supported employment services, provided by the local CMHPs, utilize an evidence based approach model called the Individual Placement and Support Supportive

Employment (IPS). EOCCO has a strong partnership with Oregon Supportive Employment Center for Excellence (OSECE) and actively supports the coordination between the ACT (Assertive Community Treatment) and IPS to meet the needs of members with severe mental illness. EOCCO actively supports the eight core principles of the IPS program throughout the EOCCO region. At intake and throughout the process of engagement in mental health treatment, members are 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.

In addition, EOCCO has been leading the effort for members to utilize their lived experiences by becoming community health peer support specialists. EOCCO through GOBHI utilizes a network of 72 peer support specialists and was one of the first CCO's to establish a rate of reimbursement to support the utilization of these workers at a competitive salary.

The access and provision of Supported Employment (SE) services in rural and frontier communities is monitored and reviewed on a regular basis by EOCCO. EOCCO collects and reviews 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 potential Corrective Action Plan (CAP) in order to restore care to the highest level possible. EOCCO reviews a copy of any amended fidelity review in response to a non-passing score and follow-up review from the Division. CMHPs receive an annual review of operational, clinical, and quality service delivery. During the site review, Division 19 criteria are used to assess multiple areas of service delivery including SE. Policies and procedures relating to SE are reviewed for quality and regulatory compliance. Member charts are reviewed for service delivery quality and compliance with encountering SE services. Referral forms, assessment, service plans, and service notes are reviewed to ensure that members are not restricted from receiving SE services, and they are receiving appropriate outreach and follow-up by service delivery providers. Items lacking in meeting Division 19 are subject to additional monitoring, oversight, technical assistance, and potential CAP in order to restore care to the highest level possible. EOCCO collects a copy of SE reports sent to the Division as required by OAR 309-019-0295 as part of contractually required reporting process. If EOCCO does not receive evidence of submission to the Division, programs are subject to sanctions.

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?

Juvenile Department, Oregon Youth Authority, Child Welfare, DHS Self Sufficiency, CASA, County Judges, Local and State Wide Child Serving partners such as YMCA, Youth Era, Made to Thrive, Boys and Girls Club, OFSN, etc., Community Mental Health, SUD Programs, Primary Care, I/DD services, Voc Rehab, Local Lawyers and District Attorneys, SSI, Child Support Enforcement Division, Police, Parole and Probation, Education Service Districts in Eastern Oregon, Early Learning Hubs, Help Me Grow, Oregon Infant Mental Health Association, CARE, Local School Districts, local child and family representatives, Tribal reservations and culturally responsive programs of the area, domestic violence shelter/programs, faith based communities and local businesses.

b. Please provide detail on how Applicant will utilize the practice level work group, advisory council, and executive council.

EOCCO works to meet the intention of these three different groups, while understanding that in rural and frontier Oregon, some communities are small enough that the individuals on the Practice Level may also be appropriate for the Advisory Council, or that there will be some overlap on the Advisory and Executive Council.

The Practice Level Workgroup will be responsible for identifying and bringing referrals to the Review Committee for approval, and support the Review Committee with any questions or needs they may have. Additionally, they will gather and review System Barriers that are identified by Wraparound Teams and other System of Care partners throughout the community. This group will work actively to address any System Barriers that are brought to the group through a collaborative effort.

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 is 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?

EOCCO employs a Systems of Care (SOC) Manager that works across the EOCCO service area. This individual continues to use a Barrier Tracking spreadsheet to monitor all Barriers identified across the EOCCO service area. Each Local Practice Level Workgroup completes a Barrier submission form and emails this to the SOC Manager who adds issues to the Barrier Tracking Spreadsheet as a submitted barrier. After the next Practice Level Workgroup is completed, the SOC Manager updates the Spreadsheet, indicating it is resolved, or unresolved and escalated to the Advisory Council. This process is then repeated after the Advisory Council, and the Executive Council if applicable. A clear benefit for EOCCO tracking these centrally is the identification of patterns of concern, which can then be targeted for strategic improvement initiatives, and allows for neighboring SOC groups to be connected to work creatively to resolve regional barriers as well.

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?

EOCCO continues to conduct Systems of Care and Wraparound 101 trainings in each community at least annually, continuing to encourage community awareness of elements of the System of Care by educating community partners. The SOC Manager continues to engage local community leaders with the support of the EOCCO 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, EOCCO provides 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, there is 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. Utilizing our Wraparound funding, EOCCO through GOBHI covers tuition and travel expenses for youth and family support partners who attend the 4 day Wraparound training. In addition, our Youth and Family Support Coordinator offers individual and group coaching to all youth and family support partners and provides orientation packets, which include the charter, previous minutes, person first language, advocacy hints, strategic sharing protocol, and positive approaches to improved communication.

Currently, EOCCO supports 10 Review Committees and Practice Level Workgroups, and five Executive Steering Committees.

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)?

EOCCO has an established procedure 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 EOCCO quarterly technical assistance meetings, Wraparound Care Coordinators across the EOCCO service are updated on results from the WFI-EZ, and use the opportunity to collaborate on improving administration and collection efforts. Further, EOCCO provider network members use the Wraparound Monitoring Tool to notify the provider when the WFI-EZ is due for each child and family. Additionally, the EOCCO Children's System Support Coordinator make contact with Wraparound Care Coordinators when the WFI-EZ due date is approaching and monitors until it is completed. This is monitored through Wraptrack for data collection at a state level.

b. How will Applicant communicate WFI-EZ and other applicable data to the System of Care Advisory Council?

EOCCO works 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. EOCCO utilizes a Children's System Support Coordinator to compile all reports, which is then provided to the chairperson of each local System of Care Advisory Council. The local chairperson then distributes this data to the local SOC Advisory Council.

EOCCO includes data that is specific to the local SOC Council which is then compared to CCO wide data. The EOCCO Systems of Care Manager reviews these reports across the CCO service area, identifying opportunities for continuous improvement. The SOC Manager and Director of Foster Care also attend System of Care Council meetings across EOCCO communities to support data review and community engagement.

A unique aspect of EOCCO is our cross system involvement with Child Welfare, which has been a major focus of many SOC Advisory Councils. The need for additional foster homes being a frequent expressed barrier to success. EOCCO provides Therapeutic Foster Care for children in the custody of Child Welfare. This allows us to track data trends of placement needs in local communities based on referrals for placement from Child Welfare. This data, combined with data related to higher levels of care, Wraparound, etc. helps our System of Care Manager provide a more complete picture of the need, root causes of the barrier, and possible solutions to local community SOC Councils. Data requests from System of Care Councils helped identify the need for a

Planned and Crisis Respite program in local communities, which EOCCO will implement throughout the EOCCO service area.

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

EOCCO has an established procedure 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. EOCCO trains 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 ensures that providers use the Wraparound Monitoring Tool to receive notification of when the WFI-EZ is due for each child and family. Additionally, the EOCCO Children's System Support Coordinator contacts Wraparound Care Coordinators when the WFI-EZ due date is approaching and monitors until it is completed. With these steps implemented response rate of 35% for youth is attainable with multiple checks in place to ensure completion.

d. How will Applicant's Wraparound policy address:

(1) How Wraparound services are implemented and monitored by Providers?

EOCCO embraces the philosophy of proactive intervention that strives to facilitate the ability of a child and family to access services at lower levels of care that are youth driven and family guided. EOCCO Providers will ensure that children and families have timely access to the System of Care Wraparound Process.

Admission into Wraparound is a referral based process. Referrals can come from any involved source, provided appropriate releases are signed when referrals come from non-legal guardian sources. The Wraparound Care Coordinator (WCC) or Children's Program Supervisor will assist the referrer with the collection of information for the referral packet and serve as point of contact for the submission of information.

A request for approval in Wraparound will be considered authorized when: A Wraparound referral form has been filled out and submitted to the WCC; A consent to participate in Wraparound has been signed by a legal guardian; A HIPAA authorization for the disclosure of protected health information has been signed by an individual authorized with lawful authority to sign on the youth's behalf; and The family and youth have received the National Wraparound Initiative Document: The Wraparound Process User's Guide: A Handbook for Families.

Upon receipt of the Wraparound referral packet, the WCC will present the packet to the local Wraparound Review Committee for approval. The local Wraparound Review Committee has established criteria based on Wraparound model designed for children & youth who have complex emotional, behavioral and social issues who typically require care coordination across two or more child-serving systems. The remaining criteria will be site specific.

If approved, the WCC will contact the youth and family within 5 business days to schedule a meeting and develop, with the Child & Family Team, a Wraparound Plan of Care, which will guide the delivery of community based supports and services. The Wraparound Process for Families User's Guide: A Handbook for Families, a Product of the National Wraparound Initiative is given to all families enrolled and can be easily accessed at the following website: http://www.nwi.pdx.edu/pdf/Wraparound_Family_Guide09-2010.pdf

System of Care Wraparound Manager will conduct random reviews of referral and approval process every 6 months for youth in Wraparound.

EOCCO utilizes the Wraparound Fidelity Index Short Version (WFI-EZ) and the Team Observation Measure (TOM) are two measures approved by the State of Oregon Wraparound Team. The Wraparound Care Coordinator, Project Site Lead, or other identified persons may be responsible for the submission, completion and collection of these measures. Additionally, a Child & Adolescent Needs and Strengths Comprehensive Screening (CANS) may also be used to support decision making. The CANS will be administered at enrollment and every 90 days following admission. EOCCO does not use the CANS to exclude participation in Wraparound; however, the CANS Oregon will serve as a multi-purpose tool to support decision making including level of care and service planning, to facilitate improvement initiatives, and to allow for the monitoring of outcomes of services.

Beginning in 2019, EOCCO began using the Team Observation Metric System (TOMS) so that data can be captured electronically through Wraptrack (mentioned above). Team Observations Measures are conducted on each Wraparound Care Coordinator to ensure twelve facilitation components and ten principles of Wraparound are being implemented in practice.

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

This is accomplished through each county's review committee: all members who reach a higher level of need or who are involved in at least two child serving agencies will have the option of being referred to Wraparound. In addition, any youth that is in Psychiatric Residential Treatment and/or Long Term Placement automatically qualify for Wraparound. If the youth and/or caregiver refuse to be enrolled in Wraparound, the youth will still have access to Intensive Care Coordination, which entails the full array of intensive services and supports. EOCCO has a System of Care Manager who provides systematic site visits to offer support and monitors whether a program is meeting fidelity. In addition, Wraparound Care Coordinators are required to submit monthly progress reports to System of Care Manager. Additionally, EOCCO requires all Wraparound providers to submit chart audits on a quarterly basis to verify that services are being provided and documented appropriately.

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.

EOCCO is committed to ensuring high quality fidelity Wraparound are immediately available to all who are eligible. All CCO members that qualify for Wraparound in EOCCO receive ICC services if the child and family declines to participate in the Wraparound process. EOCCO Systems of Care Manager continuously monitors local Review Committees to confirm youth eligible for Wraparound are not placed on a waitlist. EOCCO does not allow providers to place youth on a waitlist for Wraparound; instead, they are provided with and Intensive Care Coordinator and have access to Intensive Outpatient Services and Supports (IOSS). Additionally, to address concerns related to maintaining 15:1 caseloads GOBHI on behalf of EOCCO has directly hired Wraparound Care Coordinators in select areas to provide support to the local provider network and prevent youth from being placed on a waitlist.

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).

Each Youth and Family accepted into Wraparound is provided with an introduction to a Youth Partner (if age 12 and above) and a Family Partner during the first engagement session facilitated by the Wraparound Care Coordinator. The Youth Partner and Family partner each explain their role and offer the member the choice as to whether they would like to have a Support Partner on their Child & Family Team.

Existing Memorandum of Understanding (MOUs) with the EOCCO provider network ensure access to Family and Youth Peer Support. GOBHI on behalf of EOCCO employees a Youth and Family Support Coordinator who also operates as a Peer Coach, conducting one on one coaching with Family and Youth Peer Supports across the EOCCO service area. Additional group peer coaching sessions are held twice monthly to provide support, collaboration, and feedback from Family and Youth Peer Supports. Finally, EOCCO provides co-supervision with Family and Youth Peer Supports and Children's Clinical Supervisors within the provider network.

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:

Eastern Oregon 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
☐	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			

Go to OR

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

Eastern Oregon CCO
(Health Company)
Pro Forma Statutory Balance Sheet (Nationwide)
(In Thousands)

	2020	2021	2022
Admitted Assets			
1. Bonds	10,077	12,940	14,751
2. Stock	5,426	6,967	7,943
3. Real Estate/Mortgage Investments			
4. Affiliated Investments			
5. Affiliated Receivables			
6. Cash/Cash Equivalents	31,034	30,687	31,757
7. Aggregate write in for assets	2,115	2,185	2,256
8. Total Assets(1+2+3+4+5+6+7)	**48,652**	**52,779**	**56,707**
Liabilities			
9. Losses (Unpaid Claims for Accident and Health Policies)	20,379	21,049	21,742
10. Unpaid claims adjustment expenses	970	1,002	1,035
11. Reserve for Accident and Health Policies			
12. Ceded Reinsurance Payable	173	182	182
13. Payable to Parents, Subsidiaries & Affiliates			
14. MLR rebates			
15. Premiums received in advanced	2,781	2,872	2,967
16. All other Liabilites	4,442	4,980	5,185
17. Total Liabilities (9+10+11+12+13+14+15+16)	**28,745**	**30,085**	**31,111**
Capital and Surplus			
18. Capital Stock			
19. Gross Paid In and Contributed Surplus	17,225	17,225	17,225
20. Surplus Notes			
21. Unassigned Surplus	2,682	5,469	8,362
22. Other Items(elaborate)			
23. Total Capital and Surplus(18+19+20+21+22)	19,907	22,694	25,587
Risk-Based Capital Analysis			
24. Authorized Control Level Risk-Based Capital	$ 10,656	$ 10,805	$ 10,970
25. Calculated Risk-Based Capital (23/24)	186.8%	210.0%	233.3%

Eastern Oregon CCO
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Thousands)

	2020	2021	2022
1. Member months	600,000	600,000	600,000
2. Net Premium Income	331,640	342,512	353,751
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)	**331,640**	**342,512**	**353,751**
Hospital and Medical:			
9. Hospital/Medical Benenfits	211,127	218,071	225,251
10. Other professional Services	62,999	65,071	67,214
11. Prescription Drugs	26,218	27,080	27,971
12. Aggregate write ins for other hospital/medical	-		
13. Subtotal (L9+L10+L11+L12)	**300,344**	**310,222**	**320,436**
Less:			
14. Reinsurance recoveries	1,163	1,221	1,282
15. Total hospital and Medical (L13 -L14)	299,182	309,002	319,155
16. Non health claims			
17. Claims adjustment expenses	13,515	13,960	14,420
18. General admin expenses	16,519	17,062	17,624
19. Increase in reserves for accident and health contacts			
20. Total underwriting deductions (L15+L16+L17+L18+L19)	**329,216**	**340,024**	**351,198**
21. Net underwriting gain or loss (L8 -L20)	2,424	2,488	2,553
22. Net investment income earned	258	299	340
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)	**2,682**	**2,786**	**2,894**
28. Prior YE Surplus	0	19,907	22,694
29. Net Income	2,682	2,786	2,894
30. Capital Increases	17225		
31. Other Increases (Decreases)			
32. Dividends to Stockholders			
33. YE Surplus (L28+L29+L30+L31-L32)	**19,907**	**22,694**	**25,587**

***Itemize in Assumptions**

Eastern Oregon CCO
(Health Company)
Pro Forma Statutory Cash Flow Statement
(In Thousands)

	2020	2021	2022
Cash From Operations			
1. Premiums Collected Net of Reinsurance	332,306	342,533	353,774
2. Benefits Paid	277,833	308,299	318,428
3. Underwriting Expenses Paid	25,419	30,475	31,829
4. Total Cash From Underwriting (L1-L2-L3)	**29,054**	**3,759**	**3,516**
5. Net Investment Income	258	299	340
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)	**29,312**	**4,057**	**3,857**
Cash From Investments			
10. Net Cash from Investments	(15,503)	(4,405)	(2,786)
Cash From Financing and Misc Sources			
11. Capital and paid in Surplus	17,225		
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)	**17,225**	**-**	**-**
17. Net Change in Cash, Cash Equivalents and Short -Term Investments (L9+L10+L16)	31,034	(347)	1,070

Nationwide
Year 1

Eastern Oregon 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)	331,640							331,640			
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)	**331,640**	**-**	**-**	**-**	**-**	**-**	**-**	**331,640**	**-**	**-**	**-**
8. Hospital/medical benefits	211,127							211,127			
9. Other professional services	62,999							62,999			
10. Prescription Drugs	26,218							26,218			
11. Aggregatae writes for other hospital/ medical/health	-										XXX
12. Subtotal (8+9+10+11)	**300,344**	**-**	**-**	**-**	**-**	**-**	**-**	**300,344**	**-**	**-**	**-**
	-										
13. Net reinsurance recoveries								1162.56			
14. Total hospital and medical (12-13)	**299,182**	**-**	**-**	**-**	**-**	**-**	**-**	**299,182**	**-**	**-**	**-**
15. Non health claims	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
16. Claims adjustment expenses	13,515							13515.49			
17. General admin expenses	16,519							16518.93			
18. Increase in reserves for accident and health contracts	-										
19. Aggregate write in for Other Expenses	-										
20. Total underwriting deductions (14 to19)	**329,216**	**-**	**-**	**-**	**-**	**-**	**-**	**329,216**	**-**	**-**	**-**
21. Net underwriting Gain (Loss) (7-20)	**2,424**	**-**	**-**	**-**	**-**	**-**	**-**	**2,424**	**-**	**-**	**-**

