Marion Polk
Coordinated Care℠

April 12, 2019

Allyson Hagen
Oregon Health Authority
Capitol Street, NE Room 350
Salem, Oregon 97302

Dear Ms. Hagen:

Thank you for the opportunity to submit a Request for Application (RFA OHA-4690-19) as a Coordinated Care Organization to be effective January 1, 2020. As the driver of health care transformation in Oregon, CCOs are tasked with providing better care at a lower costs with improved outcomes for community members. While this focus on the triple aim has advanced the health of Oregon's Medicaid population, more can, and should, be done to ensure our most vulnerable populations have access to timely, cost effective and high quality care. We applaud OHA's enhancements through CCO 2.0 and look forward to being part of the next evolution of improvement to the health care system.

Marion Polk Coordinated Care is made up of entities with significant experience both bearing health care risk and caring for the community. Our proposal intends to cover all members enrolled through the Oregon Health Plan residing in Marion and Polk Counties as well as the contiguous zip codes in Yamhill, Linn, Benton and Clackamas as listed. The organizing members of Marion Polk Coordinated Care (Salem Health Hospital & Clinics, Salem Clinic and WVP Health Authority) have a long history as a Fully Capitated Health Plan and founding members of the Coordinated Care Organization, Willamette Valley Community Health. Marion Polk Coordinated Care Inc. will have capacity for primary, specialty, mental health, substance abuse and dental care for all Oregon Health Plan members in the Marion and Polk Counties.

These three partners represent 88 percent of the primary care and specialty care providers as well as the only Level II trauma center in the Marion and Polk region. Together with other partners, we will provide high quality seamless care, coordinating the physical, behavioral and oral health needs of those served by the Oregon Health Plan. We look forward to working with OHA to demonstrate our experience and vision for our community. If you have any questions, please contact Dean Andretta at 503-587-5107 or email at rfa.mpcc@mvipa.org.

Best Regards,

Cheryl Nester Wolfe
Salem Health Hospitals & Clinics

Ryan Farwell
Salem Clinic

Jan Baldwin
WVP Health Authority

Marion Polk Coordinated Care℠

Full County Coverage Exception Request

Marion Polk Coordinated Care, Inc. (MPCC) is requesting to serve less than the full county for Yamhill, Linn, Benton and Clackamas. The zip codes requested are the result of contiguous zip codes that cross the Marion and Polk county boarders. The members in these zip codes are imbedded in the Marion and Polk communities and have established relationships with providers in Marion and Polk counties.

The coverage exception request is in no way designed to minimize financial risk and does not create adverse selection. The request is to allow the members in these services areas to maintain the existing relationships with community partners and providers.

Service Area Request Table:

County	Zip Code
Marion County	All
Polk County	All
Linn County	97346, 97350, 97352, 97358, 97360, 97383
Clackamas County	97002, 97032, 97071, 97362, 97375
Yamhill County	97304
Benton County	97361

Attachment 2 - Application Checklist

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

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

Attachment 3 - Application Information and Certification Sheet

Legal Name of Proposer: Marion Polk Coordinated Care, Inc.

Address: 890 Oak Street SE
Salem, OR 97301

State of Incorporation: Oregon **Entity Type:** Non-Profit Inc.

Contact Name: Dean Andretta **Phone:** (503) 587-5107 **Email:** deana@mvipa.org

Oregon Business Registry Number: 1519690-95

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

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

9. Applicant certifies that, to the best of its knowledge, there exists no actual or potential conflict between the business or economic interests of Applicant, its employees, or its agents, on the one hand, and the business or economic interests of the State, on the other hand, arising out of, or relating in any way to, the subject matter of the RFA, except as disclosed in writing in this Application. If any changes occur with respect to Applicant's status regarding conflict of interest, Applicant shall promptly notify OHA in writing.
10. Applicant certifies that all contents of the Application (including any other forms or documentation, if required under this RFA) and this Application Certification Sheet are truthful and accurate and have been prepared independently from all other Applicants, and without collusion, Fraud, or other dishonesty.
11. Applicant understands that any statement or representation it makes, in response to this RFA, if determined to be false or fraudulent, a misrepresentation, or inaccurate because of the omission of material information could result in a "claim" {as defined by the Oregon False Claims Act, ORS 180.750(1)}, made under Contract being a "false claim" {ORS 180.750(2)} subject to the Oregon False Claims Act, ORS 180.750 to 180.785, and to any liabilities or penalties associated with the making of a False Claim under that Act.
12. Applicant acknowledges these certifications are in addition to any certifications required in the Contract and Statement of Work in Attachment 10 at the time of Contract execution.

Signature: _____ **Title:** Exec. Director **Date:** 4/18/2019
(Authorized to Bind Applicant)

State of Oregon)
) ss:
County of Marion)

Signed and sworn to before me on 4/18/19 (date) by Dean Andretta (Affiant's name).

Notary Public for the State of Oregon

My Commission Expires: 12-21-2019

OFFICIAL STAMP
MANUEL RIVERA, JR.
NOTARY PUBLIC-OREGON
COMMISSION NO. 945287
MY COMMISSION EXPIRES DECEMBER 21, 2019

Attachment 4 – Disclosure Exemption Certificate

Dean Andretta ("Representatve"), representing **Marion Polk Coordinated Care, Inc.** ("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 19, 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
Biographical Affidavits	ORS 646.461 thru 646.475	1. Personal Confidential Information (SSN)
Examples of Sub Contracted Work	ORS 646.461 thru 646.475	2. Proprietary due to contractual language provided.
Subcontractors and Delegated Entities Report	ORS 646.461 thru 646.475	3. Trade secrets and payment methodology.
DSN Provider Capacity Report	ORS 646.461 thru 646.475	4. Trade secret that if published may assist competitors.
Value Based Payment Questionnaire	ORS 646.461 thru 646.475	5. Proprietary payment methods explained. Would benefit competitors if known publicly at this time.
VBP Data Template – High and Low Enrollment	ORS 646.461 thru 646.475	6. Proprietary payment methods explained. Would benefit competitors if known publicly at this time.
Health Information Technology (Attachment 9)	ORS 646.461 thru 646.475	7. Proprietary information explained. Would benefit competitors if known publicly at this time.

Behavioral Health Questionnaire	ORS 646.461 thru 646.475	8. Proprietary information that may assist competitors.
Behavioral Health Services Report	ORS 646.461 thru 646.475	9. Proprietary information that may assist competitors.
Cost and Financial Submission (Attachment 12 and all related documents)	ORS 646.461 thru 646.475	10. Proprietary information that may assist competitors.