Nationwide
Year 2

Eastern Oregon 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)	342,512							342,512			
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)	**342,512**	**-**	**-**	**-**	**-**	**-**	**-**	**342,512**	**-**	**-**	**-**
	-										
8. Hospital/medical benefits	218,071							218,071			
9. Other professional services	65,071							65,071			
10. Prescription Drugs	27,080							27,080			
11. Aggregate write ins for other hospital/ medical/health	-										XXX
12. Subtotal (8+9+10+11)	**310,222**	**-**	**-**	**-**	**-**	**-**	**-**	**310,222**	**-**	**-**	**-**
	-										
13. Net reinsurance recoveries								1220.688			
14. Total hospital and medical (12-13)	309,002	-	-	-	-	-	-	309,002	-	-	-
15. Non health claims	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
16. Claims adjustment expenses	13,960							13960			
17. General admin expenses	17,062							17062.22			
18. Increase in reserves for accident and health contracts	-										
19. Aggregate write in for Other Expenses	-										
20. Total underwriting deductions (14 to19)	**340,024**	**-**	**-**	**-**	**-**	**-**	**-**	**340,024**	**-**	**-**	**-**
21. Net underwriting Gain (Loss) (7-20)	**2,488**	**-**	**-**	**-**	**-**	**-**	**-**	**2,488**	**-**	**-**	**-**

Nationwide
Year 3

Eastern Oregon 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)	353,751							353751.5			
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)	**353,751**	**-**	**-**	**-**	**-**	**-**	**-**	**353,751**	**-**	**-**	**-**
	-										
8. Hospital/medical benefits	225,251							225,251			XXX
9. Other professional services	67,214							67,214			XXX
10. Prescription Drugs	27,971							27,971			XXX
11. Aggregatae writes for other hospital/ medical/health	-										XXX
12. Subtotal (L8+L9+L10+L11)	**320,436**	**-**	**-**	**-**	**-**	**-**	**-**	**320,436**	**-**	**-**	
13. Net reinsurance recoveries	1,282							1281.722			
14. Total hospital and medical (L12-L13)	319,155	-	-	-	-	-	-	319,155	-	-	-
15. Non health claims	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX
16. Claims adjustment expenses	14,420							14419.63			
17. General admin expenses	17,624							17623.99			
18. Increase in reserves for accident and health contracts	-										XXX
19. Aggregate write in for Other Expenses	-										
20. Total underwriting deductions (L14 : L19)	**351,198**	**-**	**-**	**-**	**-**	**-**	**-**	**351,198**	**-**	**-**	**-**
21. Net underwriting Gain (Loss) (L7-L20)	**2,553**	**-**	**-**	**-**	**-**	**-**	**-**	**2,553**	**-**	**-**	**-**

Nationwide
Year 1

Eastern Oregon 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	333,715,679		2,076,000	331,639,679
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	333,715,679	-	2,076,000	331,639,679

Nationwide
Year 2

Eastern Oregon 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	344,691,385		2,179,800	342,511,585
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	344,691,385	-	2,179,800	342,511,585

Nationwide
Year 3

Eastern Oregon 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	356,040,265		2,288,790	353,751,475
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	356,040,265	-	2,288,790	353,751,475

Nationwide
Year 1

Eastern Oregon 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

Eastern Oregon C
(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

Eastern Oregon C
(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.

Overall Structure:
Eastern Oregon CCO will continue to be comprised of eight partners.

EOCCO currently holds enough capital and has a net worth to exceed initial requirements. It is projected that the Company currently has an RBC that exceeds 200%.
Based on the analysis tabs, of all membership-level scenarios, the Company would also have enough capital to cover all three stress test scenarios in all years.

The eight partners and interests will remain unchanged from the current structure:

Partner	Interest %
ODS Community Health (Moda)	29%
Greater Oregon Behavioral Health, Inc.	29%
Good Shepherd	10%
Grande Ronde	10%
St. Anthony's	10%
St. Alphonsus	10%
Yakima Valley Farm Workers	1%
Eastern Oregon IPA	1%

Region/Counties:
The desired geographic region that EOCCO would operate in will remain unchanged: Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wheeler counties.

Enrollment Levels:
The Company's best estimate is to retain 100% of this market. The Company believes that its strong provider partnerships will allow it to continue to deliver high-quality care while remaining within the 3.4% annual medical trend target. It is expected that EOCCO will be able to successfully manage membership levels between 75% and 125% of the total estimated enrollment and be able to stay within the 3.4% annual 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, 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, 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.

The Company's goal would be to bend the cost curve in its region to perform below the 90% loss ratio. We believe this is possible and plausible based on the strong provider-partnerships and CCO ownership structure and the success of EOCCO. The projections do not show a better-than 90% loss ratio as we believe it is the best approach for this situation to show a more conservative forecast and higher capital requirements.

Administrative expenses are estimated at approximately 9% of the total revenue for the base line. Administrative expenses for the enrollment scenarios of 75% and 125% are estimated to be 9.6% and 8.6%, respectively. This variation in total estimated administrative expenses is due to the projected "fixed cost" of administering the CCO.

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 underwrting 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 capital.

Oregon
Year 1

Eastern Oregon 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	333,715,679		2,076,000	331,639,679
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	**333,715,679**	**-**	**2,076,000**	**331,639,679**

Oregon
Year 2

Eastern Oregon 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	344,691,385		2,179,800	342,511,585
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	**344,691,385**	**-**	**2,179,800**	**342,511,585**

Oregon
Year 3

Eastern Oregon 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	356,040,265		2,288,790	353,751,475
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	**356,040,265**	**-**	**2,288,790**	**353,751,475**

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:

Eastern Oregon 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
☐	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			

Go to OR

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

Eastern Oregon CCO
(Health Company)
Pro Forma Statutory Balance Sheet (Nationwide)
(In Thousands)

	2020	2021	2022
Admitted Assets			
1. Bonds	12,431	17,160	20,649
2. Stock	6,694	9,240	11,119
3. Real Estate/Mortgage Investments			
4. Affiliated Investments			
5. Affiliated Receivables			
6. Cash/Cash Equivalents	40,296	39,944	41,359
7. Aggregate write in for assets	2,644	2,731	2,821
8. Total Assets(1+2+3+4+5+6+7)	**62,065**	**69,075**	**75,947**
Liabilities			
9. Losses (Unpaid Claims for Accident and Health Policies)	25,473	26,311	27,178
10. Unpaid claims adjustment expenses	1,213	1,252	1,294
11. Reserve for Accident and Health Policies			
12. Ceded Reinsurance Payable	216	227	227
13. Payable to Parents, Subsidiaries & Affiliates			
14. MLR rebates			
15. Premiums received in advanced	3,476	3,591	3,709
16. All other Liabilites	5,286	5,927	6,171
17. Total Liabilities (9+10+11+12+13+14+15+16)	**35,664**	**37,308**	**38,578**
Capital and Surplus			
18. Capital Stock			
19. Gross Paid In and Contributed Surplus	21,250	21,250	21,250
20. Surplus Notes			
21. Unassigned Surplus	5,150	10,518	16,108
22. Other Items(elaborate)			
23. Total Capital and Surplus(18+19+20+21+22)	26,400	31,768	37,358
Risk-Based Capital Analysis			
24. Authorized Control Level Risk-Based Capital	$ 13,298	$ 13,361	$ 13,564
25. Calculated Risk-Based Capital (23/24)	198.5%	237.8%	275.4%

Eastern Oregon CCO
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Thousands)

	2020	2021	2022
1. Member months	750,000	750,000	750,000
2. Net Premium Income	414,550	428,139	442,189
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)	**414,550**	**428,139**	**442,189**
Hospital and Medical:			
9. Hospital/Medical Benenfits	263,909	272,589	281,564
10. Other professional Services	78,749	81,339	84,017
11. Prescription Drugs	32,772	33,850	34,964
12. Aggregate write ins for other hospital/medical	-		
13. Subtotal (L9+L10+L11+L12)	**375,430**	**387,778**	**400,545**
Less:			
14. Reinsurance recoveries	1,453	1,526	1,602
15. Total hospital and Medical (L13 -L14)	373,977	386,252	398,943
16. Non health claims			
17. Claims adjustment expenses	16,083	16,612	17,159
18. General admin expenses	19,658	20,304	20,973
19. Increase in reserves for accident and health contacts			
20. Total underwriting deductions (L15+L16+L17+L18+L19)	**409,718**	**423,168**	**437,075**
21. Net underwriting gain or loss (L8 -L20)	4,832	4,971	5,114
22. Net investment income earned	319	396	477
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)	**5,150**	**5,367**	**5,591**
28. Prior YE Surplus	0	26,400	31,768
29. Net Income	5,150	5,367	5,591
30. Capital Increases	21250		
31. Other Increases (Decreases)			
32. Dividends to Stockholders			
33. YE Surplus (L28+L29+L30+L31-L32)	**26,400**	**31,768**	**37,358**

***Itemize in Assumptions**

Eastern Oregon CCO
(Health Company)
Pro Forma Statutory Cash Flow Statement
(In Thousands)

	2020	2021	2022
Cash From Operations			
1. Premiums Collected Net of Reinsurance	415,382	428,167	442,218
2. Benefits Paid	347,291	385,374	398,036
3. Underwriting Expenses Paid	30,239	36,265	37,877
4. Total Cash From Underwriting (L1-L2-L3)	**37,852**	**6,528**	**6,306**
5. Net Investment Income	319	396	477
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)	**38,171**	**6,924**	**6,782**
Cash From Investments			
10. Net Cash from Investments	(19,125)	(7,275)	(5,367)
Cash From Financing and Misc Sources			
11. Capital and paid in Surplus	21,250		
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)	**21,250**	**-**	**-**
17. Net Change in Cash, Cash Equivalents and Short -Term Investments (L9+L10+L16)	40,296	(352)	1,415

Nationwide
Year 1

Eastern Oregon 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)	414,550							414,550			
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)	**414,550**	**-**	**-**	**-**	**-**	**-**	**-**	**414,550**	**-**	**-**	**-**
8. Hospital/medical benefits	263,909							263,909			
9. Other professional services	78,749							78,749			
10. Prescription Drugs	32,772							32,772			
11. Aggregatae writes for other hospital/ medical/health	-										XXX
12. Subtotal (8+9+10+11)	**375,430**	**-**	**-**	**-**	**-**	**-**	**-**	**375,430**	**-**	**-**	**-**
	-										
13. Net reinsurance recoveries								1453.2			
14. Total hospital and medical (12-13)	**373,977**	**-**	**-**	**-**	**-**	**-**	**-**	**373,977**	**-**	**-**	**-**
15. Non health claims	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
16. Claims adjustment expenses	16,083							16083.43			
17. General admin expenses	19,658							19657.52			
18. Increase in reserves for accident and health contracts	-										
19. Aggregate write in for Other Expenses	-										
20. Total underwriting deductions (14 to19)	**409,718**	**-**	**-**	**-**	**-**	**-**	**-**	**409,718**	**-**	**-**	**-**
21. Net underwriting Gain (Loss) (7-20)	**4,832**	**-**	**-**	**-**	**-**	**-**	**-**	**4,832**	**-**	**-**	**-**

Nationwide
Year 2

Eastern Oregon 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)	428,139							428,139			
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)	**428,139**	**-**	**-**	**-**	**-**	**-**	**-**	**428,139**	**-**	**-**	**-**
	-										
8. Hospital/medical benefits	272,589							272,589			
9. Other professional services	81,339							81,339			
10. Prescription Drugs	33,850							33,850			
11. Aggregate write ins for other hospital/ medical/health	-										XXX
12. Subtotal (8+9+10+11)	**387,778**	**-**	**-**	**-**	**-**	**-**	**-**	**387,778**	**-**	**-**	**-**
	-										
13. Net reinsurance recoveries								1525.86			
14. Total hospital and medical (12-13)	386,252	-	-	-	-	-	-	386,252	-	-	-
15. Non health claims	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
16. Claims adjustment expenses	16,612							16612.4			
17. General admin expenses	20,304							20304.05			
18. Increase in reserves for accident and health contracts	-										
19. Aggregate write in for Other Expenses	-										
20. Total underwriting deductions (14 to19)	**423,168**	**-**	**-**	**-**	**-**	**-**	**-**	**423,168**	**-**	**-**	**-**
21. Net underwriting Gain (Loss) (7-20)	**4,971**	**-**	**-**	**-**	**-**	**-**	**-**	**4,971**	**-**	**-**	**-**

Nationwide
Year 3

Eastern Oregon 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)	442,189							442189.3			
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)	**442,189**	**-**	**-**	**-**	**-**	**-**	**-**	**442,189**	**-**	**-**	**-**
	-										
8. Hospital/medical benefits	281,564							281,564			XXX
9. Other professional services	84,017							84,017			XXX
10. Prescription Drugs	34,964							34,964			XXX
11. Aggregatae writes for other hospital/ medical/health	-										XXX
12. Subtotal (L8+L9+L10+L11)	**400,545**	**-**	**-**	**-**	**-**	**-**	**-**	**400,545**	**-**	**-**	
13. Net reinsurance recoveries	1,602							1602.153			
14. Total hospital and medical (L12-L13)	398,943	-	-	-	-	-	-	398,943	-	-	-
15. Non health claims	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX
16. Claims adjustment expenses	17,159							17159.36			
17. General admin expenses	20,973							20972.55			
18. Increase in reserves for accident and health contracts	-										XXX
19. Aggregate write in for Other Expenses	-										
20. Total underwriting deductions (L14 : L19)	**437,075**	**-**	**-**	**-**	**-**	**-**	**-**	**437,075**	**-**	**-**	**-**
21. Net underwriting Gain (Loss) (L7-L20)	**5,114**	**-**	**-**	**-**	**-**	**-**	**-**	**5,114**	**-**	**-**	**-**

Nationwide
Year 1

Eastern Oregon 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	417,144,599		2,595,000	414,549,599
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	417,144,599	-	2,595,000	414,549,599

Nationwide
Year 2

Eastern Oregon 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	430,864,231		2,724,750	428,139,481
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	430,864,231	-	2,724,750	428,139,481

Nationwide
Year 3

Eastern Oregon 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	445,050,331		2,860,988	442,189,344
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	445,050,331	-	2,860,988	442,189,344

Nationwide
Year 1

Eastern Oregon 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

Eastern Oregon C
(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

Eastern Oregon C
(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.

Overall Structure:
Eastern Oregon CCO will continue to be comprised of eight partners.

EOCCO currently holds enough capital and has a net worth to exceed initial requirements. It is projected that the Company currently has an RBC that exceeds 200%.
Based on the analysis tabs, of all membership-level scenarios, the Company would also have enough capital to cover all three stress test scenarios in all years.

The eight partners and interests will remain unchanged from the current structure:

Partner	Interest %
ODS Community Health (Moda)	29%
Greater Oregon Behavioral Health, Inc.	29%
Good Shepherd	10%
Grande Ronde	10%
St. Anthony's	10%
St. Alphonsus	10%
Yakima Valley Farm Workers	1%
Eastern Oregon IPA	1%

Region/Counties:
The desired geographic region that EOCCO would operate in will remain unchanged: Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wheeler counties.

Enrollment Levels:

The Company's best estimate is to retain 100% of this market. The Company believes that its strong provider partnerships will allow it to continue to deliver high-quality care while remaining within the 3.4% annual medical trend target. It is expected that EOCCO will be able to successfully manage membership levels between 75% and 125% of the total estimated enrollment and be able to stay within the 3.4% annual 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, 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, 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.

The Company's goal would be to bend the cost curve in its region to perform below the 90% loss ratio. We believe this is possible and plausible based on the strong provider-partnerships and CCO ownership structure and the success of EOCCO. The projections do not show a better-than 90% loss ratio as we believe it is the best approach for this situation to show a more conservative forecast and higher capital requirements.

Administrative expenses are estimated at approximately 9% of the total revenue for the base line. Administrative expenses for the enrollment scenarios of 75% and 125% are estimated to be 9.6% and 8.6%, respectively. This variation in total estimated administrative expenses is due to the projected "fixed cost" of administering the CCO.

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 underwrting 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 capital.