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: 0

   How many contracts did not meet those standards? Number: _ 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:

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: Marion Polk Coordinated Care, Inc	RFA: 4690-19 Project Name: Coordinated Care Organizations 2.0

Signature: _____ **Title:** Exec. Director **Date:** 4/18/2019

(Authorized to Bind Applicant)

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

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

Registry Number: 1519690-95
Type: DOMESTIC NONPROFIT CORPORATION

Next Renewal Date: 01/28/2020

MARION POLK COORDINATED CARE
890 OAK ST SE
SALEM OR 97301

Acknowledgment Letter

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

Document
ARTICLES OF INCORPORATION

Filed On
01/28/2019

Jurisdiction
OREGON

Nonprofit Type
PUBLIC BENEFIT WITH MEMBERS

Name
MARION POLK COORDINATED CARE

Registered Agent
JAMES PARR
890 OAK ST SE
SALEM OR 97301

Mailing Address
890 OAK ST SE
SALEM OR 97301

JENGRA
ACK
01/28/2019

Oregon SECRETARY OF STATE

Corporation Division
Public Service Building
255 Capitol St., Ne Ste 151
Salem, Or 97310-1327
(503) 986-2200
Fax (503) 378-4381

Cash Receipt

Receipt Date	Receipt #
1/28/2019	189666

Program: Business Registry

Code	Service Type	Reg/Lien/Not #	Name or Subject	Paid Cash	Check	TOTAL
NPNEW	BR Filing Fee	1519690-95	MARION POLK		$50.00	$50.00

Notes:

Check Payment Information: 36189

TOTAL PAID: $50.00

User ID: jengra

FILED

JAN 28 2019

OREGON
SECRETARY OF STATE

151969095-95

ARTICLES OF INCORPORATION
OF
MARION POLK COORDINATED CARE

The undersigned natural persons of the age of 21 years or more, acting as incorporators under the Oregon Nonprofit Corporation Law, adopt the following Articles of Incorporation:

ARTICLE I
NAME

The name of the corporation is Marion Polk Coordinated Care (the "Corporation").

ARTICLE II
MEMBERSHIP

The initial members of the Corporation are the following Oregon public benefit nonprofit corporations:

Salem Clinic Medical Foundation
2020 Capitol Street NE
Salem, OR 97301

WVP Health Foundation
2995 Ryan Drive SE Suite 100
Salem, OR 97301

Salem Health Hospitals & Clinics
890 Oak Street SE
Salem, OR 97301

Qualifications for membership in the Corporation, and the powers of the membership, shall be set out in the Corporation's Bylaws.

ARTICLE III
TYPE AND DURATION

The Corporation is a public benefit corporation and its duration shall be perpetual.

ARTICLE IV
REGISTERED OFFICE AND AGENT

The registered office of the Corporation is 890 Oak Street SE, Salem, OR 97301, and the registered agent at such address is James Parr.

MARION POLK COORDINATED CARE

151969095-19728654 NEWINC

ARTICLE V
PRINCIPAL OFFICE

The mailing address of the principal office of the Corporation, to which notices, as required under ORS Chapter 65, may be mailed, is Marion Polk Coordinated Care, 890 Oak Street SE, Salem, OR, 97301.

ARTICLE VI
PURPOSES, LIMITATIONS, AND POWERS

Section 6.1 Purposes. The Corporation shall be organized and operated exclusively for religious, charitable, scientific, literary, or educational purposes, within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code"), or any successor provision.

To further the Corporation's purposes it intends to submit a letter of intent and an application to Oregon Health Authority to become certified as a Coordinated Care Organization operating in Marion and Polk Counties. CCOs are intended by the Oregon Legislature to be beneficial to the community as a whole. Specifically, the Oregon Legislature made findings in Section 1 of H.B. 3650 that the use of CCOs has significant potential to reduce health care costs in Oregon, improve health, and increase the quality, reliability, availability, and continuity of care.

Section 6.2 Limitations.

6.2.1 The Corporation shall have no capital stock, and no part of its net earnings shall inure to the benefit of any director or officer of the Corporation, or of any private individual.

6.2.2 No director, officer, or any private individual shall be entitled to share in the distribution of any of the corporate assets upon dissolution of the Corporation, or upon the winding up of its affairs.

6.2.3 No substantial part of the activities of the Corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, except as may be permitted to Section 501(c)(3) organizations by the Code, and the Corporation shall not participate in, or intervene in (including the publication or distribution of statements) any political campaign on behalf of (or in opposition to) any candidate for public office.

6.2.4 Notwithstanding any other provisions of these Articles, the Corporation shall not conduct or carry on activities not permitted to be conducted or carried on by an organization qualified under Section 501(c)(3) of the Code, or any successor provision, or by an organization, contributions to which are deductible under Section 170(c)(2) of the Code, or any successor provision.

Section 6.3 Powers. In general, and subject to such limitations and conditions as are or may be prescribed by law, or in the Corporation's Articles of Incorporation or Bylaws, the Corporation shall have all powers which now or hereafter are conferred by law upon a corporation organized for the purpose set forth above, or are necessary or incidental to the powers so conferred, or are conducive to the attainment of the Corporation's purpose.

ARTICLE VII
LIMITATION OF DIRECTORS' LIABILITY

Directors and uncompensated officers of the Corporation shall have no civil liability to the Corporation or its members for conduct as a director or officer, except for breaches of the duty of loyalty to the Corporation, acts or omissions which are not in good faith or which involve intentional misconduct or knowing violations of law, unlawful distributions, transactions from which such director or officer derives an improper personal benefit, and any act or omission in violation of ORS 65.361 through 65.367, as in effect, or hereinafter amended. If the Act is hereafter amended to authorize corporate action further eliminating or limiting the personal liability of director or officers, then the liability of a director or officer shall be eliminated or limited to the full extent permitted by the Act, as so amended. Any repeal or modification of this Article shall not adversely affect any right or protection of a director or officer of the Corporation existing at the time of such repeal or modification for or with respect to an act or omission of such director occurring prior to such repeal or modification.

ARTICLE VIII
INDEMNIFICATION

Section 8.1 Indemnification. Pursuant to ORS 65.387 to 65.414, the Corporation shall indemnify, to the fullest extent provided in the Act, any Director or Officer who was or is a Party or is threatened to be made a Party to any Proceeding (other than an action by or in the right of the Corporation) by reason of or arising from the fact that such person is or was a Director or Officer of the Corporation. The determination and authorization of indemnification shall be made as provided in the Act.

Section 8.2 Advancement of Expenses. The Corporation may pay for or reimburse the reasonable Expenses incurred by a Director or Officer who is a Party to a Proceeding in advance of final disposition of the Proceeding as provided in the Act.

Section 8.3 Insurance. At the discretion of the Board of Directors, the Corporation may purchase and maintain insurance on behalf of any person who is or was a Director or Officer of the Corporation against any Liability asserted against such person and incurred by such person in any such capacity, or arising out of such person's status as such, whether or not the Corporation would have the power to indemnify such person against such Liability under the provisions of this Article.

Section 8.4 Nonexclusivity of Rights. The indemnification referred to in the various sections of this Article shall be deemed to be in addition to and not in lieu of any other rights to which those indemnified may be entitled under any statue, rule or law or equity, provision of the Articles of Incorporation, agreement, vote of the Board of Directors or otherwise.

Section 8.5 Definitions. Capitalized terms used in this Article and not otherwise defined herein shall have the same meanings given them in ORS 65.387 to 65.414.

ARTICLE IX
DIRECTORS

The management of the Corporation will be vested in a board of directors subject to the reserved powers of the Members. The number, qualifications, terms of office, manner of election, time and place of meeting, and powers and duties of directors shall be prescribed by the Bylaws of the Corporation.

ARTICLE X
AMENDMENT OF BYLAWS

The authority to make, alter, amend or repeal Bylaws is vested in the members of the Corporation. The board of directors may recommend alterations, amendments, or repeal of the Bylaws, but any such recommendation shall be effective only upon unanimous approval by the members.

ARTICLE XI
DISSOLUTION

Upon dissolution or winding up, all the Corporation's remaining assets shall be distributed equally to the Members in proportion to their capital contribution to date, provided the Members remain public benefit non-profit corporations that would then qualify for exemption under the provisions of Section 501(c)(3) of the Code, or as otherwise directed by unanimous consent of the Members for similar or identical uses and purposes, to any organization that would then qualify for exemption under the provisions of Section 501(c)(3) of the Code or any successor provision, or to a state of local government for a public purpose.