Oregon
Year 1

Eastern Oregon 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	417,144,599		2,595,000	414,549,599
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	**417,144,599**	**-**	**2,595,000**	**414,549,599**

Oregon
Year 2

Eastern Oregon 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	430,864,231		2,724,750	428,139,481
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	**430,864,231**	**-**	**2,724,750**	**428,139,481**

Oregon
Year 3

Eastern Oregon 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	445,050,331		2,860,988	442,189,344
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	**445,050,331**	**-**	**2,860,988**	**442,189,344**

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:

Eastern Oregon 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
☐	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			

Go to OR

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

Eastern Oregon CCO
(Health Company)
Pro Forma Statutory Balance Sheet (Nationwide)
(In Thousands)

	2020	2021	2022
Admitted Assets			
1. Bonds	9,506	11,009	11,464
2. Stock	5,119	5,928	6,173
3. Real Estate/Mortgage Investments			
4. Affiliated Investments			
5. Affiliated Receivables			
6. Cash/Cash Equivalents	23,793	23,225	24,019
7. Aggregate write in for assets	1,688	1,744	1,802
8. Total Assets(1+2+3+4+5+6+7)	**40,106**	**41,905**	**43,457**
Liabilities			
9. Losses (Unpaid Claims for Accident and Health Policies)	16,270	16,806	17,360
10. Unpaid claims adjustment expenses	774	800	826
11. Reserve for Accident and Health Policies			
12. Ceded Reinsurance Payable	138	145	145
13. Payable to Parents, Subsidiaries & Affiliates			
14. MLR rebates			
15. Premiums received in advanced	2,220	2,293	2,369
16. All other Liabilites	3,767	4,223	4,397
17. Total Liabilities (9+10+11+12+13+14+15+16)	**23,170**	**24,268**	**25,098**
Capital and Surplus			
18. Capital Stock			
19. Gross Paid In and Contributed Surplus	16,250	16,250	16,250
20. Surplus Notes			
21. Unassigned Surplus	687	1,387	2,102
22. Other Items(elaborate)			
23. Total Capital and Surplus(18+19+20+21+22)	16,937	17,637	18,352

Risk-Based Capital Analysis			
24. Authorized Control Level Risk-Based Capital	$ 8,690	$ 8,722	$ 8,843
25. Calculated Risk-Based Capital (23/24)	194.9%	202.2%	207.5%

Eastern Oregon CCO
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Thousands)

	2020	2021	2022
1. Member months	480,000	480,000	480,000
2. Net Premium Income	264,767	273,464	282,456
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)	**264,767**	**273,464**	**282,456**
Hospital and Medical:			
9. Hospital/Medical Benenfits	168,557	174,112	179,856
10. Other professional Services	50,297	51,954	53,668
11. Prescription Drugs	20,931	21,621	22,334
12. Aggregate write ins for other hospital/medical	-		
13. Subtotal (L9+L10+L11+L12)	**239,785**	**247,687**	**255,858**
Less:			
14. Reinsurance recoveries	930	977	1,025
15. Total hospital and Medical (L13 -L14)	238,855	246,711	254,833
16. Non health claims			
17. Claims adjustment expenses	11,461	11,838	12,228
18. General admin expenses	14,008	14,469	14,945
19. Increase in reserves for accident and health contacts			
20. Total underwriting deductions (L15+L16+L17+L18+L19)	**264,324**	**273,018**	**282,006**
21. Net underwriting gain or loss (L8 -L20)	443	447	450
22. Net investment income earned	244	254	265
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)	**687**	**701**	**715**
28. Prior YE Surplus	0	16,937	17,637
29. Net Income	687	701	715
30. Capital Increases	16250		
31. Other Increases (Decreases)			
32. Dividends to Stockholders			
33. YE Surplus (L28+L29+L30+L31-L32)	**16,937**	**17,637**	**18,352**

***Itemize in Assumptions**

Eastern Oregon CCO
(Health Company)
Pro Forma Statutory Cash Flow Statement
(In Thousands)

	2020	2021	2022
Cash From Operations			
1. Premiums Collected Net of Reinsurance	265,298	273,482	282,474
2. Benefits Paid	221,811	246,149	254,252
3. Underwriting Expenses Paid	21,564	25,843	26,992
4. Total Cash From Underwriting (L1-L2-L3)	**21,924**	**1,489**	**1,230**
5. Net Investment Income	244	254	265
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)	**22,168**	**1,743**	**1,495**
Cash From Investments			
10. Net Cash from Investments	(14,625)	(2,312)	(701)
Cash From Financing and Misc Sources			
11. Capital and paid in Surplus	16,250		
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)	**16,250**	**-**	**-**
17. Net Change in Cash, Cash Equivalents and Short -Term Investments (L9+L10+L16)	23,793	(568)	794

Nationwide
Year 1

Eastern Oregon 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)	264,767							264,767			
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)	**264,767**	**-**	**-**	**-**	**-**	**-**	**-**	**264,767**	**-**	**-**	**-**
8. Hospital/medical benefits	168,557							168,557			
9. Other professional services	50,297							50,297			
10. Prescription Drugs	20,931							20,931			
11. Aggregatae writes for other hospital/ medical/health	-										XXX
12. Subtotal (8+9+10+11)	**239,785**	**-**	**-**	**-**	**-**	**-**	**-**	**239,785**	**-**	**-**	**-**
	-										
13. Net reinsurance recoveries								930.048			
14. Total hospital and medical (12-13)	**238,855**	**-**	**-**	**-**	**-**	**-**	**-**	**238,855**	**-**	**-**	**-**
15. Non health claims	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
16. Claims adjustment expenses	-										
17. General admin expenses	14,008							14008.05			
18. Increase in reserves for accident and health contracts	-										
19. Aggregate write in for Other Expenses	-										
20. Total underwriting deductions (14 to19)	**252,863**	**-**	**-**	**-**	**-**	**-**	**-**	**252,863**	**-**	**-**	**-**
21. Net underwriting Gain (Loss) (7-20)	**11,904**	**-**	**-**	**-**	**-**	**-**	**-**	**11,904**	**-**	**-**	**-**

Nationwide
Year 2

Eastern Oregon 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)	273,464							273,464			
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)	**273,464**	**-**	**-**	**-**	**-**	**-**	**-**	**273,464**	**-**	**-**	**-**
	-										
8. Hospital/medical benefits	174,112							174,112			
9. Other professional services	51,954							51,954			
10. Prescription Drugs	21,621							21,621			
11. Aggregate write ins for other hospital/ medical/health	-										XXX
12. Subtotal (8+9+10+11)	**247,687**	**-**	**-**	**-**	**-**	**-**	**-**	**247,687**	**-**	**-**	**-**
	-										
13. Net reinsurance recoveries								976.5504			
14. Total hospital and medical (12-13)	246,711	-	-	-	-	-	-	246,711	-	-	-
15. Non health claims	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
16. Claims adjustment expenses	-										
17. General admin expenses	14,469							14468.77			
18. Increase in reserves for accident and health contracts	-										
19. Aggregate write in for Other Expenses	-										
20. Total underwriting deductions (14 to19)	**261,179**	**-**	**-**	**-**	**-**	**-**	**-**	**261,179**	**-**	**-**	**-**
21. Net underwriting Gain (Loss) (7-20)	**12,285**	**-**	**-**	**-**	**-**	**-**	**-**	**12,285**	**-**	**-**	**-**

Nationwide
Year 3

Eastern Oregon 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)	282,456							282456.1			
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)	**282,456**	**-**	**-**	**-**	**-**	**-**	**-**	**282,456**	**-**	**-**	**-**
	-										
8. Hospital/medical benefits	179,856							179,856			XXX
9. Other professional services	53,668							53,668			XXX
10. Prescription Drugs	22,334							22,334			XXX
11. Aggregatae writes for other hospital/ medical/health	-										XXX
12. Subtotal (L8+L9+L10+L11)	**255,858**	**-**	**-**	**-**	**-**	**-**	**-**	**255,858**	**-**	**-**	
13. Net reinsurance recoveries	1,025							1025.378			
14. Total hospital and medical (L12-L13)	254,833	-	-	-	-	-	-	254,833	-	-	-
15. Non health claims	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX
16. Claims adjustment expenses	-										
17. General admin expenses	14,945							14945.15			
18. Increase in reserves for accident and health contracts	-										XXX
19. Aggregate write in for Other Expenses	-										
20. Total underwriting deductions (L14 : L19)	**269,778**	**-**	**-**	**-**	**-**	**-**	**-**	**269,778**	**-**	**-**	**-**
21. Net underwriting Gain (Loss) (L7-L20)	**12,678**	**-**	**-**	**-**	**-**	**-**	**-**	**12,678**	**-**	**-**	**-**

Nationwide
Year 1

Eastern Oregon 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	266,427,503		1,660,800	264,766,703
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	266,427,503	-	1,660,800	264,766,703

Nationwide
Year 2

Eastern Oregon 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	275,208,068		1,743,840	273,464,228
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	275,208,068	-	1,743,840	273,464,228

Nationwide
Year 3

Eastern Oregon 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	284,287,172		1,831,032	282,456,140
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	284,287,172	-	1,831,032	282,456,140

Nationwide
Year 1

Eastern Oregon 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

Eastern Oregon C
(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

Eastern Oregon C
(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.

Overall Structure:
Eastern Oregon CCO will continue to be comprised of eight partners.

EOCCO currently holds enough capital and has a net worth to exceed initial requirements. It is projected that the Company currently has an RBC that exceeds 200%.
Based on the analysis tabs, of all membership-level scenarios, the Company would also have enough capital to cover all three stress test scenarios in all years.

The eight partners and interests will remain unchanged from the current structure:

Partner	Interest %
ODS Community Health (Moda)	29%
Greater Oregon Behavioral Health, Inc.	29%
Good Shepherd	10%
Grande Ronde	10%
St. Anthony's	10%
St. Alphonsus	10%
Yakima Valley Farm Workers	1%
Eastern Oregon IPA	1%

Region/Counties:
The desired geographic region that EOCCO would operate in will remain unchanged: Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wheeler counties.

Enrollment Levels:
The Company's best estimate is to retain 100% of this market. The Company believes that its strong provider partnerships will allow it to continue to deliver high-quality care while remaining within the 3.4% annual medical trend target. It is expected that EOCCO will be able to successfully manage membership levels between 75% and 125% of the total estimated enrollment and be able to stay within the 3.4% annual 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, 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, 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.

The Company's goal would be to bend the cost curve in its region to perform below the 90% loss ratio. We believe this is possible and plausible based on the strong provider-partnerships and CCO ownership structure and the success of EOCCO. The projections do not show a better-than 90% loss ratio as we believe it is the best approach for this situation to show a more conservative forecast and higher capital requirements.

Administrative expenses are estimated at approximately 9% of the total revenue for the base line. Administrative expenses for the enrollment scenarios of 75% and 125% are estimated to be 9.6% and 8.6%, respectively. This variation in total estimated administrative expenses is due to the projected "fixed cost" of administering the CCO.

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 underwrting 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 capital.

Oregon
Year 1

Eastern Oregon 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	266,427,503		1,660,800	264,766,703
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	**266,427,503**	**-**	**1,660,800**	**264,766,703**

Oregon
Year 2

Eastern Oregon 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	275,208,068		1,743,840	273,464,228
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	**275,208,068**	**-**	**1,743,840**	**273,464,228**

Oregon
Year 3

Eastern Oregon 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	284,287,172		1,831,032	282,456,140
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	**284,287,172**	**-**	**1,831,032**	**282,456,140**

APPLICANT NAME: **Eastern Oregon 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.

Eastern Oregon CCO
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Whole Numbers)

			2020	2021	2022
1.	Desired Service Area (List Counties): Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow Sherman, Umatilla, Union, Wallowa, Wheeler				
2.	Membership totals for Desired Service Area:		50,000	50,000	50,000
3.	Best Estimate Membership Percentage:		100%	100%	100%
4.	Best Estimate Member Months	(BE MM)	600,000	600,000	600,000
5.	Estimated Minimum viable Membership Percentage:		80%	80%	80%
6.	Minimum Member Months	(MIN MM)	480,000	480,000	480,000
7.	Estimated Maximum viable Membership Percentage:		125%	125%	125%
8.	Maximum Member Months	(MAX MM)	750,000	750,000	750,000
	Administrative Costs:				
9.	What is the total "fixed" administrative costs for CCO Operations?		7,208,259	7,445,334	7,690,470
10.	What is the variable administrative costs for CCO Operations on a Per Member Per Month basis:		38	39	41

Eastern Oregon CCO
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Whole Numbers)

Scenario Summary

	2020	2021	2022
Best Estimate MM:	600,000	600,000	600,000
Net Income	2,682,092	2,786,408	2,893,738
Net Income Claims +2%	(3,301,539)	(3,393,623)	(3,489,353)
MLR Claims +2%	92%	92%	92%
RBC Claims +2%	1.307	1.528	1.751
Net Income Claims +4%	(9,285,170)	(9,573,654)	(9,872,443)
MLR Claims +4%	94%	94%	94%
RBC Claims +4%	0.745	0.956	1.169
Minimum MM:	480,000	480,000	480,000
Net Income	686,568	700,719	714,629
Net Income Claims +2%	(4,090,526)	(4,233,495)	(4,382,032)
MLR Claims +2%	92%	92%	92%
RBC Claims +2%	1.399	1.456	1.499
Net Income Claims +4%	(8,867,620)	(9,167,709)	(9,478,694)
MLR Claims +4%	94%	94%	94%
RBC Claims +4%	0.849	0.891	0.923
Maximum MM:	750,000	750,000	750,000
Net Income	5,150,461	5,367,093	5,590,800
Net Income Claims +2%	(2,329,078)	(2,357,946)	(2,388,063)
MLR Claims +2%	92%	92%	92%
RBC Claims +2%	1.423	1.800	2.166
Net Income Claims +4%	(9,808,617)	(10,082,985)	(10,366,926)
MLR Claims +4%	94%	94%	94%
RBC Claims +4%	0.860	1.221	1.578

Eastern Oregon 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:		600,000	600,000	600,000
Fixed Administrative Costs	Assumptions Line 9	7,208,259	7,445,334	7,690,470
Variable Administrative Costs	Assumptions Line 10	22,826,152	23,576,891	24,353,154
Total Administrative Costs	calculated	30,034,411	31,022,225	32,043,624
Reported Administrative Costs	P and L Lines 17, 18	30,034,411	31,022,225	32,043,624
Difference (should be 0)	calculated	-	-	-
Minimum MM:		480,000	480,000	480,000
Fixed Administrative Costs	Assumptions Line 9	7,208,259	7,445,334	7,690,470
Variable Administrative Costs	Assumptions Line 10	18,260,922	18,861,513	19,482,523
Total Administrative Costs	calculated	25,469,181	26,306,847	27,172,993
Reported Administrative Costs	P and L Lines 17, 18	25,469,181	26,306,847	27,172,993
Difference (should be 0)	calculated	-	-	-
Maximum MM:		750,000	750,000	750,000
Fixed Administrative Costs	Assumptions Line 9	7,208,259	7,445,334	7,690,470
Variable Administrative Costs	Assumptions Line 10	28,532,691	29,471,113	30,441,443
Total Administrative Costs	calculated	35,740,949	36,916,447	38,131,912
Reported Administrative Costs	P and L Lines 17, 18	35,740,949	36,916,447	38,131,912
Difference (should be 0)	calculated	-	-	-

Eastern Oregon 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	10,076,625	12,939,610	14,750,775
2.	Stocks (Preferred & Common)	5,425,875	6,967,482	7,942,725
3.	Real Estate/Mortgage Loans on Real Estate			
4.	Cash/Cash Equivalents/Short-Term Investments	31,034,429	30,687,261	31,757,424
5.	Other Invested Assets			
6.	Aggregate Write-Ins For Invested Assets	2,114,943	2,184,502	2,256,426
7.	All Other Assets			
8.	Total Admitted Assets (Lines 1+2+3+4+5+6+7)	**48,651,872**	**52,778,855**	**56,707,350**
	Liabilities			
9.	Losses (Unpaid Claims for Accident and Health Policies)	20,378,794	21,049,040	21,742,074
10.	Unpaid Claims Adjustment Expenses	970,031	1,001,934	1,034,923
11.	Aggregate Health Policy Reserves	-	-	-
12.	Ceded Reinsurance Premiums Payable	173,000	181,650	181,650
13.	Amounts Due To Parents, Subsidiaries & Affiliates	-	-	-
14.	MLR Rebates	-	-	-
15.	Premiums Received In Advance	2,780,964	2,872,428	2,967,002
16.	All Other Liabilites	4,441,992	4,980,302	5,185,381
17.	Total Liabilities (Lines 9+10+11+12+13+14+15+16)	**28,744,780**	**30,085,355**	**31,111,030**
	Capital and Surplus			
18.	Capital Stock			
19.	Gross Paid In And Contributed Surplus	17,225,000	17,225,000	17,225,000
20.	Surplus Notes			
21.	Unassigned Funds (Surplus)	2,682,092	5,468,500	8,362,238
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)	19,907,092	22,693,500	25,587,238
25.	Liabilities and Surplus (Lines 17+24)	48,651,872	52,778,855	56,698,268
	Risk-Based Capital Analysis			
25.	Authorized Control Level Risk-Based Capital	10,655,751	10,805,047	10,969,682
26.	Calculated Risk-Based Capital (Line 24 / Line 25)	186.8%	210.0%	233.3%

Eastern Oregon 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	600,000	600,000	600,000
2. Net Premium Income	331,639,679	342,511,585	353,751,475
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)	**331,639,679**	**342,511,585**	**353,751,475**
Hospital and Medical:			
9. Hospital/Medical Benefits	211,127,196	218,071,041	225,250,977
10. Other Professional Services	62,999,316	65,071,325	67,213,782
11. Prescription Drugs	26,217,600	27,079,881	27,971,479
12. Aggregate Write-Ins For Other Hospital and Medical			
13. Subtotal (Lines 9+10+11+12)	**300,344,111**	**310,222,246**	**320,436,238**
Less:			
14. Net Reinsurance Recoveries	1,162,560	1,220,688	1,281,722
15. Total Hospital and Medical (Lines 13 - 14)	299,181,551	309,001,558	319,154,516
16. Non-Health Claims (net)			
17. Claims Adjustment Expenses	13,515,485	13,960,001	14,419,631
18. General Administrative Expenses	16,518,926	17,062,224	17,623,993
19. Increase In Reserves For Life & Accident And Health Contacts			
20. Total underwriting deductions (Lines 15+16+17+18+19)	**329,215,962**	**340,023,783**	**351,198,140**
21. Net underwriting gain or loss (Lines 8 - 20)	2,423,717	2,487,802	2,553,335
22. Net investment income earned	258,375	298,606	340,403
23. Net investment gains (losses) (Lines 22 + 26)	258,375	298,606	340,403
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)	**2,682,092**	**2,786,408**	**2,893,738**
29. Capital and Surplus Prior Reporting Year		19,907,092	22,693,500
30. Net Income or (Loss)	2,682,092	2,786,408	2,893,738
31. Capital Changes	17,225,000		
32. Other Increases (Decreases)			
33. Dividends to Stockholders			
34. Capital and Surplus End of Reporting Year (Lines 29 + 30 + 31 + 32 - 33)	**19,907,092**	**22,693,500**	**25,587,238**
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)	1666%	1509%	1383%
44 Authorized Control Level Risk-Based Capital	10,655,751	10,805,047	10,969,682
45 Risk Based Capital Calculation	1.868	2.100	2.333