1519690-95

We, the undersigned Incorporators, each for ourselves and not for one another, herewith execute the foregoing, and under penalty of perjury, declare that we have examined these Articles of Incorporation and to the best of our knowledge and belief, the statements contained herein are true, correct, and complete, as we verily believe.

Cheryl Nester Wolfe
Incorporator

1/28/19
Date

Jan Baldwin
Incorporator

1-28-2019
Date

Barbara Gunder
Incorporator

1-28-2019
Date

Marion Polk Coordinated Care℠

MPCC Attachment 6 - General Questions

A. Background Information about the Applicant

A.1 Marion Polk Coordinated Care (MPCC) is a non-profit public benefit corporation. The company is domiciled in the city of Salem, Oregon in the County of Marion.

A.1.a MPCC is affiliated with Salem Health Hospitals and Clinics, Salem Clinic and WVP Health Authority, each of which are provider organizations with a long history of service to patients in the Marion and Polk County region.

A.1.b MPCC will not need to invoke the alternative dispute resolution process.

A.1.c MPCC administrative offices are located within Marion County at 2995 Ryan Drive SE, Salem, OR 97301. The service area MPCC intends to serve is Marion and Polk Counties.

A.1.d The Service Area for MPCC is all of Marion and Polk Counties as well as contiguous zip codes in Yamhill County (97304), Clackamas County (97002, 97032, 97071, 97362, 97375), Linn County (97346, 97350, 97352, 97358, 97360, and 97383) and Linn County (97361). The contiguous zip codes are included as many of the people living in those areas seek services in Marion or Polk Counties where MPCC providers are located.

The agreements with County Governments include Marion County Health and Human Services and Polk County Health and Human Services. The agreements include the services required by ORS 414.153 including Public Health Services, Mental Health Services, Substance Abuse Services and Crisis Services. The agreements recognize the Counties have responsibility as the local mental health authority and have been negotiated to fund the necessary infrastructure of the mental health safety net system and to meet the requirements of ORS 414.153.

A.1.e MPCC is a newly formed not-for-profit public benefit organization. It has not had a contract with the OHA in 2019 or in the past. The principal organizations are Salem Clinic, Salem Health Hospitals & Clinics and WVP Health Authority. Each of the principle organizations have financial risk via their ownership percentage of the CCO in operation in Marion and Polk Counties, Willamette Valley Community Health LLC, as well as a full risk capitation arrangement for medical and pharmacy services that comprise over 70,000 members. Each of the principle organizations have experience in providing care and administration of the Oregon Health Plan via Willamette Valley Community Health since 2012. WVP Health Authority also had experience prior to that as a Fully Capitated Health Plan for 11 years.

A.1.f As indicated in Section E of this attachment, MPCC is a newly formed organization. It is not a licensed insurer at this time and does not have a contract with the listed entities. MPCCs principle organizations have had full-risk contracts with Willamette Valley Community Health

(WVCH) since 2012 and a contract with WVCH to administer the Oregon Health Authority (OHA), CCO contract for WVCH. WVP Health Authority has the necessary administrative infrastructure in place now to successfully meet contract requirements.

A.1.g MPCC as an entity, does not have experience as a Medicare Advantage contractor, however its affiliate, WVP Health Authority has owned and operated a dual eligible Special Needs Plan (SNP) and a Medicare Advantage Plan in the Marion and Polk region which is now operated by its affiliate Medicare Advantage Plan, ATRIO Health Plans. ATRIO Health Plan operates in Marion and Polk Counties and will be the companion SNP for MPCC.

A.1.h MPCCs affiliated Medicare Advantage Plan, ATRIO Health Plan, has a current Dual Special Needs Coordination of Benefits Agreement with OHA to serve Fully Dual Eligible Members.

A.1.i No, MPCC does not hold an HSC License at this time.

A.1.j No, MPCC does not hold a contract with the Oregon Health Insurance Marketplace at this time.

A.1.k MPCC principle organizations value diversity and employ individuals from a wide range of backgrounds. The CCO firmly believes that exposure to diverse insights and experiences are critical to the success of the organization and will work actively to ensure that MPCC staff reflect the diverse characteristics of the community it serves.

In addition to the organization's commitment to promoting a diverse and inclusive workforce, MPCC principle organizations have extensive experience implementing policies and programs that address regional, cultural, socioeconomic and racial disparities. WVP Health Authority has an extensive Peer Support Program (PSP) that was established to ensure OHA recipients have access to services that are provided by individuals with backgrounds and experiences that are similar to their own. The WVP Health Authority PSP has proven to be an invaluable resource to engage and support members from a broad range of backgrounds. Prominent WVP PSP's include

Emergency Department Intervention Team (EDIT): A bilingual team of current and former OHP recipients dedicated to working directly with patients who have excessive emergency department utilization.

Marion-Polk Obstetric Mentoring Services (MOMs): A bilingual team of current and former OHP recipients who have previously struggled with maintaining sobriety during pregnancy. These women (most of whom are former graduates of the MOMs program) draw from their own personal experience to support pregnant women with substance abuse disorders. The program has proven to be extremely successful, with 99% of participants delivering clean and sober babies.

Marion Polk Coordinated Care℠

Family Support Coordinators (FSC): The FSC program was designed to help families effectively navigate the medical and social service system. The program targets families with children who have high medical complexity and provides them with a single point of contact to ensure the effective and efficient delivery of services.

At the clinic and provider levels, MPCC supports the development and enhancement of Patient Centered Primary Care Home (PCPCH) core competencies. MPCC believes that the proliferation of the PCPCH Model strengthens system-wide capacity to identify and address healthcare disparities. The CCO has made PCPCH a primary component of the organization's Value-Based-Payment (VBP) program and will continue to provide financial and technical support to clinics that achieve certification.

Finally, MPCC principle organizations have a long track record of working effectively to minimize health disparities in the community. WVP Health Authority serves as the Third Party Administrator (TPA) for the CCO currently serving Marion and Polk counties. As part of WVP's work supporting the CCO, staff have developed standing reports that stratify utilization and health outcomes data by pertinent demographic categories. This process has enabled the Plan and its providers to identify existing and emerging disparities across racial, ethnic, linguistic, geographic, and diagnostic identifiers. This information is regularly incorporated into the strategies and objectives developed by the CCO's Governance Board, Clinical Advisory Panel and Community Advisory Council.

A.1.l Executive staff listed below. Resumes attached separately in this file.
Executive Officer – Dean Andretta
Financial Officer – To be determined
Medical Affairs Director - Manuel Rivera
Compliance Director – Kim Hanson
Health Plan Operations Director – Kristie Whiting

A.1.m Contact chart included with submission: RFA4690-MPCC-Att6-RFA Contact Chart

B. Corporate Organization and Structure

B.1.a Certified copy of the articles of MPCCs articles of incorporation included with submission: RFA4690-MPCC-Att6-RFA Articles of Incorporation.

B.1.b As a non-profit Public Benefit Corporation there is no equity ownership. Please see the RFA4690-MPCC-Att6-Organizational Chart.

B.1.c MPCC does not possess any licenses.

B.1.d MPCC does not have any administrative service or management contracts with other parties where MPCC is the provider or recipient of the service under the contract.

C. Corporate Affiliations, Transactions, Arrangements

C.1.a Please see RFA4690-MPCC-Att6-Organizational Chart.

C.1.b MPCC will have contract arrangements with the three affiliated organizations (Salem Health Hospitals and Clinics, Salem Clinic and WVP Health Authority) to provide covered medical services. These contracts will be based on historical and projected cost of services and will have material financial risk, quality expectations and value-based compensation components. MPCC will also utilize administrative services provided by affiliates for provider credentialing, facilities and other potentially necessary administrative structures.

C.1.c MPCC affiliates have a long and successful history of managing financial risk and establishing financial reserves. MPCC affiliates comprise the majority of health care services spending under the current CCO for our proposed service area (WVCH) and will craft shared risk and full risk contracts to ensure the financial viability of MPCC. Each organization has successfully managed Oregon Health Plan (OHP) contracts and populations for close to 20 years. All three organizations were integral in the management of financial risk with the Marion Polk Community Health Plan from 2001 thru 2012 and with WVCH from 2012 to the present.

MPCC will meet the requirements of OAR 410-141-3350 through initial capital contributions and retained earnings. Please refer to financial pro forma submissions in this proposal.

D. Subcontracts

D.1.a MPCC will contract with an affiliate, WVP Health Authority, for credentialing and contracting services.

D.2.b MPCC will contract with a third party administrator for services related to claims processing, member and provider customer service and encounter data submission. MPCC will provide oversight as well as require service level guarantees in the TPA contract.

In addition, MPCC will contract with a Pharmacy Benefits Manager (PBM) to administer the prescription drug benefit.

MPCC will contract with a Non-Emergent Medical Transport (NEMT) broker for the call center and transportation provider contracting for the NEMT benefit.

Please see the enclosed files: RFA4690-MPCC-Att6-Subcontrators-and-Delegated-Entities-Report and RFA4690-MPCC-Att6-Example of Subcontracted Work.

MPCC will monitor performance via the Oversight of Delegated Entities policy and procedure included with the submission: RFA4690-MPCC-Att6-Oversight of Delegated Entities.

E. Third Party Liability

E.1.a MPCC systems allow for entry of pertinent Third Party Liability (TPL) information on the member record. This will allow claims to process properly and require coordination of benefits with the primary payer. In addition, MPCC will utilize the Phia Group for subrogation and claims recovery from third parties as well as HMA to identify enrollment and primary insurance on other commercial health plans in Oregon.

E.1.b MPCC identifies patients with Medicare coverage on the primary eligibility search portal available to all providers. The Medicare ID number from the Medicare Advantage Plan is made available to providers so that claims can be processed properly. The PBM is provided information on Medicare Primary coverage to ensure claims are directed to the proper carrier which is seamless to the patient.

F. Oversight and Governance

F.1.a MPCC principle organizations representatives will elect the Board of Directors.

F.1.b Key Committees include:

1. Community Advisory Committee: Please see F.1.c
2. Finance Committee:

The Finance Committee is responsible for reviewing and monitoring the organization's financial status, policies and the adequacy of its financial reporting. The Committee has the overall responsibility for ensuring that policies and procedures are in place to protect the integrity of the organization and the community investment. The Compliance Committee shall retain authority and accountability to the CCO Board of Directors.

Finance Committee key functions and activities:

- Recommend annual budget and benchmarks to Board of Directors
- Review Annual Financial Audit and appoint Audit Committee
- Review monthly financial statements and compare actual performance to budget
- Create and monitor adherence to Investment Policy
- As directed by Board policy, design financial/risk models and monitor the results
- Evaluate and monitor capital/solvency requirements
- Evaluate and analyze opportunities for financial viability
- The Committee may, as it deems appropriate, establish subcommittees to facilitate the work of The Committee

3. Compliance Committee: The Compliance Committee is charged with overseeing Marion Polk Coordinated Care's compliance program and its compliance with the requirements under the OHA contract. The Compliance Committee shall retain authority and accountability to the CCO Board of Directors.

Compliance Committee members shall include:

- Executive Director; and
- Health Plan Operations Director; and
- Compliance Director; and
- Medical Director; and
- Pharmacy Director; and
- Appeals and Grievance Manager; and
- HIPAA Security and Privacy Director; and
- Board Representation.

4. Transformation and Quality Committee (TraQ):

The Transformation and Quality Committee (TraQ) is responsible for monitoring, evaluating, and improving the access, quality and appropriateness of services provided to CCO members. The TraQ shall retain authority and accountability to the CCO Board of Directors. The TraQ will also establish a Clinical Advisory Panel (CAP) to serve as a subcommittee and provide guidance and feedback on pertinent clinical issues.

TraQ membership shall include the CCO Medical Director, Quality Improvement Director and a minimum of each of the following:

- Three primary care representatives; and
- Two behavioral health representatives; and
- One dental health representative; and
- One Local Public Health Department (LPHD) representative; and
- A minimum of at least one representative from WVP Health Authority, Salem Clinic and Salem Health

F.1.c The MPCC Community Advisory Council (CAC) is responsible for ensuring that MPCC is addressing the healthcare needs of CCO members and the community at-large. It provides community members with a mechanism to hold the MPCC accountable for meeting Triple Aim Objectives by participating the organization's decision making process.

CAC members shall be selected by a committee composed of an equal number of representatives from Marion and Polk counties and members of the governing body of the CCO. The composition of the CAC shall:

- Designate a current OHP recipient or family member serving as CAC Chair; and
- Ensure CAC members include representatives from the community and the Marion and Polk county governments, with consumer representatives constituting a majority of the membership; and
- Include a representative from a primary care office serving OHP members

The CAC Chair shall also serve on the CCO Board and have the authority to appoint a CAC representative to attend and participant in any CCO standing committee.

The CAC will have broad authority to ensure MPCC is addressing the health care needs of the community and will provide monthly updates to the CCO Board. Key CAC reporting activities include, but are not limited to, the following:

- Identifying and advocating for preventive care practices to be utilized by the CCO.
- Overseeing a Community Health Assessment (CHA) and adopting a Community Health Improvement Plan (CHP) to serve as a strategic population health and health care system service plan for the community served by the CCO.
- Annually publishing a report on the progress of the CHP.
- Identifying trainings and resources to improve the provider community's ability to meet the unique needs of the OHP population.
- Reviewing CCO member communications to ensure materials are culturally and linguistically appropriate.
- Reviewing qualitative and quantitative data to promote health equity.

Title: Oversight of Delegated Entities
Category: Compliance
Sub-Section:

Document Owner: Hanson, Kim (Director of Compliance)	Date Created: 04/09/2019
Approver(s): Andretta, Dean (Executive Director)	Date Approved: 04/09/2019

Scope

Marion Polk Coordinated Care (MPCC), a Coordinated Care Organization (CCO), delegated entities.

Purpose

This policy serves as a framework used to identify non-compliance of delegated entities' administrative or healthcare services through monitoring, auditing, and oversight for the Centers for Medicare and Medicaid Services (CMS), the Oregon Health Authority (OHA) rules, regulations, guidance and laws, and MPCC's policies.

Definitions

Abuse: Improper use of Medicaid/CMS programs by a health plan member, health plan or health plan provider, or other individual: may include provision of or payment for services not needed or services which are billed in error and not reported once discovered.

Delegated Entity: MPCC's first tier, downstream, or related entity (FDR) who provides, under contract, administrative or healthcare services to MPCC members.

Fraud: Infraction or series of infractions against: the Centers for Medicare and Medicaid program rules; the federal False Claims Act (both intentional and unintentional): Oregon Health Authority's Oregon Health Plan rules and regulations; and State and federal rules, regulations, and laws committed by healthcare providers, health plans or program beneficiaries, including fraudulently obtaining services, billing for services not provided, or billing for a service which has a higher reimbursement than the service provided.