Eastern Oregon 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	48,651,872	52,778,855	56,707,350
Real Estate/Mortgage Loans on Real Estate	Bal Sht Line 3	-	-	-
Stocks (Preferred & Common)	Bal Sht Line 2	-	-	-
Restricted Reserve	calculated	12,590,898	13,000,065	13,423,105
Liquid assets	calculated	48,651,872	52,778,855	56,707,350
Aggregate Health Policy Reserves	Bal Sht Line 11	20,378,794	21,049,040	21,742,074
Ceded Reinsurance Premiums Payable	Bal Sht Line 12	970,031	1,001,934	1,034,923
Total claims reserves	calculated	21,348,824	22,050,974	22,776,997
Total liabilities	Bal Sht Line 17	28,744,780	30,085,355	31,111,030
Total capital and surplus	Bal Sht Line 24	19,907,092	22,693,500	25,587,238
Capitol stock	Bal Sht Line 18	-	-	-
Surplus	calculated	19,907,092	22,693,500	25,587,238
Net Premium Income	P and L Line 2	331,639,679	342,511,585	353,751,475
Total Hospital and Medical (net)	P and L Line 15	299,181,551	309,001,558	319,154,516
Divided by months in year	given	12	12	12
Avg claims expense	calculated	24,931,796	25,750,130	26,596,210
Ratio/Financial Analysis				
Primary Restricted Reserve	calculated	250,000	250,000	250,000
Secondary Restricted Reserve	calculated	12,340,898	12,750,065	13,173,105
Total Restricted Reserve Requirement	calculated	12,590,898	13,000,065	13,423,105
Minimum Net Worth Required	calculated	16,581,984	17,125,579	17,687,574
Working capital	given	500,000	500,000	500,000
Total Initial Required Net Worth	calculated	17,081,984	17,625,579	18,187,574
Liabilities to Liquid Assets	calculated	59%	57%	55%
Capital & Surplus/Liabilities	calculated	69%	75%	82%
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	2,423,717	2,487,802	2,553,335
Test #1 Combined Ratio plus 2 pts	calculated	97%	97%	97%
Additional underwriting expense	calculated	6,632,794	6,850,232	7,075,029
Test #2 Combined Ratio plus 4 pts	calculated	99%	99%	99%
Additional underwriting expense	calculated	13,265,587	13,700,463	14,150,059
Test #3 Combined Ratio plus 6 pts	calculated	101%	101%	101%
Additional underwriting expense	calculated	19,898,381	20,550,695	21,225,088
C&S after test #1	calculated	13,274,298	15,843,268	18,512,208
C&S after test #2	calculated	6,641,505	8,993,037	11,437,179
C&S after test #3	calculated	8,711	2,142,805	4,362,149

Eastern Oregon 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	9,506,250	11,008,769	11,464,237
2.	Stocks (Preferred & Common)	5,118,750	5,927,799	6,173,050
3.	Real Estate/Mortgage Loans on Real Estate			
4.	Cash/Cash Equivalents/Short-Term Investments	23,792,698	23,224,500	24,018,521
5.	Other Invested Assets			
6.	Aggregate Write-Ins For Invested Assets	1,688,500	1,744,147	1,801,687
7.	All Other Assets			
8.	Total Admitted Assets (Lines 1+2+3+4+5+6+7)	**40,106,198**	**41,905,215**	**43,457,495**
	Liabilities			
9.	Losses (Unpaid Claims for Accident and Health Policies)	16,269,751	16,805,948	17,360,376
10.	Unpaid Claims Adjustment Expenses	774,440	799,963	826,354
11.	Aggregate Health Policy Reserves	-	-	-
12.	Ceded Reinsurance Premiums Payable	138,400	145,320	145,320
13.	Amounts Due To Parents, Subsidiaries & Affiliates	-	-	-
14.	MLR Rebates	-	-	-
15.	Premiums Received In Advance	2,220,229	2,293,401	2,369,060
16.	All Other Liabilites	3,766,809	4,223,297	4,397,203
17.	Total Liabilities (Lines 9+10+11+12+13+14+15+16)	**23,169,630**	**24,267,928**	**25,098,313**
	Capital and Surplus			
18.	Capital Stock			
19.	Gross Paid In And Contributed Surplus	16,250,000	16,250,000	16,250,000
20.	Surplus Notes			
21.	Unassigned Funds (Surplus)	686,568	1,387,287	2,101,916
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)	16,936,568	17,637,287	18,351,916
25.	Liabilities and Surplus (Lines 17+24)	40,106,198	41,905,215	43,450,229

	Risk-Based Capital Analysis			
25.	Authorized Control Level Risk-Based Capital	8,690,498	8,721,951	8,842,848
26.	Calculated Risk-Based Capital (Line 24 / Line 25)	194.9%	202.2%	207.5%

Eastern Oregon 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	480,000	480,000	480,000
2. Net Premium Income	264,766,703	273,464,228	282,456,140
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)	**264,766,703**	**273,464,228**	**282,456,140**
Hospital and Medical:			
9. Hospital/Medical Benefits	168,556,934	174,112,010	179,855,959
10. Other Professional Services	50,296,559	51,954,166	53,668,132
11. Prescription Drugs	20,931,260	21,621,085	22,334,364
12. Aggregate Write-Ins For Other Hospital and Medical			
13. Subtotal (Lines 9+10+11+12)	**239,784,753**	**247,687,261**	**255,858,455**
Less:			
14. Net Reinsurance Recoveries	930,048	976,550	1,025,378
15. Total Hospital and Medical (Lines 13 - 14)	238,854,705	246,710,711	254,833,077
16. Non-Health Claims (net)			
17. Claims Adjustment Expenses	11,461,131	11,838,081	12,227,847
18. General Administrative Expenses	14,008,049	14,468,766	14,945,146
19. Increase In Reserves For Life & Accident And Health Contacts			
20. Total underwriting deductions (Lines 15+16+17+18+19)	**264,323,886**	**273,017,557**	**282,006,070**
21. Net underwriting gain or loss (Lines 8 - 20)	442,818	446,671	450,070
22. Net investment income earned	243,750	254,049	264,559
23. Net investment gains (losses) (Lines 22 + 26)	243,750	254,049	264,559
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)	**686,568**	**700,719**	**714,629**
29. Capital and Surplus Prior Reporting Year	-	16,936,568	17,637,287
30. Net Income or (Loss)	686,568	700,719	714,629
31. Capital Changes	16,250,000		
32. Other Increases (Decreases)			
33. Dividends to Stockholders			
34. Capital and Surplus End of Reporting Year (Lines 29 + 30 + 31 + 32 - 33)	**16,936,568**	**17,637,287**	**18,351,916**
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)	1563%	1550%	1539%
44 Authorized Control Level Risk-Based Capital	8,690,498	8,721,951	8,842,848
45 Risk Based Capital Calculation	1.949	2.022	2.075

Eastern Oregon 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	40,106,198	41,905,215	43,457,495
Real Estate/Mortgage Loans on Real Estate	Bal Sht Line 3	-	-	-
Stocks (Preferred & Common)	Bal Sht Line 2	-	-	-
Restricted Reserve	calculated	10,077,279	10,404,613	10,743,045
Liquid assets	calculated	40,106,198	41,905,215	43,457,495
Aggregate Health Policy Reserves	Bal Sht Line 11	16,269,751	16,805,948	17,360,376
Ceded Reinsurance Premiums Payable	Bal Sht Line 12	774,440	799,963	826,354
Total claims reserves	calculated	17,044,191	17,605,911	18,186,730
Total liabilities	Bal Sht Line 17	23,169,630	24,267,928	25,098,313
Total capital and surplus	Bal Sht Line 24	16,936,568	17,637,287	18,351,916
Capitol stock	Bal Sht Line 18	-	-	-
Surplus	calculated	16,936,568	17,637,287	18,351,916
Net Premium Income	P and L Line 2	264,766,703	273,464,228	282,456,140
Total Hospital and Medical (net)	P and L Line 15	238,854,705	246,710,711	254,833,077
Divided by months in year	given	12	12	12
Avg claims expense	calculated	19,904,559	20,559,226	21,236,090
Ratio/Financial Analysis				
Primary Restricted Reserve	calculated	250,000	250,000	250,000
Secondary Restricted Reserve	calculated	9,827,279	10,154,613	10,493,045
Total Restricted Reserve Requirement	calculated	10,077,279	10,404,613	10,743,045
Minimum Net Worth Required	calculated	13,238,335	13,673,211	14,122,807
Working capital	given	500,000	500,000	500,000
Total Initial Required Net Worth	calculated	13,738,335	14,173,211	14,622,807
Liabilities to Liquid Assets	calculated	58%	58%	58%
Capital & Surplus/Liabilities	calculated	73%	73%	73%
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	442,818	446,671	450,070
Test #1 Combined Ratio plus 2 pts	calculated	98%	98%	98%
Additional underwriting expense	calculated	5,295,334	5,469,285	5,649,123
Test #2 Combined Ratio plus 4 pts	calculated	100%	100%	100%
Additional underwriting expense	calculated	10,590,668	10,938,569	11,298,246
Test #3 Combined Ratio plus 6 pts	calculated	102%	102%	102%
Additional underwriting expense	calculated	15,886,002	16,407,854	16,947,368
C&S after test #1	calculated	11,641,234	12,168,002	12,702,794
C&S after test #2	calculated	6,345,900	6,698,718	7,053,671
C&S after test #3	calculated	1,050,566	1,229,433	1,404,548

Eastern Oregon 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	12,431,250	17,160,299	20,648,910
2.	Stocks (Preferred & Common)	6,693,750	9,240,161	11,118,644
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	40,296,238	39,944,341	41,359,285
7.	All Other Assets	2,643,678	2,730,627	2,820,533
8.	Total Admitted Assets (Lines 1+2+3+4+5+6+7)	**62,064,917**	**69,075,429**	**75,947,371**
	Liabilities			
9.	Losses (Unpaid Claims for Accident and Health Policies)	25,473,492	26,311,300	27,177,593
10.	Unpaid Claims Adjustment Expenses	1,212,538	1,252,418	1,293,653
11.	Aggregate Health Policy Reserves	-	-	-
12.	Ceded Reinsurance Premiums Payable	216,250	227,063	227,063
13.	Amounts Due To Parents, Subsidiaries & Affiliates	-	-	-
14.	MLR Rebates	-	-	-
15.	Premiums Received In Advance	3,476,205	3,590,535	3,708,753
16.	All Other Liabilites	5,285,971	5,926,560	6,170,603
17.	Total Liabilities (Lines 9+10+11+12+13+14+15+16)	**35,664,456**	**37,307,875**	**38,577,665**
	Capital and Surplus			
18.	Capital Stock			
19.	Gross Paid In And Contributed Surplus	21,250,000	21,250,000	21,250,000
20.	Surplus Notes	-	-	-
21.	Unassigned Funds (Surplus)	5,150,461	10,517,553	16,108,353
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)	26,400,461	31,767,553	37,358,353
25.	Liabilities and Surplus (Lines 17+24)	62,064,917	69,075,429	75,936,018
	Risk-Based Capital Analysis			
25.	Authorized Control Level Risk-Based Capital	13,297,904	13,360,582	13,564,419
26.	Calculated Risk-Based Capital (Line 24 / Line 25)	198.5%	237.8%	275.4%

Eastern Oregon 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	750,000	750,000	750,000
2. Net Premium Income	414,549,599	428,139,481	442,189,344
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)	**414,549,599**	**428,139,481**	**442,189,344**
Hospital and Medical:			
9. Hospital/Medical Benefits	263,908,995	272,588,801	281,563,721
10. Other Professional Services	78,749,145	81,339,156	84,017,228
11. Prescription Drugs	32,772,000	33,849,851	34,964,349
12. Aggregate Write-Ins For Other Hospital and Medical	-		
13. Subtotal (Lines 9+10+11+12)	**375,430,139**	**387,777,808**	**400,545,298**
Less:			
14. Net Reinsurance Recoveries	1,453,200	1,525,860	1,602,153
15. Total Hospital and Medical (Lines 13 - 14)	373,976,939	386,251,948	398,943,145
16. Non-Health Claims (net)			
17. Claims Adjustment Expenses	16,083,427	16,612,401	17,159,361
18. General Administrative Expenses	19,657,522	20,304,046	20,972,552
19. Increase In Reserves For Life & Accident And Health Contacts			
20. Total underwriting deductions (Lines 15+16+17+18+19)	**409,717,888**	**423,168,395**	**437,075,057**
21. Net underwriting gain or loss (Lines 8 - 20)	4,831,711	4,971,086	5,114,286
22. Net investment income earned	318,750	396,007	476,513
23. Net investment gains (losses) (Lines 22 + 26)	318,750	396,007	476,513
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)	**5,150,461**	**5,367,093**	**5,590,800**
29. Capital and Surplus Prior Reporting Year	-	26,400,461	31,767,553
30. Net Income or (Loss)	5,150,461	5,367,093	5,590,800
31. Capital Changes	21,250,000		
32. Other Increases (Decreases)			
33. Dividends to Stockholders			
34. Capital and Surplus End of Reporting Year (Lines 29 + 30 + 31 + 32 - 33)	**26,400,461**	**31,767,553**	**37,358,353**
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)	1570%	1348%	1184%
44 Authorized Control Level Risk-Based Capital	13,297,904	13,360,582	13,564,419
45 Risk Based Capital Calculation	1.985	2.378	2.754

Eastern Oregon 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	62,064,917	69,075,429	75,947,371
Real Estate/Mortgage Loans on Real Estate	Bal Sht Line 3	-	-	-
Stocks (Preferred & Common)	Bal Sht Line 2	-	-	-
Restricted Reserve	calculated	15,707,372	16,218,831	16,747,631
Liquid assets	calculated	62,064,917	69,075,429	75,947,371
Aggregate Health Policy Reserves	Bal Sht Line 11	25,473,492	26,311,300	27,177,593
Ceded Reinsurance Premiums Payable	Bal Sht Line 12	1,212,538	1,252,418	1,293,653
Total claims reserves	calculated	26,686,030	27,563,717	28,471,246
Total liabilities	Bal Sht Line 17	35,664,456	37,307,875	38,577,665
Total capital and surplus	Bal Sht Line 24	26,400,461	31,767,553	37,358,353
Capitol stock	Bal Sht Line 18	-	-	-
Surplus	calculated	26,400,461	31,767,553	37,358,353
Net Premium Income	P and L Line 2	414,549,599	428,139,481	442,189,344
Total Hospital and Medical (net)	P and L Line 15	373,976,939	386,251,948	398,943,145
Divided by months in year	given	12	12	12
Avg claims expense	calculated	31,164,745	32,187,662	33,245,262
Ratio/Financial Analysis				
Primary Restricted Reserve	calculated	250,000	250,000	250,000
Secondary Restricted Reserve	calculated	15,457,372	15,968,831	16,497,631
Total Restricted Reserve Requirement	calculated	15,707,372	16,218,831	16,747,631
Minimum Net Worth Required	calculated	20,727,480	21,406,974	22,109,467
Working capital	given	500,000	500,000	500,000
Total Initial Required Net Worth	calculated	21,227,480	21,906,974	22,609,467
Liabilities to Liquid Assets	calculated	57%	54%	51%
Capital & Surplus/Liabilities	calculated	74%	85%	97%
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	4,831,711	4,971,086	5,114,286
Test #1 Combined Ratio plus 2 pts	calculated	97%	97%	97%
Additional underwriting expense	calculated	8,290,992	8,562,790	8,843,787
Test #2 Combined Ratio plus 4 pts	calculated	99%	99%	99%
Additional underwriting expense	calculated	16,581,984	17,125,579	17,687,574
Test #3 Combined Ratio plus 6 pts	calculated	101%	101%	101%
Additional underwriting expense	calculated	24,872,976	25,688,369	26,531,361
C&S after test #1	calculated	18,109,469	23,204,764	28,514,566
C&S after test #2	calculated	9,818,477	14,641,974	19,670,779
C&S after test #3	calculated	1,527,485	6,079,184	10,826,992

Please provide any text, tables, numbers, etc. that you would like to communicate but were not able to include within the prece

Overall Structure:
Eastern Oregon CCO will continue to be comprised of eight partners.

EOCCO currently holds enough capital and has a net worth to exceed initial requirements. It is projected that the Company cu
Based on the analysis tabs, of all membership-level scenarios, the Company would also have enough capital to cover all three

The eight partners and interests will remain unchanged from the current structure:

Partner	Interest %
ODS Community Health (Moda)	29%
Greater Oregon Behavioral Health, Inc.	29%
Good Shepherd	10%
Grande Ronde	10%
St. Anthony's	10%
St. Alphonsus	10%
Yakima Valley Farm Workers	1%
Eastern Oregon IPA	1%

Region/Counties:
The desired geographic region that EOCCO would operate in will remain unchanged: Baker, Gilliam, Grant, Harney, Lake, Ma

Enrollment Levels:

The Company's best estimate is to retain 100% of this market. The Company believes that its strong provider partnerships will
care while remaining within the 3.4% annual medical trend target. It is expected that EOCCO will be able to successfully mana
125% of the total estimated enrollment and be able to stay within the 3.4% annual trend target while effectively managing fixed
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 Ra
for its rating area. The gross rate was chosen because the Company intends to achieve 100% of the bonus pool. While the Co
achieve, it also believes that its structure and strong provider-partnerships and success record with administering the EOCCO

Included in the revenue amount is the projected maternity payments based on the projected rate from Attachment 12 - CCO 2
rate, excluding tax, for its rating area and multiplied that with the projected births for the region based on the projected enrollm

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
90% of total revenues.

Administrative Expenses:
The adminstrative expenses have been estimated using the rating methodology for the non-medical load administration and c
underwriting results.

Other:
Reinsurance - Reinsurance premiums are based on the current market per member per month rate and increases 5

	Reinsurance recoveries are based on a conservative 56% of premium.
Investment Income -	Investment income is assumed at 1.5% of invested capital.

eding reports.

rrently has an RBC that exceeds 200%.
stress test scenarios in all years.

lheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wheeler counties.

l allow it to continue to deliver high-quality
age membership levels between 75% and
l and variable administrative costs and

ate Methodology Appendix. The company assumed the average gross rate, excluding tax,
ompany acknowledges that the performance metrics are progressively more difficult to
through its affiliates demonstrates that this is achievable.

.0 Procurement Rate Methodology Appendix. The Company assumed the average gross
ent targets.

t.

l non-medical load amounts. Total Pay-for-Performance amounts were also projected at

ase management services. The 1% profit contingency has been factored into the

% each year.

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.**

   EOCCO has numerous ways to track and report on clinical value and efficiency of services delivered to 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 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 employ risk-adjusted cost analysis to identify areas of opportunity for efficiency improvement. A retrospective risk score is used to provide a treatment-agnostic view of the conditions present in the population, so that 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 track avoidable costs in several ways. For example, we 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 is further broken down into ‘potentially avoidable’ vs. ‘not avoidable’ events, and frequent ED utilizers are tracked. In evaluating readmissions, we 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 regularly monitor rates of

primary care utilization, with the intent that investment there will reduce downstream ED, hospital, and specialist costs. Members with chronic conditions but without primary care utilization are identified 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 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. EOCCO uses predictive modeling, in combination with aggregate member-level cost reports, to identify and track these members. Output is then 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.

EOCCO also reviews 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 are identified and discussed. For example, we recently have been looking into billing intensity of office visits and ED visits, to address the creep of RVUs over time.