Waste: An overuse of services or other practices that, directly or indirectly result in unnecessary cost; the misuse of resources.

Policy

The MPCC Compliance Department identifies potential compliance risks through routine monitoring and auditing of the administrative or healthcare services as part of their oversight

of delegated entities contracted with MPCC. This is done to ensure compliance training, best practices, regulatory guidance, and polices are adhered to.

Procedure

1. MPCC's oversight of delegated entities through the year includes risk assessments, monitoring, and auditing activities to ensure compliance with federal and State laws, CMS, OHA, best practices, regulatory guidance, and MPCC policies and procedures.
   - 1.1. MPCC and delegated workforce members must immediately report to MPCC's Director of Compliance any non-compliance and/or potential, suspected, or actual fraud, waste, or abuse issues that are discovered via monitoring, auditing, or other oversight activity.
   - 1.2. All delegated entities are required to provide documentation of their downstream entity/contracted vendor monitoring, either by providing supporting policies and procedures, or documented proof of monitoring activities to MPCC within 35 days of the end of a quarter.
2. Delegated Entity Expectations.
   - 2.1. MPCC's Director of Compliance communicates compliance expectations of all delegated entities.
   - 2.2. The delegated entities are required to monitor their downstream entities/vendors through annual training, unless otherwise specified, including but not limited to:
     - 2.2.1. General compliance, including conflict of interest and code of conduct;
     - 2.2.2. HIPAA Privacy Rule;
     - 2.2.3. Fraud, waste, and abuse;
     - 2.2.4. Advance directives and declaration for mental health treatment;
     - 2.2.5. Passenger Service and Safety (PASS) driver certification (three year certification for non-emergent medical transportation delegate only); and,
     - 2.2.6. Any other required training deemed necessary by MPCC.
   - 2.3. Delegated entities are required to submit monthly Service Level Agreement (SLA) reports, a contractual requirement found in Exhibit C of the Subcontractor Agreement.

2.3.1. At the discretion of MPCC, or due to not meeting set benchmarks, SLAs may be required to be reported in more frequent intervals of time to monitor trends.

2.4. Delegated entities are required to submit to MPCC, on an annual basis according to their contract:

2.4.1. Policies and procedures pertaining to MPCC members;
2.4.2. Compliance plans;
2.4.3. Business continuity/disaster recovery plans;
2.4.4. Fraud, waste, and abuse plans;
2.4.5. Financial solvency attestations and documents;
2.4.6. OIG LEIE/SAM exclusion reports; and
2.4.7. Any other documentation as deemed necessary by MPCC.

2.5. The delegated entities are required to conduct training annually, unless otherwise specified, and forward all training attestations of completion or Certificates of Completion to MPCC Compliance.

2.5.1. All delegated entities train new workforce members within the first 90 days of employment.

3. Reporting.

3.1. Delegated entities are required to report any suspected act of non-compliance or incident in good faith to the MPCC Compliance Department.

3.2. The MPCC Director of Compliance reports incidents to the MPCC Compliance Committee and Executive Director.

3.3. Depending on the severity of an act of non-compliance or incident, either the MPCC Compliance Committee shall report acts or incidents to the MPCC Board of Directors, or the CEO shall report directly to the MPCC Board Chairperson.

Regulatory or Administrative Citations

42 CFR 438.608(a); 42 CFR 438.608 (b)

Email: deana@mvipa.org
Phone: 503-587-5107

DEAN GAGE ANDRETTA

PROFESSIONAL PROFILE

Healthcare executive with over 25 years of experience. Key experiences include healthcare finance and operations in health plans, hospitals and clinic settings. Teamwork, collaboration, trust and integrity are paramount.

SKILLS & ABILITIES

- Direct Management of Oregon Health Plan CCO
- Intimate knowledge of Oregon Health Plan operation and funding model
- Health Plan, Hospital, and Clinic Finance Skills
- Health Plan Accounting Skills (GAAP and Statutory)
- Develop and Implement Advanced Payment Models
- Strategic Planning
- Entrepreneurial Spirit

PROFESSIONAL EXPERIENCE

WVP HEALTH AUTHORITY – CHIEF FINANCIAL OFFICER

Dates From July 1995 – To Current
Manage the day-to-day finance/accounting, provider contracting, health plan contracting, data analysis, quality reporting and business intelligence staff. Also manage the finance and operations of Willamette Valley Community Health via an administrative contract for past 7 years.

WILLAMETTE VALLEY COMMUNITY HEALTH – EXECUTIVE DIRECTOR

Dates From June 2012 – To August 2014
Provided executive leadership for CCO in startup phase for one of the initial 16 CCO's in Oregon. Notable accomplishments include meeting quality goals, managing explosive growth in membership by ensuring provider network had capacity to serve 35,000 additional members on boarded in less than 6 months, met all solvency requirements for a startup plan and crafted financial model that supported global budget concept.

COLUMBIA HOSPITAL CORPORATION, DIRECTOR OF MANAGED CARE

Dates From 1993 – To July 1995
Negotiated payer contracts for Columbia facilities in Oregon and the Northwest. Reported to Chief Financial and Executive Officers for Oregon Based Facilities.

EDUCATION

UNIVERSITY OF THE PACIFIC — STOCKTON, CA—B.S. BUSINESS ADMINITRATION, FINANCE CONCENTRATION

Student-Athlete Award 1983-1986 as member of Division I basketball team.

UNIVERSITY OF OREGON – EUGENE, OR – MBA PROGRAM

Attended from 1990 to 1992

kimh@mvipa.org
503-587-5138 (W)

KIMBERLY R. HANSON

PROFESSIONAL PROFILE

A capable and knowledgeable Compliance Officer who is well-versed in compliance guidelines and corporate governance best practices. Able to promote, develop and establish a positive safety culture within a company so that it can meet its legal requirements in terms of Health, Safety and Compliance. Proven track record of helping a company to manage risk, maintain a positive reputation, and mitigate legal risks.

SKILLS & ABILITIES

- Motivating, developing, and directing people as they work, identifying the best people for the job.
- Communicating effectively in writing as appropriate for the needs of the audience.
- Giving full attention to what other people are saying, taking time to understand the points being made, asking questions as appropriate, and not interrupting at inappropriate times.
- Using logic and reasoning to identify the strengths and weaknesses of alternative solutions, conclusions or approaches to problems.
- Determining how a system should work and how changes in conditions, operations, and the environment will affect outcomes.
- Identifying complex problems and reviewing related information to develop and evaluate options and implement solutions.

PROFESSIONAL EXPERIENCE

COMPLIANCE OFFICER

November 2011- Current

WVP Health Authority

- Responsible for day to day operations of the Compliance Department at WVP Health Authority.
- Responsible for the development of a Corporate Compliance Plan along with developing and monitoring the implementation and compliance with all plan related policies and procedures.
- Create and coordinate educational training programs to ensure that the Plan's officers, directors, managers, employees, other individuals and first tier, downstream and related entities working on the various programs are knowledgeable of the Plan's compliance program; its written standards of conduct, policies, and procedures; and the applicable statutory, regulatory, and other requirements
- Respond to reports of potential instances of fraud, waste or abuse, including the coordination of internal investigations and the development of appropriate corrective or disciplinary actions, if necessary
- Monitor and oversight of auditing processes across departments.

Additional Experience

- Appeals and Grievance Manager April 2010- November 2011
  WVP Health Authority

- Medical Management September 1998- April 2010
  WVP Health Authority

EDUCATION

M.J. Master of Jurisprudence in Health Law, Loyola University Chicago School of Law, Chicago, IL 60660. Degree anticipated August 2019.

B.A. Health Care Administration, George Fox University, Newberg, OR 97132

C.N.A Certified Nursing Assistant, Salem Hospital, Salem, OR, 97301

kwhiting@mvipa.org
(503) 587-5140

KRISTIE WHITING

PROFESSIONAL PROFILE

Qualified by more than 15 years in the healthcare industry, including ten years in healthcare insurance, and eight years in management with Oregon healthcare organizations. Skilled in providing strategic leadership to achieve growth, retention, and financial goals with strengths in data analytics and relationship building. Results-oriented and committed to using proven methodologies and performance metrics to streamline operations and maximize quality, efficiency, and market share.

SKILLS & ABILITIES

- **Subject Matter Expertise:** Comprehensive knowledge of the administrative services marketplace, health payer administration, business intelligence and data analytics.
- **Department Operations:** Seasoned manager with proven ability to coordinate multiple departments, develop / manage / monitor budgets, develop strategic plans, manage customer service, and play key role in policy and procedure development.
- **Cross-department Collaboration:** In-depth understanding of complex interdepartmental processes and business relationships. Able to maintain collaborative partnerships, manage conflict, and work with other department managers to expedite resolution and identify opportunities for improved customer service.
- **Dedicated Team Leader:** Solid experience in all aspects of employee hiring, training, development, and performance management. Experience managing large teams with up to 96 people.

PROFESSIONAL EXPERIENCE

PARTNER RELATIONS DIRECTOR, WVP HEALTH AUTHORITY

Dates From 09/15 – To Present

Manage complex contracting relationships and create / negotiate partner contracts, administrative service agreements, provider service contracts, payer contracts, risk group agreements, dental network contracts, sub delegation agreements, and vendor contracts. Supervise contracting and credentialing teams and ensure all services are compliant with contract guidelines and state and federal rules. Conduct financial analysis, identify cost trends, validate and strategize contract implications, and create / review / model alternative payment methodologies. Create and execute monthly reporting processes. Cultivated relationships and gained recognition as a trusted advisor and subject matter expert.

SENIOR CLAIMS ADMINISTRATION MANAGER, PERFORMANCE HEALTH TECHNOLOGY

Dates From 07/13 – To 09/15

Coached and led five teams with 96+ employees in two cities. Coordinated all teams and ensured the highest level of collaboration, integrity, and efficiency. Managed operations and ensured compliance with Service Level Agreements, policies /

procedures, and customer expectations. Created and managed action plans for any areas not meeting standards. Collaborated with internal and external customers to develop solutions for operational challenges. Worked with team members to develop processes and solutions for fee schedules, benefit configuration, and claim edits. Reviewed outside service contracts and negotiated rates as needed. Performed demonstrations online and in person for potential customers.

CLAIMS OPERATION MANAGER, MID ROGUE MANAGEMENT SERVICES/ALLCARE CCO

Dates From 04/09 – To 07/13

Managed claims operations, including electronic data exchange, claims call center, claims processing and business analytics team. Evaluated operational needs, determined efficient work flow, and ensured that departments were operating within budget. Created, updated, and maintained system configuration, including authorization and claim auto-adjudication tables, benefit configuration, and contracts / fee schedules. Analyzed reports to confirm that Risk Adjustment Processing System and Oregon Health Authority encounter data submissions were completed in an accurate and timely manner. Served as member of Leadership Team.

EDUCATION

SCHOOL NAME —LOCATION —DEGREE

CERTIFICATIONS

- CPMA / Certified Professional Medical Auditor
- CPC-P / Certified Professional Coder - Payer

riveramanny@msn.com
503-999-2870

MANUEL RIVERA

PROFESSIONAL PROFILE

Experienced and educated leader with over 20 years of healthcare experience. Knowledgeable in all aspects of healthcare operations with the affinity to adapt to the changing landscape and delivery of the healthcare system.

SKILLS & ABILITIES

- Focused leader, recognized for delivering superior results.
- Well qualified executive with over 20 years of healthcare experience.
- Articulate communicator, capable of building lasting relationships with internal and external stakeholders, clients, partners and vendors.
- Visionary, with track record for finding innovative ways to grow staff and reduce turnover ratios.
- History of success, leading initiatives for all aspects of healthcare including quality improvement, customer service, IT, appeals and grievances, provider relations, provider recruitment, medical management, home health, human resources and compliance.
- Known for managing turnaround projects with 100% success rate.
- Well versed in presentations, accustomed to addressing clients, vendors, partners, shareholders and corporate board of directors.
- Championed the development and implementation of strategic plans and innovative across the healthcare management spectrum.

PROFESSIONAL EXPERIENCE

CHIEF OPERATIONS OFFICER, WVP HEALTH AUTHORITY

2009 – Current

Primary duties include but are not limited to the overall management of Human Resources, Information Technology, Provider Relations, Government Programs, Medical Management, Provider Recruitment and Appeals and Grievances. Provide leadership to health plan operations including, but not limited to enrollment & eligibility, call center, claims, and encounters, partner with multiple stakeholders and leadership to establish strategic visions, operational objectives, and policies and procedures ensuring compliance with state contracts, related laws, regulations and executive orders. Monitor and report achievement of committed action plans to senior management. Direct the development and implementation of operational work processes and systems with direct oversight for multiple departments within the business unit. Provide direction to health plan expansion activities and coordinate with appropriate corporate resources.

LEAD PREPAID HEALTH PLAN COORDINATOR, OREGON DEPARTMENT OF HUMAN SERVICES-DIVISION OF MEDICAL ASSISTANCE PLANS

2001 – 2007
Responsible for the on-going development and improvement of managed care delivery systems and their contracts. Responsible for the program coordination to design, develop and implement the managed health care delivery systems. Assessment of health care access by evaluation the various programs and identifying the needs of the department, capacity indicators and the development and coordination of community resources.

HEALTH RESOURCES COORDINATOR
CUSTOMER SERVICE SPECIALIST
REGENCE BLUE CROSS BLUE SHILED

1996 – 2001
Responsibilities encompassed the training, coaching on-going monitoring of new employees. Coaching and monitoring all of the calls, to ensure compliance with company standards. Responsibilities also included processing of member and provider call, encompassing all lines of business (group, individual, traditional, OHP and Medicare).