We 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 includes a count of ED visits in the prior year to help clinics manage high utilizers; the same report also includes 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 report identifies 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, EOCCO maintains 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 EOCCO, GOBHI and provider staff focused on improving quality and reducing costs.

Our HIE tool, Arcadia Analytics, 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 is strongly tied to our control of cost, quality, and outcomes. Similarly, PreManage gives providers the ability to coordinate and manage care for members utilizing ED and inpatient services.

Through long experience managing health plans for EOCCO and Moda, we have a highly developed infrastructure for managing utilization of services that are high cost and/or have

potential for overutilization. We 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 are investigated for the purpose of determining whether prior authorization is warranted. In some cases, prior auth requirements are 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 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 works with internal data analytics teams to run queries on a regular basis that may trigger a focused review. The team also initiates inquires based upon employee or external tips, as well as knowledge gained form participation in local and national Anti-Fraud groups. We are in the process of implementing new FWA detection software, HealthCare Fraud Shield, which will be in place by the end of 2019. 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 identifies incorrect coding and recommends corrections or denials prior to payment. In addition to pre-payment editing, we utilize our embedded clinical editing to 'profile' providers who may be utilizing abusive billing practices. We 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 is 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.

EOCCO 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:

- Continue to 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.
- Continue to distribute Community Benefit Initiative Reinvestments (CBIRs) through the local CACs and through Grant funds that focus on reducing avoidable healthcare services utilization and costs.

- Continue collaboration 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?

The 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. The reason for this is that the vast impact to a member and/or community when Health-Related Services are deployed. The strategy is listed again below:

- Continue to 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.

- Continue to distribute Community Benefit Initiative Reinvestments (CBIRs) through the local CACs and through Grant funds that focus on reducing avoidable healthcare services utilization and costs.

- Continue collaboration 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?

EOCCO has two unique processes to fund SDOH-HE initiatives. First EOCCO distributes Community Benefit Initiative Reinvestments (CBIRs) to the 12 local CACs to utilize for SDOH-HE and transformation projects that connect to their Community Health Improvement Plans (CHIPs). LCACs are required to select appropriate interventions, evaluation metrics, and methods to measure impact which is reported to EOCCO on a quarterly basis. The second way EOCCO funds SDOH-HE initiatives is through the use of Health Related Services for needs that are unique to each community. Examples of how EOCCO utilizes these funds include providing backpacks for children at a community event, gift cards for members who complete a wellness visit, and cribs for mothers who complete a prenatal care visit. Primary care clinics and other community partners within our service area frequently submit requests for health related services that they need funding for. This is then approved and administered accordingly. EOCCO tracks which members these services are provided to in order to evaluate the success of these investments. Many of the funded initiatives are 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.**

   EOCCO produces 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 are able to identify areas of relative efficiency or inefficiency between hospitals. As a further example, we 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 by 2021, 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.**

   EOCCO has a long history of reinvesting 100% of its quality pool dollars back into providers and communities. Those reinvestments occur in a variety of different forms and funds are routinely distributed to non-clinical providers including public health and other partners for addressing SDOH and health related services. For example, on an annual basis 7% of quality pool funding is dedicated to our 12 local community advisory councils to fund Community Health Improvement Plan (CHIP) activities to address social determines of health and 10% of quality pool funds are dedicated to community benefit initiative reinvestment projects that any partner in the service area can apply for. Examples of SDOH-HE funding include but are not limited to funding a frontier Veggie Rx voucher

program, funding for the Union County Warming Station, and funding for various public health departments to implement projects to help meet quality metrics or address CHIP activities. In 2019 EOCCO created a Public Health fund using quality pool earnings to pay for upstream investments that address projects to meet quality metrics targets, CHIP identified activities or items addressed in the State Health Improvement plan. EOCCO 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.

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.**

   EOCCO plans to continue reinvesting 100% of its available quality pool funds back into providers and communities. Approximately 25% of the funds are available and have historically been distributed to non-clinical providers. A new public health fund has been established using quality pool earnings for upstream investments into CHIP identified activities in 2019. As we transition to CCO 2.0 EOCCO will make further 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, food insecurity, transportation and early childhood education as well as support partnerships identified in the community engagement plan tables. EOCCO will continue to engage our Regional and Local Community Advisory Councils, our Clinical Advisory Council, the EOCCO 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?**

   EOCCO reinvests 100% of its available quality pool funding back into providers and communities. 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 Local 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 EOCCO Board.

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

   In collaboration with its Clinical Advisory Panel (CAP), Local Community Advisory Councils (LCACs) and Regional Community Advisory Council (RCAC), EOCCO's risk contract surplus incentive measure settlement (RCSIMS) subcommittee of the board recommends the quality pool funding projects, initiatives and the annual allocation of funds. These recommendations are discussed and approved by the EOCCO board annually.

5. **When will Applicant invest its Quality Pool earnings, compared with when these earning are received?**

   Currently quality pool investments are distributed after the earnings are received. This is to ensure we know what dollars are available to reinvest. Due to our history of reinvesting quality pool dollars back into providers and communities most ongoing initiatives are funded on an annual basis and then replenished 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.

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.**

   EOCCO 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 audit and market check provisions to ensure market competitiveness. EOCCO affiliate, 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 EOCCO.

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, EOCCO's PBM relationship using OPDP requires that all pharmacy claims and manufacturer rebates administered through its PBM are 100% pass-through. We have established a long history ensuring this dating to October 2016 when we were the first CCO in Oregon to convert our PBM program to OPDP once legislative authority was established allowing OPDP to provide PBM services for Medicaid. EOCCO validates 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 EOCCO. 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.**

   Yes, EOCCO currently publishes its PDL. EOCCO's 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.**

   EOCCO's coverage criteria is not currently published online; however, coverage criteria is 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 can be found at: https://www.eocco.com/eocco/-/media/eocco/pdfs/rx/rx_priorauth_ohp.pdf

   EOCCO 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 EOCCO's PDL aligns with OHA's fee-for-service PDL, there is a key area where the PDLs differ. EOCCO'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, EOCCO will fully align its PDL with OHA's fee-for-service PDL. However, in doing so, EOCCO 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, EOCCO 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 EOCCO).

2. **Does the Applicant currently participate and file financial statements with the NAIC?**

   No, EOCCO does not file financial statements with the NAIC. As mentioned above, EOCCO 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, EOCCO has not prepared a RBC calculation. As mentioned above, EOCCO 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, EOCCO 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 EOCCO).

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, EOCCO seeks an exemption from SAP and NAIC reporting for 2020 in order to allow sufficient time for hiring and training personnel. EOCCO'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 with our response.

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 VBP's 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 EOCCO's financial and actuarial teams develop a global budget which is approved by the EOCCO Board. The global budget is developed using a ground up approach to ensure adequate funding is available to cover all services we are required to provide to the EOCCO population. To ensure that expenditures are tracking with the budget, the EOCCO analytics team produces a variety of reports and analysis that highlight areas for focus across service categories.

   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 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) are summarized by provider to spot trends and outliers. Reports are reviewed regularly by the EOCCO board, CAP, and Community Advisory Councils, 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 EOCCO's existing VBP arrangements which include foundational payments for PCPCH's, shared savings/shared risk models, payments for meeting quality targets and full risk capitation, EOCCO 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 are 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, EOCCO has 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.**

   Yes, 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.)**

   EOCCO has active reinsurance coverage with RGA where EOCCO receives 90% coinsurance for eligible claims paid on members in excess of $350,000 for:
   - Inpatient Hospital Services
   - Outpatient Health Services
   - Inpatient Rehabilitation Services
   - Physician Services
   - Skilled Nursing Facility Services
   - Drug Related Services

2. **What is the Applicant's reasoning for selecting the reinsurance policy described above?**

   EOCCO selected 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 the Applicant 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?**

   EOCCO's contract with RGA is for the period January 1, 2019 through December 31, 2019. EOCCO renews coverage annually. The renewal process and binding of coverage typically occurs in October.

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.**

   EOCCO has experienced positive operating cash flow and net income subsequent to EOCCO's initial source of capital in 2012-2013. EOCCO has not required additional external sources of capital.

2. **Please describe Applicant's possible future sources of capital.**

   EOCCO has generated positive operating cash flow and anticipates positive cash flow in the future, eliminating the need for external sources of capital.

3. **What strategies will the Applicant use to ensure solvency thresholds are maintained?**

   EOCCO has historically reported loss ratios in excess of minimum requirements and, primarily based on its low risk investment portfolio weighted in cash and cash equivalents, has sufficient capital in the event claims experience is unfavorable. In addition, EOCCO has established value based payment models including full risk 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.**

   EOCCO performs an annual validation of encounter data audit, in compliance with OHA requirements established in 2016. Member chart notes are 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?

EOCCO will continue to perform validation of encounter data annual audit in compliance with the OHA requirements.

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.**

   EOCCO 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, EOCCO 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. EOCCO 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.

Assurances of Compliance with Medicaid Regulations

a. Medicaid Assurance #1 – 42 CFR § 438.206 Availability of services.

EOCCO ensures that all members have access to services in a timely manner consistent with the appropriateness of their health need. EOCCO 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. EOCCO 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.

EOCCO and its provider partners ensure that the capacity of providers is sufficient in numbers to meet the healthcare needs of EOCCO's membership. EOCCO 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.

EOCCO has policies and procedures that ensure it coordinates the care its members receive. EOCCO utilizes a Multidisciplinary Team and Health Risk assessment process to identity and coordinate member health concerns in a timely manner. Once concerns are identified EOCCO assures that care is coordinated among the member's care team and primary care physician. Additionally, EOCCO 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.

EOCCO 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 ithin 24 hours of receipt of a request. If preauthorization for a prescription cannot be completed within 24 hours, EOCCO 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.

EOCCO 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 EOCCO'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.

EOCCO 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. EOCCO 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.

EOCCO will safeguard confidential information about individuals. We will inform individuals about our privacy practices and will respect individual privacy rights. EOCCOs 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. EOCCO 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.

EOCCO 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. EOCCO 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.

EOCCO may delegate functions to third parties related to its Medicaid Plans. Medicaid program requirements apply to subcontractors who contract with EOCCO to provide certain administrative or health care services for enrollees on behalf of EOCCO. EOCCO shall require all subcontractors to comply with all applicable State and Federal requirements. EOCCO 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.

EOCCO'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. EOCCO clinical practice guidelines are reviewed and approved by the EOCCO's Quality Improvement Committee to ensure guidelines are being applied consistently. Clinical practice guidelines are posted on EOCCO'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.

EOCCO 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. EOCCO utilizes systems that accurately collect, report and process member, claims and provider data in a timely and accurate fashion. Additionally, EOCCO 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.

EOCCO CCO 2.0 DSN Report

This report has been redacted per ORS 192.355(2)

Attachment 13 — Attestations

Applicant Name: Eastern Oregon Coordinated Care Organization

Authorizing Signature: _____

Printed Name: Sean Jessup

Instructions: For each attestation, Applicant will check "yes," or "no." A "yes" answer is normal, and an explanation will be furnished if Applicant's response is "no". Applicant must respond to all attestations. If an attestation has more than one question and Applicant's answer is "no" to any question, check "no" and provide an explanation.

These attestations must be signed by a representative of Applicant.

Unless a particular item is expressly effective at the time of Application, each attestation is effective starting at the time of Readiness Review and continuing throughout the term of the Contract. Each section of attestations refers to a questionnaire in an Attachment, which may furnish background and related questions.

A. General Questions Attestations (Attachment 6)

1. Contract

a. Is Applicant willing to enter into a Contract for 2020 in the form of Appendix B?

☒ Yes ☐No

If "no" please provide explanation: _____

b. Is Applicant willing to satisfy Readiness Review standards by September 30, 2019?

☒ Yes ☐No

If "no" please provide explanation: _____

2. Subcontracts

a. Is Applicant willing to hold written agreements with Subcontractors that clearly describe the scope of work?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to provide to OHA an inventory of all work described in this Contract that is delegated or subcontracted and identify the entity performing the work?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to provide to OHA unredacted copies of written agreements with Subcontractors?

☒Yes ☐No

If "no" please provide explanation: _____

_____

3. Third Party Liability and Personal Injury Lien

a. Is Applicant willing to identify and require its Subcontractors and Providers to identify and promptly report the presence of a Member's Third Party Liability?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to document all efforts to pursue financial recoveries from third party insurers?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to report and require its Subcontractors to report all financial recoveries from third party insurers?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to provide and require its Affiliated entities and Subcontractors to provide to OHA all information related to TPL eligibility to assist in the pursuit of financial recovery?

☒Yes ☐No

If "no" please provide explanation: _____

_____

4. Oversight and Governance

a. Is Applicant willing to provide its organizational structure, identifying any relationships with subsidiaries and entities with an ownership or Control stake?

☒Yes ☐No

If "no" please provide explanation: _____

_____

B. Provider Participation and Operations Attestations (Attachment 7)

1. General Questions

a. Will Applicant have an individual accountable for each of the operational functions described below?

- Contract administration
- Outcomes and evaluation
- Performance measurement
- Health management and Care Coordination activities
- System coordination and shared accountability between DHS Medicaid-funded LTC system and CCO
- Behavioral Health (mental health and addictions) coordination and system management
- Communications management to Providers and Members
- Provider relations and network management, including credentialing
- Health information technology and medical records
- Privacy officer
- Compliance officer
- Quality Performance Improvement
- Leadership contact for single point of accountability for the development and implementation of the Health Equity Plan
- Traditional Health Workers Liaison

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Will Applicant participate in the Learning Collaboratives required by ORS 442.210?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Will Applicant collect, maintain and analyze race, ethnicity, and preferred spoken and written languages data for all Members on an ongoing basis in accordance with standards jointly established by OHA and DHS in order to identify and track the elimination of health inequities?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Will Applicant (i) authorize the provision of a drug requested by the Primary Care Physician (PCP) or Referral Provider, if the approved prescriber certifies medical necessity for the drug such as: the formulary's equivalent has been ineffective in the treatment or the formulary's drug causes or is reasonably expected to cause adverse or harmful reactions to the Member and (ii) reimburse Providers for dispensing a 72-hour supply of a drug that requires Prior Authorization?

☒Yes ☐No

If "no" please provide explanation: _____

_____

e. Will Applicant comply with all applicable Provider requirements of Medicaid law under 42 CFR Part 438, including Provider certification requirements, anti-discrimination requirements, Provider participation and consultation requirements, the prohibition on interference with Provider advice, limits on Provider indemnification, rules governing payments to Providers, and limits on physician incentive plans?

☒Yes ☐No

If "no" please provide explanation: _____

_____

f. Will Applicant ensure that all Provider, facility, and supplier contracts or agreements contain the required contract provisions that are described in the Contract?

☒Yes ☐No

If "no" please provide explanation: _____

_____

g. Will Applicant have executed Provider, facility, and supplier contracts in place to demonstrate adequate access and availability of Covered Services throughout the requested Service Area?

☒Yes ☐No

If "no" please provide explanation: _____

_____

h. Will Applicant have all Provider contracts or agreements available to OHA in unredacted form?

☒Yes ☐No

If "no" please provide explanation: _____

_____

i. Will Applicant's contracts for administrative and management services contain the OHA required Contract provisions?

☒Yes ☐No

If "no" please provide explanation: _____

_____

j. Will Applicant establish, maintain, and monitor the performance of a comprehensive network of Providers to ensure sufficient access to Medicaid Covered Services, including comprehensive behavioral and oral health services, as well as supplemental services offered by the CCO in accordance with written policies, procedures, and standards for participation established by the CCO? Participation status will be revalidated at appropriate intervals as required by OHA regulations and guidelines.

☒Yes ☐No

If "no" please provide explanation: _____

_____

k. Will Applicant have executed written agreements with Providers (first tier, downstream, or related entity instruments) structured in compliance with OHA regulations and guidelines?

☒Yes No

If "no" please ☐provide explanation: _____

_____

l. Will Applicant have executed written agreements with Local Mental Health Authorities throughout its Service Area, structured in compliance with OHA regulations and guidelines?

☒Yes ☐No

If "no" please provide explanation: _____

_____

m. Will Applicant develop a comprehensive Behavioral Health plan in collaboration with the Local Mental Health Authority and other Community partners?

☒Yes ☐No

If "no" please provide explanation: _____

_____

n. Will Applicant coordinate and collaborate on the development of the Community health improvement plan (CHP) under ORS 414.627 with the Local Mental Health Authority's comprehensive local plan for the delivery of mental health services (ORS 430.630)?

☒Yes ☐No

If "no" please provide explanation: _____

_____

o. Will Applicant, through its contracted Participating Provider Network, along with other specialists outside the network, Community resources or social services within the CCO's Service Area, provide ongoing primary care, Behavioral Health care, oral health care, and specialty care as needed and will guarantee the continuity of care and the integration of services as described below?

- Prompt, convenient, and appropriate access to Covered Services by Members 24 hours a day, 7 days a week;
- The coordination of the individual care needs of Members in accordance with policies and procedures as established by the Applicant;
- Member involvement in decisions regarding treatment, proper education on treatment options, and the coordination of follow-up care;
- Effectively addressing and overcoming barriers to Member compliance with prescribed treatments and regimens; and
- Addressing diverse patient populations in a linguistically diverse and culturally competent manner.

☒Yes ☐No

If "no" please provide explanation: _____

_____

p. Will Applicant establish policies, procedures, and standards that:

- Ensure and facilitate the availability, convenient, and timely access to all Medicaid Covered Services as well as any supplemental services offered by the CCO;
- Ensure access to medically necessary care and the development of medically necessary individualized care plans for Members;
- Promptly and efficiently coordinate and facilitate access to clinical information by all Providers involved in delivering the individualized care plan of the Member while following Timely Access to Services standards;
- Communicate and enforce compliance by Providers with medical necessity determinations; and
- Do not discriminate against Medicaid Members, including providing services to individuals with disabilities in the most integrated Community setting appropriate to the needs of those individuals.

☒Yes ☐No

If "no" please provide explanation: _____

_____

q. Will Applicant have verified that contracted Providers included in the CCO Facility Table are Medicaid certified and the Applicant certifies that it will only contract with Medicaid certified Providers in the future?