EDUCATION

WILLAMETTE UNIVERSITY —SALEM, OREGON —MASTERS BUSINESS ADMINISTRATION

PORTLAND STATE UNIVERSITY —PORTLAND, OREGON —BACHELOR'S DEGREE OF SCIENCE

CHEMEKETA COMMUNITY COLLEGE—SALEM, OREGON —ASSOCIATES OF ARTS AND ASSOCIATES OF SCIENCE

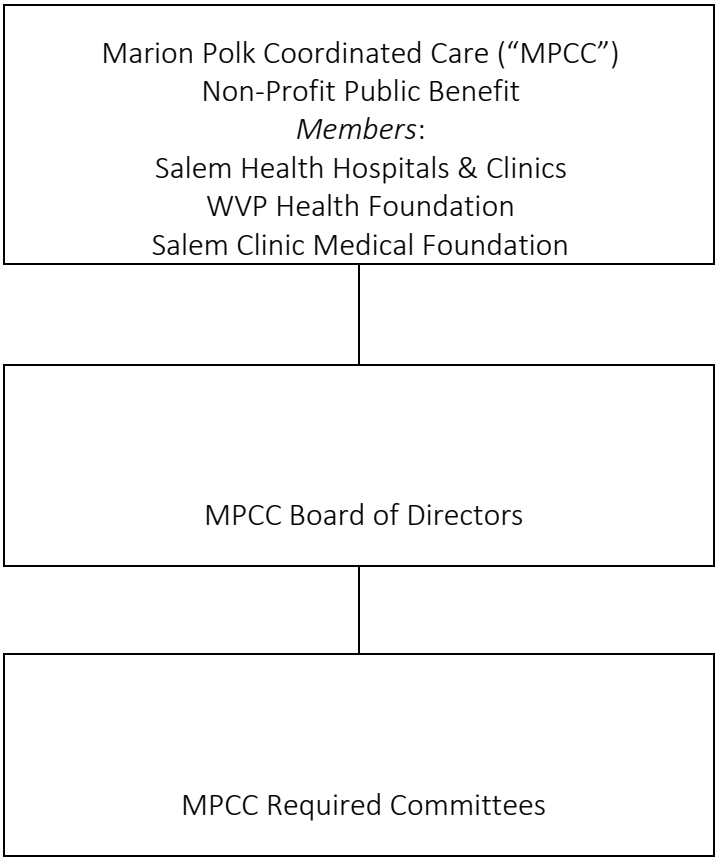
Marion Polk Coordinated Care℠

Attachment 6 1.m: Contact Chart

Attachment	Name	Phone Number	Email Address
General Application	Kristie Whiting	503-587-5140	kwhiting@mvipa.org
Attachment 3	Kristie Whiting	503-587-5140	kwhiting@mvipa.org
Attachment 4	Kristie Whiting	503-587-5140	kwhiting@mvipa.org
Attachment 5	Dean Andretta	503-587-5107	deana@mvipa.org
Attachment 6	Dean Andretta	503-587-5107	deana@mvipa.org
Attachment 7.1	Dean Andretta	503-587-5107	deana@mvipa.org
Attachment 7.2	Krista Lovaas	503-587-5123	krista@mvipa.org
Attachment 7.3	Dean Andretta	503-587-5107	deana@mvipa.org
Attachment 7.4	Krista Lovaas	503-587-5123	krista@mvipa.org
Attachment 7.5	Vannessa Ramirez	503-587-5123	vannessa@mvipa.org
Attachment 7.6	Mindi Burdick	503-587-5126	mburdick@mvipa.org
Attachment 7.7	Dean Andretta	503-587-5107	deana@mvipa.org
Attachment 7.8	Kim Hanson	503-587-5138	kimh@mvipa.org
Attachment 7.9	Stuart Bradley	503-485-3237	sbradley@mvipa.org
Attachment 7.10	Sarah Smith	503-587-5166	ssmith@mvipa.org
Attachment 7.11	Kristie Whiting	503-587-5140	kwhiting@mvipa.org
Attachment 7.12	Krista Lovaas	503-587-5123	krista@mvipa.org
Attachment 8	Dean Andretta	503-587-5107	deana@mvipa.org
Attachment 9	Dr. Greg Fraser	503-587-5114	Fraser@mvipa.org
Attachment 10	Dean Andretta	503-587-5107	deana@mvipa.org
Attachment 11	Dean Andretta	503-587-5107	deana@mvipa.org
Attachment 12	Dean Andretta	503-587-5107	deana@mvipa.org
Attachment 13	Kristie Whiting	503-587-5140	kwhiting@mvipa.org
Attachment 14	Kristie Whiting	503-587-5140	kwhiting@mvipa.org
Attachment 15	Kristie Whiting	503-587-5140	kwhiting@mvipa.org
Attachment 16	Mindi Burdick	503-587-5126	mburdick@mvipa.org
Sample Contract	Kristie Whiting	503-587-5140	kwhiting@mvipa.org

Rates and Solvency	Dean Andretta	503-587-5107	deana@mvipa.org
Readiness Review	Kristie Whiting	503-587-5140	kwhiting@mvipa.org
Membership and Enrollment	Krista Lovaas	503-587-5123	krista@mvipa.org

Attachment 6-C.1-Organizational Chart



As a non-profit Public Benefit Corporation there is no equity ownership.

Marion Polk Coordinated Care℠

Attachment 7-Provider Participation and Operations Questionnaire

1. Governance and Organizational Relationships

1.a The Marion Polk Coordinated Care, Inc. (MPCC) Governance Structure draws upon a diverse range of individuals and organizations to ensure adequate community representation in the pursuit of achieving Triple Aim Objectives. The majority of the MPCC Governing Body will be composed of persons that share financial risk in the organization. The Governance Board shall include the following:

- WVP Health Authority representative
- Salem Health representative
- Salem clinic representative
- Practicing dentist serving OHP members
- Practicing physician serving OHP members
- Practicing mental health or chemical dependency treatment provider
- Two Community Representatives
- Community Advisory Council Chair

The Community Advisory Council's (CAC) relationship with the MPCC governance structure has been designed to ensure transparency and accountability for the governing body's consideration of CAC recommendations. The MPCC CAC Chair will serve on the governing body and provide the board with updates, suggestions, and requests as appropriate. The MPCC CAC will also produce written reports on the activities of the CCO that will be provided to the board while further allowing CAC members to directly submit written or oral comments directly to the board.

CAC members shall be selected by a committee composed of an equal number of representatives from Marion and Polk counties and members of the governing body of the CCO. The composition of the CAC shall follow the guidelines below:

- Designate a current OHP recipient or family member serving as CAC Chair; and
- Ensure CAC members include representatives from the community and the Marion and Polk county governments, with consumer representatives constituting a majority of the membership; and
- Include a representative from a primary care office serving OHP members

The CAC will have broad authority to ensure MPCC is addressing the health care needs of the community and will provide monthly updates to the CCO Board. Key CAC reporting activities include, but are not limiting to the following:

- Identifying and advocating for preventive care practices to be utilized by the coordinated care organization;

- Overseeing a community health assessment and adopting a community health improvement plan to serve as a strategic population health and health care system service plan for the community served by the coordinated care organization; and
- Annually publishing a report on the progress of the community health improvement plan.
- Identifying trainings and resources to improve the provider community's ability to meet the unique needs of the OHP population.
- Reviewing CCO member communications to ensure materials are culturally and linguistically appropriate
- Reviewing qualitative and quantitative data to promote health equity

Finally, MPCC will make a concerted effort to ensure that members with Severe and Persistent Mental Illness (SPMI), as well as those receiving DHS Medicaid-funded LTC services and supports have adequate representation. The CCO will recruit members from the aforementioned groups to directly serve on the CAC or have a representative advocate on their behalf. MPCC will also incorporate SPMI and DHS Medicaid funded-LTC services into standing dashboard reports to be reviewed and discussed at the CAC, Clinical Quality Committee and Governance Board.

1.b MPCC will develop and maintain a Transformation and Quality Committee (TraQ) which is responsible for monitoring, evaluating, and improving the access, quality and appropriateness of services provided to CCO members. The (TraQ) shall retain authority and accountability to the CCO Board of Directors and oversee a Clinical Advisory Panel (CAP) subcommittee.

1.c.1 MPCC brings contracting experience with the local AAA for LTSS MOU(s) with the contracting team of its WVP member and its role played in contracting MOU's with the current CCO for the past few years. MPCC will continue to utilize this established relationship WVP contracting has maintained for continuity of the MOU(s) moving forward. Conversations have already taken place to secure a two year MOU with MPCC. The established workflow and relationships will continue in order to ensure compliance with the State's deadline of final signatures of all parties.