☒Yes ☐No

If "no" please provide explanation: _____

_____

r. Will Applicant provide all services covered by Medicaid and comply with OHA coverage determinations?

☒Yes ☐No

If "no" please provide explanation: _____

_____

s. Will Applicant have an Medicare plan to serve Fully Dual Eligibles either through contractual arrangement or owned by Applicant or Applicant parent company to create integrated Medicare-Medicaid opportunities during the contract period? [Plan can be a Dual Special Needs Plan or MA plan that offers low premiums and integrated Part D medications options].

☒Yes ☐No

If "no" please provide explanation:

t. Will Applicant, Applicant staff and its Affiliated companies, subsidiaries or Subcontractors (first tier, downstream, and related entities), and Subcontractor staff be bound by 2 CFR 376 and attest that they are not excluded by the Department of Health and Human Services Office of the Inspector General or by the General Services Administration? Please note that this attestation includes any member of the board of directors, key management or executive staff or major stockholder of the Applicant and its Affiliated companies, subsidiaries or Subcontractors (first tier, downstream, and related entities).

☒Yes ☐No

If "no" please provide explanation: _____

_____

u. Is it true that neither the state nor federal government has brought any past or pending investigations, legal actions, administrative actions, or matters subject to arbitration involving the Applicant (and Applicant's parent corporation, subsidiaries, or entities with an ownership stake, if applicable) or its Subcontractors, including key management or executive staff, or major shareholders over the past three years on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services?

☒Yes ☐No

If "no" please provide explanation: _____

_____

2. Network Adequacy

a. Is Applicant willing to monitor and evaluate the adequacy of its Provider Network?

☒ Yes ☐No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to remedy any deficiencies in its Provider Network within a specified timeframe when deficiencies are identified?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to report on its Provider Network in a format and frequency specified by OHA?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to collect data to validate that its Members are able to access care within time and distance requirements?

☒Yes ☐No

If "no" please provide explanation: _____

_____

e. Is Applicant willing to collect data to validate that its Members are able to make appointments within the required timeframes?

☒Yes ☐No

If "no" please provide explanation: _____

_____

f. Is Applicant willing to collect data to validate that its Members are able to access care within the required timeframes?

☒Yes ☐No

g. Is Applicant willing to arrange for Covered Services to be provided by Non-Participating Providers if the services are not timely available within Applicant's Provider Network?

☒Yes ☐No

3. Fraud, Waste and Abuse Compliance

a. Is Applicant willing to designate a Compliance Officer to oversee activities related to the prevention and detection of Fraud, Waste and Abuse?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to send two representatives, including the Applicant's designated Compliance Officer and another member of the senior executive team to attend a mandatory Compliance Conference on May 30, 2019?

☒Yes ☐No

If "no" please provide explanation: _____

_____

C. Value-Based Payment (VBP) Attestations (Attachment 8)

1. Have you reviewed the VBP Policy Requirements set forth in the VBP Questionnaire?

☒ Yes ☐No

If "no" please provide explanation: _____

_____

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

☒ Yes ☐No

If "no" please provide explanation: _____

_____

3. Can you implement and report on VBP as defined by VBP Questionnaire and the Health Care Payment Learning and Action Network's (LAN's) "Alternative Payment Model Framework White Paper Refreshed 2017" (https://hcp-lan.org/apm-refresh-white-paper/) and the OHA Value-Based Payment Roadmap Categorization Guidance for Coordinated Care Organizations?

☒Yes ☐No

If "no" please provide explanation: _____

_____

4. Will you begin CCO 2.0 – January 2020 – with at least 20% of your projected annual payments to your Providers under contracts that include a Value-Based Payment component as defined by the Health Care Payment Learning and Action Network's (LAN's) "Alternative Payment Model Framework White Paper Refreshed 2017" (https://hcp-lan.org/apm-refresh-white-paper/), Pay for Performance category 2C or higher and the OHA Value-Based Payment Roadmap Categorization Guidance for Coordinated Care Organizations?

☒Yes ☐No

If "no" please provide explanation: _____

_____

5. Do you permit OHA to publish your VBP data such as the actual VBP percent of spending that is LAN category 2C or higher and spending that is LAN category 3B or higher, as well as data pertaining to your care delivery areas, Patient-Centered Primary Care Home (PCPCH) payments, and other information about VBPs required by this RFA? (OHA does not intend to publish specific payments amounts from an Applicant to a specific rovider.)

☒Yes ☐No

If "no" please provide explanation: _____

_____

6. Do you agree to develop mitigation plans for adverse effects VBPs may have on health inequities, health disparities, or any adverse health-related outcomes for any specific population (including racial, ethnic and culturally-based communities; LGBTQ people; persons with disabilities; people with limited English proficiency; and immigrants or refugees and Members with complex health care needs, as well as populations at the intersections of these groups) and to report on these plans to OHA annually?

☒Yes ☐No

If "no" please provide explanation: _____

_____

7. Do you agree to the requirements for VBP targets, care delivery areas and PCPCH clinics for years 2020 through 2024, as set forth in the VBP Questionnaire?

☒Yes ☐No

If "no" please provide explanation: _____

_____

8. Do you agree to the requirements for VBP data reporting for years 2020 through 2024, as set forth in the VBP Questionnaire?

☒Yes ☐No

If "no" please provide explanation: _____

_____

9. Should OHA contract with one or more other CCOs serving Members in the same geographical area, will you participate in OHA-facilitated discussions to select performance measures to be incorporated into each CCO's VBP Provider contracts for common Provider types and specialties?

☒Yes ☐No

If "no" please provide explanation: _____

_____

10. If, after the discussion described in the previous question, OHA informs you of the Provider types and specialties for which the performance measures apply, will you incorporate all selected measures into applicable Provider contracts?

☒Yes ☐No

If "no" please provide explanation: _____

_____

D. Health Information Technology (HIT) Attestations (Attachment 9)

1. HIT Roadmap

a. Does Applicant agree to participate in an interview/demonstration and deliver an HIT Roadmap with any refinements/adjustments agreed to with OHA during Readiness Review, for OHA approval?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Does Applicant agree to provide an annual HIT Roadmap update for OHA approval to include status/progress on CCO-identified milestones, and any adjustments to the HIT Roadmap; as well as participate in an annual interview with OHA?

☒Yes ☐No

If "no" please provide explanation: _____

_____

2. HIT Partnership

a. Does Applicant agree to participate in the HIT Commons beginning 2020, including agreeing to do all of the following:

- Maintaining an active, signed HIT Commons MOU and adhering to its terms,
- Paying annual HIT Commons assessments, and
- Serving, if elected, on the HIT Commons Governance Board or one of its committees?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Does Applicant agree to participate in OHA's HIT Advisory Group, (HITAG), at least once annually?

☒Yes ☐No

If "no" please provide explanation: _____

_____

3. Support for EHR Adoption

a. Will Applicant support EHR adoption for its contracted physical health Providers?

☒ Yes ☐No

If "no" please provide explanation: _____

_____

b. Will Applicant support EHR adoption for its contracted Behavioral Health Providers?

☒ Yes ☐No

If "no" please provide explanation: _____

_____

c. Will Applicant support EHR adoption for its contracted oral health Providers?

☒ Yes ☐No

If "no" please provide explanation: _____

_____

d. During Year 1, will Applicant report on the baseline of EHR adoption among its contracted physical health Providers, set Improvement Targets, and provide supporting detail about its implementation approach?

☒Yes ☐No

If "no" please provide explanation: _____

_____

e. During Year 1, will Applicant report on the baseline of EHR adoption among its contracted Behavioral Health Providers, set Improvement Targets, and provide supporting detail about its implementation approach?

☒Yes ☐No

If "no" please provide explanation: _____

_____

f. During Year 1, will Applicant report on the baseline of EHR adoption among its contracted oral health Providers, set Improvement Targets, and provide supporting detail about its implementation approach?

☒Yes ☐No

If "no" please provide explanation: _____

_____

g. Will Applicant report to the state annually on which EHR(s) each of its contracted physical health Providers is using, by means of definitions and data sources agreed upon during Readiness Review? Will reports include product and vendor name, version, and, if applicable, certification year the ONC Certification (CHPL) number for Certified EHR Technology? See https://chpl.healthit.gov/ and https://www.healthit.gov/topic/certification-ehrs/2015-edition for more information about Certified EHR Technology.

☒Yes ☐No

If "no" please provide explanation: _____

_____

h. Will Applicant report to the state annually on which EHR(s) each of its contracted Behavioral Health Providers are using, by means of definitions and data sources agreed upon during Readiness Review? Will reports include product and vendor name, version, and, if applicable, certification year the ONC Certification (CHPL) number for Certified EHR Technology? See https://chpl.healthit.gov/ and https://www.healthit.gov/topic/certification-ehrs/2015-edition for more information about Certified EHR Technology.

☒Yes ☐No

If "no" please provide explanation: _____

_____

i. Will Applicant report to the state annually on which EHR(s) each of its contracted oral health Providers is using, by means of definitions and data sources agreed upon during Readiness Review? Will reports include product and vendor name, version, and, if applicable, certification year the ONC Certification (CHPL) number for Certified EHR Technology? See https://chpl.healthit.gov/ and https://www.healthit.gov/topic/certification-ehrs/2015-edition for more information about Certified EHR Technology.

☒Yes ☐No

If "no" please provide explanation: _____

_____

4. Support for HIE

a. Will Applicant ensure access to timely Hospital event notifications for its contracted physical health Providers? If there are costs associated with ensuring access to timely Hospital event notifications for contracted Providers, will the Applicant be responsible for those costs?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Will Applicant ensure access to timely Hospital event notifications for its contracted Behavioral Health Providers? If there are costs associated with ensuring access to timely Hospital event notifications for contracted Providers, will the Applicant will be responsible for those costs?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Will Applicant ensure access to timely Hospital event notifications for its contracted oral health Providers? If there are costs associated with ensuring access to timely Hospital event notifications for contracted Providers, will the Applicant will be responsible for those costs.

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Will Applicant use Hospital event notifications within the CCO, for example to support Care Coordination and/or population health efforts?

☒Yes ☐No

If "no" please provide explanation: _____

_____

e. Will Applicant support access to health information exchange that enables sharing patient information for Care Coordination for its contracted physical health Providers?

☒Yes ☐No

If "no" please provide explanation: _____

_____

f. Will Applicant support access to health information exchange that enables sharing patient information for Care Coordination for its contracted Behavioral Health Providers?

☒Yes ☐No

If "no" please provide explanation: _____

_____

g. Will Applicant support access to health information exchange that enables sharing patient information for Care Coordination for its contracted oral health Providers?

☒Yes ☐No

If "no" please provide explanation: _____

_____

h. During Year 1, will Applicant report on the baseline of HIE access and use among its contracted physical health Providers (inclusive of Hospital event notifications and HIE for Care Coordination), set Improvement Targets, and provide supporting detail about its implementation approach?

☒Yes ☐No

If "no" please provide explanation: _____

_____

i. During Year 1, will Applicant report on the baseline of HIE access and use among its contracted Behavioral Health Providers (inclusive of Hospital event notifications and HIE for Care Coordination), set Improvement Targets, and provide supporting detail about its implementation approach?

☒Yes ☐No

If "no" please provide explanation: _____

_____

j. During Year 1, will Applicant report on the baseline of HIE access and use among its contracted oral health Providers (inclusive of Hospital event notifications and HIE for Care Coordination), set Improvement Targets, and provide supporting detail about its implementation approach?

☒Yes ☐No

If "no" please provide explanation: _____

_____

k. Will Applicant report to the state annually on which HIE tool(s) each of its contracted physical health Providers is using, using definitions and data sources agreed upon during Readiness Review?

☒Yes ☐No

If "no" please provide explanation: _____

_____

l. Will Applicant report to the state annually on which HIE tool(s) each of its contracted Behavioral Health Providers is using, using definitions and data sources agreed upon during Readiness Review?

☒Yes ☐No

If "no" please provide explanation: _____

_____

m. Will Applicant report to the state annually on which HIE tool(s) each of its contracted oral health Providers is using, using definitions and data sources agreed upon during Readiness Review?

☒Yes ☐No

If "no" please provide explanation: _____

_____

5. Health IT for VBP and Population Management.

a. For the initial VBP arrangements, will Applicant have by the start of Year 1 the HIT needed to administer the arrangements (as described in its supporting detail)?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. For the planned VBP arrangements for Years 2 through 5, does Applicant have a roadmap to obtain the HIT needed to administer the arrangements (as described in its supporting detail)?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. By the start of Year 1, will the Applicant provide contracted Providers with VBP arrangements with timely (e.g., at least quarterly) information on measures used in the VBP arrangement(s) applicable to the Providers?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. By the start of Year 1, will the Applicant provide contracted Providers with VBP arrangements with accurate and consistent information on patient attribution?

☒Yes ☐No

If "no" please provide explanation: _____

_____

e. By the start of Year 1, will the Applicant identify for contracted Providers with VBP arrangements specific patients who need intervention through the year, so they can take action before the year end?

☒Yes ☐No

If "no" please provide explanation: _____

_____

f. By the start of Year 1, will the Applicant have the capability to risk stratify and identify and report upon Member characteristics, including but not limited to past diagnoses and services, that can inform the targeting of interventions to improve outcomes?

☒Yes ☐No

If "no" please provide explanation: _____

_____

g. By the start of each subsequent year for Years 2 through 5, will the Applicant CCO provide risk stratification and Member characteristics to your contracted Providers with VBP arrangements for the population(s) included in the arrangement(s) in place for each year?

☒Yes ☐No

If "no" please provide explanation: _____

_____

E. Social Determinants of Health and Health Equity (SDOH-HE) Attestations (Attachment 10)

1. Social Determinants of Health and Health Equity Spending, Priorities, and Partnership

a. Is Applicant willing to direct a portion of its annual net income or reserves, as required by Oregon State Statute and defined by OHA in rule, to addressing health disparities and SDOH-HE?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to enter into written agreements with SDOH-HE partners that describe the following: any relationship or financial interest that may exist between the SDOH-HE partner and the CCO, how funds will be distributed, the scope of work including the domain of SDOH-HE addressed and the targeted population, whether CCO will refer Members to the SDOH-HE partner, the geographic area to be covered, how outcomes will be evaluated and measured, and how the CCO will collect and report data related to outcomes?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. When identifying priorities for required SDOH-HE spending, is Applicant willing to designate, define and document a role for the CAC in directing, tracking and reviewing spending?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to align its SDOH-HE spending priorities with the priorities identified in the Community Health Improvement Plan and its Transformation and Quality Strategy, and to include at least one statewide priority (e.g. housing-related services and supports, including Supported Housing) in addition to its Community priorities?

☒Yes ☐No

If "no" please provide explanation: _____

_____

2. Health-related Services

a. Is Applicant willing to align HRS Community benefit initiatives with Community priorities from the CCO's Community Health Improvement Plan?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to align HRS Community benefit initiatives with a designated statewide priority should OHA require it?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to designate, define and document a role for the CAC when determining how Health-Related Services Community benefit initiatives decisions are made?

☒Yes ☐No

If "no" please provide explanation: _____

_____

3. Community Advisory Council membership and role

a. Is the Applicant willing to provide to OHA an organizational chart that includes the Community Advisory Council, and notes relationships between entities, including the CAC and the Board, how information flows between the bodies, the CAC and Board connection to various committees, and CAC representation on the board?

☒Yes ☐No

If "no" please provide explanation: _____

_____

4. Health Equity Assessment and Health Equity Plan

a. Is Applicant willing to develop and implement a Health Equity Plan according to OHA guidance, which includes a plan to provide cultural responsiveness and implicit bias education and training across the Applicant's organization and Provider Network? See Sample Contract and Cultural Responsiveness Training Plan Guidance Document.

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to include in its Health Equity Plan at least one initiative using HIT to support patient engagement?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to adopt potential health equity plan changes, including requirements, focus areas and components, based on OHA plan review feedback and, when applicable, based on guidance provided by the Oregon Health Policy Board's Health Equity Committee?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to designate a single point of accountability within the organization, who has budgetary decision-making authority and health equity expertise, for the development and implementation of the Health Equity Plan?

☒Yes ☐No

If "no" please provide explanation: _____

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

☒ Yes ☐No

If "no" please provide explanation: _____

f. Is Applicant willing to a) ask vendors for cultural and linguistic accessibility when discussing bringing on new HIT tools for patient engagement and b) when possible, seek out HIT tools for patient engagement that are culturally and linguistically accessible?

☒Yes ☐No

If "no" please provide explanation: _____

5. Traditional Health Workers (THW) Utilization and Integration

a. Is Applicant willing to develop and fully implement a Traditional Health Workers Integration and Utilization Plan?

☒Yes ☐No

If "no" please provide explanation: _____

b. Is Applicant willing to work in collaboration with the THW Commission to implement the Commission's best practices for THW integration and utilization?

☒Yes ☐No

If "no" please provide explanation: _____

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

☒Yes ☐No

If "no" please provide explanation: _____

d. Is Applicant willing to develop and implement a payment strategy for THWs that is informed by the recommendations from the Payment Model Committee of the THW Commission?

☒Yes ☐No

If "no" please provide explanation: _____

e. Is Applicant willing to designate an individual within the organization as a THW Liaison as of the Effective Date of the Contract?

☒Yes ☐No

If "no" please provide explanation: _____

_____

f. Is Applicant willing to engage THWs during the development of the CHA and CHP?

☒ Yes ☐No

If "no" please provide explanation: _____

_____

g. For services that are not captured on encounter claims, is Applicant willing to track and document Member interactions with THWs?

☒Yes ☐No

If "no" please provide explanation: _____

_____

6. Community Health Assessment and Community Health Improvement Plan

a. Is Applicant willing to partner with local public health authorities, non-profit Hospitals, any CCO that shares a portion of its Service Area, and any Tribes that are developing a CHA/CHP to develop shared CHA and CHP priorities?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to align CHP priorities with at least two State Health Improvement Plan (SHIP) priorities and implement statewide SHIP strategies based on local need?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to submit its Community Health Assessment and Community Health Improvement Plan to OHA?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to develop and fully implement a community engagement plan?

☒ Yes ☐No

If "no" please provide explanation:

F. Behavioral Health Attestations (Attachment 11)

1. Behavioral Health Benefit

a. Will Applicant report performance measures and implement Evidence-Based outcome measures, as developed by the OHA Metrics and Scoring Committee, and as specified in the Contract?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Will Applicant work collaboratively with OHA and its partners to implement all of the requirements in Exhibit M of the Contract?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Will Applicant be fully responsible for the Behavioral Health benefit for Members beginning in CY 2020?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Will Applicant manage the Global Budget (as defined in ORS 414.025) in a fully integrated manner? Fully integrated manner means that Applicant will not sub-capitate any Provider or entity for Behavioral Health services separately from physical health services nor will Applicant enter into any Value-Based Payment arrangements under which Behavioral Health spending is tracked separately from physical health services.

☒Yes ☐No

If "no" please provide explanation: _____

_____

e. Will Applicant report on the information and data specified in the Performance Expectations section as specified in the Contract and submit an annual report to OAH for review and approval?

☒Yes ☐No

If "no" please provide explanation: _____

_____

f. Will Applicant have sufficient resources, including technological, financial, Provider and workforce, to integrate the Behavioral Health benefit with oral and physical health care benefits?

☒Yes ☐No

If "no" please provide explanation: _____

_____

g. Will Applicant ensure the provision of cost-effective, comprehensive, person-centered, Culturally Responsive, and integrated Community-based Behavioral Health services for Members?

☒Yes ☐No

If "no" please provide explanation: _____

_____

h. Will Applicant provide oversight, Care Coordination, transition planning and management of the Behavioral Health needs of Members to ensure Culturally Responsive and linguistically appropriate Behavioral Health services are provided in a way that Members are served in a most natural and integrated environment possible and that minimizes the use of institutional care?

☒Yes ☐No

If "no" please provide explanation: _____

_____

i. Will Applicant follow Intensive Care Coordination standards as identified in OAR 410-141-3160/70?

☒Yes ☐No

If "no" please provide explanation: _____

_____

j. Will Applicant ensure Members have access to Referral and screening at multiple health system or health care entry points?

☒Yes ☐No

If "no" please provide explanation: _____

_____

k. Will Applicant use a standardized Assessment tool, to adapt the intensity and frequency of Behavioral Health services to the Behavioral Health needs of the Member?

☒Yes ☐No

If "no" please provide explanation: _____

_____

l. Will Applicant work collaboratively to improve services for adult Members with SPMI as a priority population? Will Applicant make significant commitments and undertake significant efforts to continue to improve treatment and services so that adults with SPMI can live and prosper in integrated Community settings?

☒Yes ☐No

If "no" please provide explanation: _____

_____

m. Will Applicant ensure Members have timely access to all services under the Behavioral Health benefit in accordance with access to service standards as developed in Appendix C, the Administrative Rules Concept Document, under OHPB #17?

☒Yes ☐No

If "no" please provide explanation: _____

_____

n. Will Applicant have an adequate Provider Network to ensure Members have timely access to Behavioral Health services and effective treatment in accordance with the Delivery System and Provider Capacity section of the Contract?

☒Yes ☐No

If "no" please provide explanation: _____

_____

o. Will Applicant establish written policies and procedures for Prior Authorizations, in compliance with the Mental Health Parity and Addiction Equity Act of 2008, and be responsible for any inquiries or concerns and not delegate responsibility to Providers?

☒Yes ☐No

If "no" please provide explanation: _____

_____

p. Will Applicant establish written policies and procedures for the Behavioral Health benefit and provide the written policies and procedures to OHA by the beginning of CY 2020?

☒Yes ☐No

If "no" please provide explanation: _____

_____

q. Will Applicant require mental health and substance use disorder programs be licensed or certified by OHA to enter the Provider Network?

☒Yes ☐No

If "no" please provide explanation: _____

_____

r. Will Applicant require Providers to screen Members for adequacy of supports for the Family in the home (e.g., housing adequacy, nutrition/food, diaper needs, transportation needs, safety needs and home visiting)?

☒Yes ☐No

If "no" please provide explanation: _____

_____

s. Will Applicant ensure Applicant's staff and Providers are trained in recovery principles, motivational interviewing, integration, and Foundations of Trauma Informed Care (https://traumainformedoregon.org/tic-intro-training-modules/)?

☒Yes ☐No

If "no" please provide explanation: _____

_____

t. Will Applicant ensure Providers are trained in Trauma Informed approaches and provide regular periodic oversight and technical assistance to Providers?

☒Yes ☐No

If "no" please provide explanation: _____

_____

u. Will Applicant require Providers, in developing Individual Service and Support Plans for Members, to assess for Adverse Childhood Experiences (ACEs) and trauma in a Culturally Responsive and Trauma Informed framework and approach?

☒Yes ☐No

If "no" please provide explanation: _____

_____

v. Will Applicant ensure Behavioral Health services are Culturally Responsive and Trauma Informed?

☒Yes ☐No

If "no" please provide explanation: _____

_____

w. Will Applicant assume responsibility for the entire Behavioral Health residential benefit by the beginning of CY 2022?

☒Yes ☐No

If "no" please provide explanation: _____

_____

x. Will Applicant include OHA approved Behavioral Health homes (BHHs) in Applicant's network as the BHHs qualify in Applicant's Region?

☒Yes ☐No

If "no" please provide explanation: _____

_____

y. Will Applicant assist Behavioral Health organizations within the delivery system to establish BHHs?

☒Yes ☐No

If "no" please provide explanation: _____

_____

z. Will Applicant utilize BHHs in their network for Members to the greatest extent possible?

☒Yes ☐No

If "no" please provide explanation: _____

_____

aa. Will Applicant provide a full psychological evaluation and child psychiatric consultation for children being referred to the highest levels of care (day treatment, subacute or PRTS)?

☒Yes ☐No

If "no" please provide explanation: _____

_____

2. MOU with Community Mental Health Program (CMHP)

a. Will Applicant enter into a written memorandum of understanding (MOU) with the local Community Mental Health Program (CMHP) in Applicant's Region by beginning of CY 2020, in accordance with ORS 414.153?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Will Applicant develop a comprehensive Behavioral Health plan for Applicant's Region in collaboration with the Local Mental Health Authority and other Community partners (e.g., education/schools, Hospitals, corrections, police, first responders, Child Welfare, DHS, public health, Peers, families, housing authorities, housing Providers, courts)?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Will Applicant coordinate and collaborate on the development of the Community health improvement plan (CHP) under ORS 414.627 with the local Community Mental Health Program (CMHP) for the delivery of mental health services under ORS 430.630

☒Yes ☐No

If "no" please provide explanation: _____

_____

3. Provisions of Covered Services – Behavioral Health

a. Will Applicant provide services as necessary to achieve compliance with the mental health parity requirements of 42 CFR§ 438, subpart K and ensure that any quantitative treatment limitations (QTLs), or non-quantitative treatment limitations (NQTLs) placed on Medically Necessary Covered Services are no more restrictive than those applied to fee-for-service medically necessary covered benefits, as described in 42 CFR 438.210(a)(5)(i)?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Will Applicant assume accountability for Members that are civilly committed and are referred to and enter Oregon State Hospital; be financially responsible for the services for Members on waitlist for Oregon State Hospital after the second year of the Vontract, with timeline to be determined by OHA; and be financially responsible for services for Members admitted to Oregon State Hospital after the second year of the Vontract, with timeline to be determined by OHA?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Will Applicant reimburse for covered Behavioral Health services rendered in a primary care setting by a qualified Behavioral Health Provider, and reimburse for covered physical health services in Behavioral Health care settings, by a qualified medical Provider?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Will Applicant ensure Members receive services from Non-Participating Providers for Behavioral Health services if those services are not available from Participating Providers or if a Member is not able to access services within the timely access to care standards? Will Applicant remain responsible for coordinating Behavioral Health services with Non-Participating Providers and reimbursing for services?

☒Yes ☐No

If "no" please provide explanation: _____

_____

e. Will Applicant ensure continuity of care throughout episodes of care and provide Intensive Care Coordination and general Care Coordination as specified in the Contract?

☒Yes ☐No

If "no" please provide explanation: _____

_____

4. Covered Services Component – Behavioral Health

a. Will Applicant establish written policies and procedures for an emergency response system, including post-stabilization care services and Urgent Services for all Members on a 24-hour, 7-day-a-week basis consistent with OAR 410-141-3140 and 42 CFR 438.114? Will the emergency response system provide an immediate, initial or limited duration response for emergency situations or potential Behavioral Health emergency situations that may include Behavioral Health conditions?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Will Applicant ensure access to Mobile Crisis Services for all Members in accordance with OAR 309-019-0105, OAR 309-019-0150, 309-019-0242, and 309-019-0300 to 309-019-0320 to promote stabilization in a Community setting rather than arrest, presentation to an Emergency Department, or admission to an Acute psychiatric care facility?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Will Applicant establish written policies and procedures for a Quality Improvement plan for the emergency response system?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Will Applicant collaboratively work with OHA and CMHPs to develop and implement plans to better meet the needs of Members in Community integrated settings and to reduce recidivism to Emergency Departments for Behavioral Health reasons?

☒Yes ☐No

If "no" please provide explanation: _____

_____

e. Will Applicant work with Hospitals to provide data on Emergency Department (ED) utilization for Behavioral Health reasons and length of time in the ED? Will Applicant develop remediation plans with EDs with significant numbers of ED stays longer than 23 hour?

☒Yes ☐No

If "no" please provide explanation: _____

_____

f. Will Applicant establish a policy and procedure for developing a management plan for contacting and offering services to each Member who has two or more readmissions to an ED in a six-month period?

☒Yes ☐No

If "no" please provide explanation: _____

_____

g. Will Applicant make a reasonable effort to provide Covered Services on a voluntary basis and consistent with current Declaration for Mental Health Treatment as provided at: http://www.oregon.gov/oha/amh/forms/declaration.pdf in lieu of involuntary treatment?

☒Yes ☐No

If "no" please provide explanation: _____

_____

h. Will Applicant establish written policies and procedures describing the appropriate use of Emergency Psychiatric Holds consistent with ORS 426 and alternatives to involuntary psychiatric care when a less restrictive voluntary service will not meet the Medically Appropriate needs of the Member and the behavior of the Member meets legal standards for the use of an Emergency Psychiatric Hold?

☒Yes ☐No

If "no" please provide explanation: _____

_____

i. Will Applicant assure that any involuntary treatment provided under the Contract is provided in accordance with administrative rule and statute, and coordinate with the CMHP Director in assuring that all statutory requirements are met? Will Applicant also work with the CMHP Director in assigning a civilly committed Member to any placement and participate in circuit court hearings related to planned placements, if applicable?

☒Yes ☐No

If "no" please provide explanation: _____

_____

j. If Applicant identifies a Member, over age 18 with no significant nursing care needs due to a general medical condition, Acute medical condition or physical disorder, is appropriate for Long Term Psychiatric Care (State Facility level of care), will Applicant request a LTPC determination from the OHA LTPC reviewer?

☒Yes ☐No

If "no" please provide explanation: _____

_____

k. If Applicant identifies a Member, age 18 to age 64, with no significant nursing care needs due to a general medical condition, Acute medical condition or physical disorder of an enduring nature, is appropriate for LTPC, will Applicant request a LTPC determination from the applicable HSD Adult Mental Health Services Unit, as described in Procedure for LTPC Determinations for Members 18 to 64, available on the Contract Reports Web Site?

☒Yes ☐No

If "no" please provide explanation: _____

_____

l. If Applicant identifies a Member, age 65 and over, or age 18 to age 64 with significant nursing care needs due to a general medical condition, Acute medical condition or physical disorder of an enduring nature, is appropriate for LTPC, will Applicant request a LTPC determination from the State hospital-NTS, Outreach and Consultation Service (OCS) Team as described in Procedure for LTPC Determinations for Member Requiring Neuropsychiatric Treatment, available on the Contract Reports Web Site?

☒Yes ☐No

If "no" please provide explanation: _____

_____

m. For the Member age 18 and over, will Applicant work with the Member to assure timely discharge and transition from LTPC to the most appropriate, independent and integrated Community-based setting possible consistent with Member choice?

☒Yes ☐No

If "no" please provide explanation: _____

_____

n. Will Applicant authorize and reimburse Care Coordination services, in particular for Members who receive ICC, that are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are provided to Members receiving care through licensed Community treatment programs? Will Applicant authorize and reimburse for ICC services, in accordance with standards identified in OAR 410-141-3160-70?

☒Yes ☐No

If "no" please provide explanation: _____

_____

o. Will Applicant ensure that any involuntary treatment provided under the Contract is provided in accordance with administrative rule and statute and coordinate with the CMHP Director in assuring that all statutory requirements are met? Will Applicant work with the CMHP Director in assigning a civilly committed Member to any placement and participate in circuit court hearings related to planned placements, if applicable?

☒Yes ☐No

If "no" please provide explanation: _____

_____

p. Will Applicant provide Acute Inpatient Hospital Psychiatric Care for Members who do not meet the criteria for LTPC?

☒Yes ☐No

If "no" please provide explanation: _____

_____

q. Will Applicant ensure that all Members discharged from Acute Care Psychiatric Hospitals are provided a Warm Handoff to a Community case manager, Peer bridger, or other Community provider prior to discharge, and that all such Warm Handoffs are documented?

☒Yes ☐No

If "no" please provide explanation: _____

_____

r. Will Applicant ensure that all Members discharged from Acute Care Psychiatric Hospitals have linkages to timely, appropriate behavioral and primary health care in the Community prior to discharge and that all such linkages are documented, in accordance with OAR provisions 309-032-0850 through 309-032-0870?

☒Yes ☐No

If "no" please provide explanation: _____

_____

s. Will Applicant ensure all adult Members receive a follow-up visit with a Community Behavioral Health Provider within seven (7) days of their discharge from an Acute Care Psychiatric Hospital?

☒Yes ☐No

If "no" please provide explanation: _____

_____

t. Will Applicant reduce readmissions of adult Members with SPMI to Acute Care Psychiatric Hospitals?

☒Yes ☐No

If "no" please provide explanation: _____

_____

u. Will Applicant coordinate with system Community partners to ensure Members who are homeless and who have had two or more readmissions to an Acute Care Psychiatric Hospital in a six-month period are connected to a housing agency or mental health agency to ensure these Members are linked to housing in an integrated Community setting, Supported Housing to the extent possible, consistent with the individual's treatment goals, clinical needs and the individual's informed choice?

☒Yes ☐No

If "no" please provide explanation: _____

_____

v. Will Applicant ensure coordination and appropriate Referral to Intensive Care Coordination to ensure that Member's rights are met and there is post-discharge support? If Member is connected to ICC coordinator, will Applicant ensure coordination with this person as directed in OAR 410-141-3160-3170?

☒Yes ☐No

If "no" please provide explanation: _____

_____

w. Will Applicant work with OHA and the CMHPs to ensure that Members who are discharged from Acute Care Psychiatric Hospitals are discharged to housing that meets the individuals' immediate need for housing and work with Acute Care Psychiatric Hospitals in the development of each individual's housing assessment?

☒Yes ☐No

If "no" please provide explanation: _____

_____

x. Will Applicant establish a policy and procedure for developing a management plan for contacting and offering services to each Member who has two (2) or more readmissions to an Acute Care Psychiatric Hospital in a six-month period?

☒Yes ☐No

If "no" please provide explanation: _____

_____

y. Will Applicant work with OHA, other state agencies, and other state funded or operated entities to identify areas where treatment and services for adult Members with SPMI can be improved?

☒Yes ☐No

If "no" please provide explanation: _____

_____

z. Will Applicant coordinate services for each adult Member with SPMI who needs assistance with Covered or Non-covered Services?

☒Yes ☐No

If "no" please provide explanation: _____

_____

aa. Will Applicant provide oversight, Care Coordination, transition planning and management for Members receiving Behavioral Health services, including Mental Health Rehabilitative Services and Personal Care Services, in licensed and non-licensed home and Community-based settings, ensuring that individuals who no longer need placement in such settings are transitioned to a Community placement in the most integrated Community setting appropriate for that person?

☒Yes ☐No

If "no" please provide explanation: _____

_____

bb. Will Applicant provide Utilization Review and utilization management, for Members receiving Behavioral Health Services, including Mental Health Rehabilitative Services and Personal Care Services, in licensed and non-licensed home and Community-based settings, ensuring that individuals who no longer need placement in such setting transition to the most integrated Community setting, Supported Housing to the extent possible, consistent with the individual's treatment goals, clinical needs, and the individual's informed choice?

☒Yes ☐No

If "no" please provide explanation: _____

_____

cc. Will Applicant encourage utilization of Peer-Delivered Services (PDS) and ensure that Members are informed of their benefit to access and receive PDS from a Peer Support Specialist, Peer Wellness Specialist, Family Support Specialist, or Youth Support Specialist as applicable to the Member's diagnosis and needs?

☒Yes ☐No

If "no" please provide explanation: _____

_____

dd. Will Applicant ensure that Members with SPMI receive Intensive Care Coordination (ICC) support in finding appropriate housing and receive coordination in addressing Member's housing needs?

☒Yes ☐No

If "no" please provide explanation: _____

_____

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

☒Yes ☐No

If "no" please provide explanation: _____

_____

ff. Will Applicant ensure ACT services are provided for all adult Members with SPMI who are referred to and eligible for ACT services in accordance with OAR 309-019-0105 and 309-019-0225 through 309-019-0255?

☒Yes ☐No

If "no" please provide explanation: _____

_____

gg. Will Applicant ensure additional ACT capacity is created to serve adult Members with SPMI as services are needed?

☒Yes ☐No

If "no" please provide explanation: _____

_____

hh. Will Applicant, when ten (10) or more of Applicant's adult Members with SPMI in Applicant's Service Area are on a waitlist to receive ACT for more than thirty (30) days, without limiting other Applicant solutions, create additional capacity by either increasing existing ACT team capacity to a size that is still consistent with Fidelity standards or by adding additional ACT teams?

☒Yes ☐No

If "no" please provide explanation: _____

_____

If Applicant lacks qualified Providers to provide ACT services, will Applicant consult with OHA and develop a plan to develop additional qualified Providers? Will lack of capacity not be a reason to allow individuals who are determined to be eligible for ACT to remain on the waitlist? Will no individual on a waitlist for ACT services be without such services for more than 30 days?

☒Yes ☐No

If "no" please provide explanation: _____

_____

ii. Will Applicant ensure all denials of ACT services for all adult Members with SPMI are: based on established, evidence-based medical necessity criteria; reviewed, recorded and compiled in a manner that allows denials to be accurately reported out as appropriate or inappropriate; and follow the Notice of Adverse Benefit Determination process for all denials as described in the Contract?

☒Yes ☐No

If "no" please provide explanation: _____

_____

jj. Will Applicant be responsible for finding or creating a team to serve Members who have appropriately received a denial for a particular ACT team but who meet ACT eligibility standards?

☒Yes ☐No

If "no" please provide explanation: _____

_____

kk. Will Applicant be responsible for engaging with all eligible Members who decline to participate in ACT in an attempt to identify and overcome barriers to the Member's participation?

☒Yes ☐No

If "no" please provide explanation: _____

_____

ll. Will Applicant require that a Provider or care coordinator meets with the Member to discuss ACT services and provide information to support the Member in making an informed decision regarding participation? Will this include a description of ACT services and how to access them, an explanation of the role of the ACT team and how supports can be individualized based on the Member's self-identified needs, and ways that ACT can enhance a Member's care and support independent Community living?

☒Yes ☐No

If "no" please provide explanation: _____

_____

mm. Will Applicant provide alternative evidence-based intensive services if Member continues to decline participation in ACT, which must include coordination with an ICC?

☒Yes ☐No

If "no" please provide explanation: _____

_____

nn. Will Applicant report the number of individuals referred to ACT, number of individuals admitted to ACT programs, number of denials for the ACT benefit, number of denials to ACT programs, and number of individuals on waitlist by month?

☒Yes ☐No

If "no" please provide explanation: _____

_____

oo. Will Applicant ensure a Member discharged from OSH who is appropriate for ACT shall receive ACT or an evidence-based alternative?

☒Yes ☐No

If "no" please provide explanation: _____

_____

pp. Will Applicant document efforts to provide ACT to individuals who initially refuse ACT services, and document all efforts to accommodate their concerns?

☒Yes ☐No

If "no" please provide explanation: _____

_____

qq. Will Applicant offer alternative evidence-based intensive services for individuals discharged from OSH who refuse ACT services?

☒Yes ☐No

If "no" please provide explanation: _____

_____

rr. Will Applicant ensure a Member discharged from OSH who is determined not to meet the level of care for ACT shall be discharged with services appropriate to meet their needs?

☒Yes ☐No

If "no" please provide explanation: _____

_____

ss. Will Applicant coordinate with system partners as needed regarding Oregon State Hospital discharges for all adult Members with SPMI in accordance with OAR 309-091-0000 through 0050?

☒Yes ☐No

If "no" please provide explanation: _____

_____

tt. Will Applicant ensure access to Supported Employment Services for all adult Members eligible for these services, in accordance with OAR 309-019-0275 through 309-019-0295? ("Supported Employment Services" means the same as "Individual Placement and Support (IPS) Supported Employment Services" as defined in OAR 309-019-0225.)

☒Yes ☐No

If "no" please provide explanation: _____

_____

uu. Will Applicant work with local law enforcement and jail staff to develop strategies to reduce contacts between Members and law enforcement due to Behavioral Health reasons, including reduction in arrests, jail admissions, lengths of stay in jails and recidivism?

☒Yes ☐No

If "no" please provide explanation: _____

_____

vv. Will Applicant work with SRTFs to expeditiously move civilly committed adult Members with SPMI who no longer need placement in an SRTF to a Community placement in the most integrated setting, Supported Housing to the extent possible, consistent with the individual's treatment goals, clinical needs, and the individual's informed choice?

☒Yes ☐No

If "no" please provide explanation: _____

_____

ww. Will Applicant provide Substance Use Disorder (SUD) services to Members, which include outpatient, intensive outpatient, medication assisted treatment including Opiate Substitution Services, residential and detoxification treatment services consistent with OAR Chapter 309, Divisions 18, 19 and 22, and OAR Chapter 415 Divisions 20, and 50?

☒Yes ☐No

If "no" please provide explanation: _____

_____

xx. Will Applicant comply with Substance Use Disorder (SUD) waiver program designed to improve access to high quality, clinically appropriate treatment for opioid use disorder and other SUDs, upon approval by Centers for Medicare and Medicaid Services (CMS)?

☒Yes ☐No

If "no" please provide explanation: _____

_____

yy. Will Applicant inform all Members using Culturally Responsive and linguistically appropriate means that Substance Use Disorder outpatient, intensive outpatient, residential, detoxification and medication assisted treatment services, including opiate substitution treatment, are Covered Services consistent with OAR 410-141-3300?

☒Yes ☐No

If "no" please provide explanation: _____

_____

zz. Will Applicant participate with OHA in a review of OHA provided data about the impact of these criteria on service quality, cost, outcome, and access?

☒Yes ☐No

If "no" please provide explanation: _____

_____

5. Children and Youth

a. Will Applicant develop and implement cost-effective comprehensive, person-centered, individualized, and integrated Community-based Child and Youth Behavioral Health services for Members, using System of Care (SOC) principles?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Will Applicant utilize evidence-based Behavioral Health interventions for the needs of children 0-5, and their caregivers, with indications of Adverse Childhood Experiences (ACEs) and high complexity?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Will Applicant provide Intensive Care Coordination (ICC) that is Family and youth-driven, strengths based and Culturally Responsive and linguistically appropriate and abide by ICC standards as set forth in Appendix C, Administrative Rules Concept under OHPB #24 and in accordance with the ICC section in the Contract? Will Applicant abide by ICC standards as forth in Appendix C, Administrative Rules Concept, under OHPB #24, and in accordance with the ICC section in the Contract?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Will Applicant provide services to children, young adults and families of sufficient frequency, duration, location, and type that are convenient to the youth and Family? Will Services alleviate crisis while allowing for the development of natural supports, skill development, normative activities and therapeutic resolution to Behavioral Health disorders and environmental conditions that may impact the remediation of a Behavioral Health disorder?

☒Yes ☐No

If "no" please provide explanation: _____

_____

e. Will Applicant adopt policies and guidelines for admission into Psychiatric Residential Treatment Services (PRTS), Psychiatric Day Treatment Services (PDTS) and/or Intensive Outpatient Services and Supports?

☒Yes ☐No

If "no" please provide explanation: _____

_____

f. Will Applicant ensure the availability of service, supports or alternatives 24 hours a day/7 days a week to remediate a Behavioral Health crisis in a non-emergency department setting?

☒Yes ☐No

If "no" please provide explanation: _____

_____

g. Will Applicant encourage utilization of Peer-Delivered Services (PDS) and ensure that Members are informed of their benefit to access and receive PDS from a Peer Support Specialist, Peer Wellness Specialist, Family Support Specialist, or Youth Support Specialist as applicable to the Member's diagnosis and needs?

☒Yes ☐No

If "no" please provide explanation: _____

_____

h. If Applicant identifies a Member is appropriate for LTPC Referral, will Applicant request a LTPC determination from the applicable HSD Child and Adolescent Mental Health Specialist, as described in Procedure for LTPC Determinations for Members 17 and Under, available on the Contract Reports Web Site?

☒Yes ☐No

If "no" please provide explanation: _____

_____

i. Will Applicant arrange for the provision of non-health related services, supports and activities that can be expected to improve a Behavioral Health condition?

☒Yes ☐No

If "no" please provide explanation: _____

_____

j. Will Applicant coordinate admissions to and discharges from Acute Inpatient Hospital Psychiatric Care and Sub-Acute Care for Members 17 and under, including Members in the care and custody of DHS Child Welfare or OYA? For a Member 17 and under, placed by DHS Child Welfare through a Voluntary Placement Agreement (CF 0499), will Applicant also coordinate with such Member's parent or legal guardian?

☒Yes ☐No

If "no" please provide explanation: _____

_____

k. Will Applicant ensure a CANS Oregon is administered to a Member who is a child or youth and the data is entered into OHA approved data system according to the eligibility and timeline criteria in the Contract?

☒Yes ☐No

If "no" please provide explanation: _____

_____

l. Will Applicant have funding and resources to implement, to fidelity, Wraparound Services?

☒Yes ☐No

If "no" please provide explanation: _____

_____

m. Will Applicant enroll all eligible youth in Wraparound and place no youth on a waitlist?

☒ Yes ☐No

If "no" please provide explanation: _____

_____

n. Will Applicant screen all eligible youth with a Wraparound Review Committee in accordance with Wraparound Services as described in the OHA System of Care Wraparound Initiative (SOCWI) guidance document found at the link below and in Wraparound Service OARs? http://www.oregon.gov/oha/hsd/amh/pages/index.aspx.

☒Yes ☐No

If "no" please provide explanation: _____

_____

o. Will Applicant establish and maintain a functional System of Care in its Service Area in accordance with the Best Practice Guide located at https://www.pdx.edu/ccf/best-practice-guide including a Practice Level Workgroup, Advisory Committee and Executive Council with a goal of youth and Family voice representation to be 51 percent?

☒Yes ☐No

If "no" please provide explanation: _____

_____

p. Will Applicant have a functional SOC governance structure by the beginning of CY 2020 that consists of a practice level work group, advisory council, and executive council?

☒Yes ☐No

If "no" please provide explanation: _____

_____

q. By end of CY 2020, will Applicant have written Charters and new Member handbooks for Practice Level Work group, Advisory Council and Executive Council?

☒Yes ☐No

If "no" please provide explanation: _____

_____

G. Cost and Financial Attestations (Attachment 12)

1. Rates

Does Applicant accept the CY 2020 Rate Methodology appended to Attachment 12?

☒Yes ☐No

If "no" please provide explanation: _____

_____

2. Evaluate CCO performance to inform CCO-specific profit margin

a. Does Applicant agree to performance and efficiency evaluation being used to set profit margins in CCO capitation rates?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Does Applicant agree to accept the CCO 2.0 capitation rate methodology as described in the Oregon CY20 Procurement Rate Methodology document and also accept the performance evaluation methodology and its use in setting CCO-specific profit margins?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Does Applicant agree to report additional data as needed to inform the performance evaluation process, including data on utilization of Health-Related Services?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to have OHA use efficiency analysis to support managed care efficiency adjustments that may result in adjustments to the base data used in capitation rate development to further incentivize reductions in Waste in the system?

☒Yes ☐No

If "no" please provide explanation: _____

_____

3. Qualified Directed Payments to Providers

a. Is Applicant willing to make OHA-directed payments to certain Hospitals within five Business Days after receipt of a monthly report prepared and distributed by OHA?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to report to OHA promptly if it determines payments to Hospitals will be significantly delayed?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to exclude the portion of OHA-directed payments for provider tax repayment when negotiating alternative or Value-Based Payment reimbursement arrangements?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to provide input and feedback to OHA on the selection of measures of quality and value for OHA-directed payments to Providers?

☒Yes ☐No

If "no" please provide explanation: _____

_____

4. Quality Pool Operations and Reporting

a. Does Applicant agree to having a portion of capitation withheld from monthly Capitation Payment and awarded to the Applicant based on performance on metrics based on the Quality Incentive Pool program?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Does Applicant agree to report to OHA separately on expenditures incurred based on Quality Pool revenue earned?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Does Applicant agree to report on the methodology it uses to distribute Quality Pool earnings to Providers, including SDOH-HE partners and public health partners?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Does Applicant have a plan to evaluate contributions made by SDOH-HE and public health partners toward the achievement of Quality Pool metrics?

☒Yes ☐No

If "no" please provide explanation: _____

_____

5. Transparency in Pharmacy Benefit Management Contracts

a. Will Applicant select and contract with the Oregon Prescription Drug Program to provide Pharmacy Benefit Management services? If yes, please skip to section 5. If not, please answer parts b-f of this question.

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Will Applicant use a pharmacy benefit manager that will provide pharmacy cost passthrough at 100% and pass back 100% of rebates received to Applicant?

☐Yes ☐No

If "no" please provide explanation: _____

_____

c. Will Applicant separately report to OHA any and all administrative fees paid to its PBM?

☐ Yes ☐No

If "no" please provide explanation: _____

_____

d. Will Applicant require reporting from PBM that provides paid amounts for pharmacy costs at a claim level?

☐Yes ☐No

If "no" please provide explanation: _____

_____

e. Will Applicant obtain market check and audits of their PBMs by a third party on an annual basis, and share the results of the market check with the OHA?

☐Yes ☐No

If "no" please provide explanation: _____

_____

f. Will Applicant require its PBM to remain competitive with enforceable contract terms and conditions driven by the findings of the annual market check and report auditing?

☐Yes ☐No

If "no" please provide explanation: _____

_____

6. Alignment Preferred Drug Lists (PDLs) and Prior Authorization Criteria

a. Will Applicant partner with OHA on the goal of increasing the alignment of CCO preferred drug lists (PDL) with the Fee-For-Service PDL set every year by OHA?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Will Applicant align its PDL in any and all categories of drugs as recommended by the P&T committee and as required by OHA?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Will Applicant post online in a publicly accessible manner the Applicant's specific PDL with coverage and Prior Authorization criteria in a format designated by OHA and update the posting concurrently or before any changes to the PDL or coverage/PA criteria become effective?

☐Yes ☒No

If "no" please provide explanation: EOCCO 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: EOCCO 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: EOCCO 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: EOCCO 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: _____

_____

eocco

Attachment 14 — Assurances

Applicant Name: Eastern Oregon Coordinated Care Organization

Authorizing Signature: _____

Printed Name: Sean Jessup

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.

Attachment 15 — Representations

Applicant Name: Eastern Oregon Coordinated Care Organization

Authorizing Signature: [signature]

Printed Name: Sean Jessup

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: EOCCO administrative functions are provided by EOCCO affiliates/equity partner's ODS Community Health, Inc. (ODSCH) and Greater Oregon Behavioral Health Inc. (GOBHI) through administrative services agreements with EOCCO.

ODSCH performs all medical administration including all corporate functions for EOCCO such as staffing, information technology, claims, enrollment, credentialing, utilization management, quality improvement, compliance, customer service, encounter data, data analytics, actuarial, financial, legal, etc. GOBHI provides all behavioral health and non-emergency medical transportation administration.

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, EOCCO will subcontract with entities to perform Dental administration, Pharmacy/PBM 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: EOCCO has a value based payment arrangement with its affiliate/equity partner, GOBHI for behavioral health and NEMT services. GOBHI receive a capitated premium for these services and shares in both upside and downside financial risk for these benefits.

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: EOCCO has 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 a 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.

EOCCO is dedicated to ensuring a smooth transitions for all members by providing continued access to care while a member is transitioning from/to EOCCO to/from another CCO. EOCCO 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. EOCCO 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, EOCCO 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, EOCCO 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).

EOCCO is able to pull customized reports and provide historical data for all services provided to EOCCO members. As proposed by OHA to the CCOs in November 2018, as a result of the OHA Transition of Care Survey to CCO, EOCCO is able to provide the requirements outlined below. This would be a starting point in the discussion with the receiving CCO and EOCCO may be able to be adjusted to suit the needs of the receiving CCO. EOCCO 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, EOCCO is able to provide data on non-emergent medical transportation rides and information on members accessing case management services.

EOCCO 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 EOCCO 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).

EOCCO 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, EOCCO 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).

EOCCO 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, EOCCO 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.

EOCCO'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.

EOCCO 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.

EOCCO 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).

EOCCO 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. EOCCO has pre-established methods of sharing data with partners. This transfer would follow current processes and file formats established.

(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.

EOCCO 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. EOCCO would assign members to their current PCP and Behavioral Health home to promote continuity of care.

EOCCO 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.

EOCCO is dedicated to support Member continuity of care. As outlined in OAR 410-141-3061, EOCCO 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 EOCCO 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.

EOCCO'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.

NAIC Biographical Affidavits

Name of publicly funded program	Type of public program (i.e. County Mental Health Department)
APD District 11	State APD district offices
APD District 12	State APD district offices
APD District 13 and 14	State APD district offices
APD District 9	State APD district offices
Asher Community Health Centers	Local public health authority
Baker County Health Department	Local public health authority
Center for Human Development	Community Mental Health Program
Community Counseling Solutions	Community Mental Health Program
Grant County Health Department	Local public health authority
Harney County Health Department	Local public health authority
Lake County Public Health Office	Local public health authority
Lake Health District (Lakeview Center for Change)	Community Mental Health Program
Lifeways	Community Mental Health Program
Malheur County Health Dept	Local public health authority
Mid-Columbia Center for Living	Community Mental Health Program
Morrow County Health Department	Local public health authority
New Directions Northwest	Community Mental Health Program
North Central Public Health District	Local public health authority
Symmetry	Community Mental Health Program
Umatilla County Human Services	County SUD Program
Umatilla County Public Health Division	Local public health authority
Union County Public Health	Local public health authority
Wallowa Center for Wellness	Community Mental Health Program
Wallowa County Health Department	Local public health authority

County in which program provides service	**Specialty/Sub- Specialty Codes**
Lake	
Morrow, Umatilla, and Wheeler	
Baker, Grant, Harney, Malheur, Union, and Wallowa	
Gilliam and Sherman	
Wheeler	15 / 097
Baker	64 / 505
Union	03 / 004
Gilliam, Grant, Morrow, Wheeler	03, 33 / 004, 369, 092, 209
Grant	14 / 085
Harney	47 / 079
Lake	47 / 079
Lake	33, 03 / 369, 004
Umatilla, Malheur	33 / 092, 093, 207, 445
Malheur	64 / 509, 513, 515
Wasco, Hood River, Sherman	03, 33 / 004, 206, 209, 092
Morrow	47 / 079
Baker	03, 33 / 004, 092
Gilliam and Sherman	22 / 145
Harney	03, 33, / 013, 209 450, 445, 092
Umatilla	64, 47, 22 / 509, 513, 515, 079, 145
Umatilla	64, 47, 22 / 509, 513, 515, 079, 145
Union	64, 22 / 105, 509
Wallowa	03, 33 / 016, 092, 369, 445
Wallowa	47, 64, 22, 33 / 079, 509, 145, 092