1.c.2. MPCC has obtained a Letter of Agreement with Long Term Services and Support (LTSS) and the AAA Organization of Northwest Senior & Disability Services (NWSDS) to work in good faith to complete and execute the MOU agreement.

1.d.1,2 MPCC currently has a Memorandum of Understanding (MOU) with Marion and Polk County which represents the County's commitment to collaborate with MPCC in the development of a plan for shared responsibility for the full continuum of health care services in the Marion/Polk region.

1.d.3 MPCC has established and will maintain relationships with social and support services. Several MPCC principle partners serve on a variety of boards for local non-profits. These relationships are already established and the MPCC principles have a track record of community involvement to ensure opportunities for improved coordination of care are quickly identified and capitalized upon. Below are some examples or current participation.

- MPCC principles have established relationships with DHS Child Welfare. MPCC principles partners have current representatives that serve on the Liberty House Board of Directors, County Child Abuse Team, Domestic Violence Council, Child Fatality, Neonatal Opioid Withdrawal Team and After Hours Response group. These relationships will be leveraged and expanded in the new CCO to identify opportunities for improved coordination of care.

- MPCC principles have established relationships with OYA and Marion and Polk County Juvenile Departments. MPCC principles partners have current representation on Civil Commitment committee, Law Enforcement Assisted Diversion (LEAD), Justice Reinvestment Committees and other Sexual Assault Response teams. These relationships will be leveraged and expanded in the new CCO to identify opportunities for improved coordination of care.

- MPCC principles have established relationships with local law enforcement and corrections. MPCC principles partners have representatives which serve on Civil Commitment committee, Law Enforcement Assisted Diversion (LEAD), Justice Reinvestment Committees and other Sexual Assault Response teams. Regular meetings occur between Salem Health Emergency Departments and emergency responders and local law enforcement. The groups currently work together to problem solve patient access and care. These relationships will be leveraged and expanded in the new CCO to identify opportunities for improved coordination of care.

- MPCC principles have established relationships with K-12, ESDs and higher education. MPCC principles partners are currently partnering with Salem-Keizer Public Schools on a Suicide Prevention initiative. Regular meetings occur with higher education institutions such as Willamette University, Chemeketa Community College and Western Oregon University to identify employment training gaps, augment existing educational programs and offer practicum hours. Salem Health and West Valley Hospital, a MPCC principal partner, also offer job shadow programs to local high school students and actively partners with two local high schools health occupations programs to allow students hands on experience. High school and college students make up approximately 20% of volunteers at Salem Health Hospitals and Clinics.

- MPCC is sensitive to the special needs population in our service area. When Easter Seals exited Marion and Polk counties several years ago, Salem Health's Outpatient

Rehabilitation team added seven therapists to meet the community's need for pediatric physical, occupational and speech therapy. In 2017, a Parent Navigator was added to the team to provide peer support and guidance to parents whose children had recently been diagnosed with autism. An inclusive playground shared by therapists and the community alike opened in 2017. Let's All Play Place is designed for child of all ages and abilities to play and learn together.

- MPCC has reached out to tribal organizations to determine how we can best partner.

- MPCC principles have established relationships with housing organizations. MPCC principles partners serve on local homeless task forces and are partnering with Salem Housing Authority on a new transitional housing project in NE Salem, which will include medical respite beds for patients with injuries or illness not severe enough to remain in the hospital but also not appropriate for discharge to the street. Patients will be able to recover in a warm, dry and secure environment with access to care as well as wraparound services designed to move them toward stability.

- MPCC principles have established relationships with numerous family and peer support organizations. Salem Health Hospitals and Clinics representatives serve on local boards and volunteer actively for organizations such as Family Building Blocks, MWV Community Action Agency, United Way and Salvation Army. Salem Health provides Community Partner Grants to many organizations to fund population health and identified community health needs. Salem Health's Suicide Prevention Steering Committee includes representatives from peer based organizations such as Oregon Family Support Network and Youth Era. Salem Health is sensitive to the needs of the community and is constantly adapting to meet those needs.

- MPCC principles work closely with nearly all social services agencies that impact social determinants of health. MPCC will work to provide health education to the community through preventative screenings, health fairs and the Community Health Education Center open five days a week on the Salem Hospital campus.

2. Member Engagement and Activation

2.a,b MPCC recognizes that meaningful patient engagement is a critical component of any health improvement strategy. MPCC's founding members have extensive experience engaging OHP recipients at both the clinic and systems levels. Moving forward, the organization will continue to deploy a wide range of strategies to strengthen member engagement on behalf of the health plan and its providers.

Prominent strategies shall include:

1) Leveraging Patient Centered Primary Care Home (PCPCH) requirements that support meaningful member engagement: The CCO will provide practice facilitation and shared resources to enhance performance on patient engagement components of PCPCH Standards. Example activities include:

- Working with PCPCH's to develop and maintain practice-level processes for the application, interview, orientation and training of patient advisors;
- Assisting PCPCH's recruit and train patient and family advisors to serve on patient advisory councils;
- Providing PCPCH's with technical support to ensure they have access to usable data that measures patient experience (surveys, focus groups etc.);
- Development of culturally and linguistically appropriate resources;
- Supporting PCPCH's implement processes to engage patients in end-of-life planning conversations and the completion of advanced directives as well as other forms that reflect wishes for end-of-life care; and
- Helping PCPCH's utilize individualized care plans for patients and families with complex medical or social concerns.

These activities and resources will be coupled with a primary care payment model that provides financial incentives to reward clinics for improving PCPCH designation.

2) Identification and promotion of best practices that promote meaningful member engagement. The CCO will work in conjunction with the MPCC Clinical Advisory Panel (CAP) to proliferate evidence-based practices such as:

- Shared Decision-Making;
- Motivational Interviewing; and
- Trauma-Informed Care

3) Developing and supporting system-wide structures that enable patients to meaningfully engage the health plan:

- Establishment of a robust Community Advisory Council (CAC) that includes broad community representation;
- Application of the Mobilizing for Action through Planning and Partnerships (MAPP) model in the development of Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP);
- Using data to identify over/under utilization patterns amongst vulnerable populations;
- Instituting network-wide primary care standards that promote workforce diversity
- Centralized access to THW's and other wraparound services for patients assigned to practices that are too small to employ such staff independently;
- Support primary care practices adherence to National CLAS Standards; and

- Mandate Social Determinants of Health training across primary care network.

4) Expanding the use of HIT for patient engagement and health equity:
   - Application of targeted HIT-based programs that take into consideration member demographics, language, accessibility and literacy;
   - Support behavioral health providers' access to HIE for care coordination across systems;
   - Ensure timely hospital event notifications to devise interventions and follow-up;
   - Expand telehealth capabilities; and enhance collection and meaningful use of race, ethnicity and language (REAL) data.

5) Enhanced member communication and education:
   - Provide incentives for members attending wellness programs when appropriate;
   - Utilize CAC to ensure member materials are culturally and linguistically appropriate;
   - Develop web-based communications that are accessible and appropriate for CCO members; and
   - Expand use of text communication and outreach.

6) Implement payment models that reward meaningful member engagement.
   - PCPCH provider bonuses;
   - Including THW's and other wrap-around services in value-based payment methodologies;
   - Expand payment arrangements to include more group visits, e-visits and other alternative patient encounters; and
   - Devise compensation model for pre-visit planning for non-urgent complex patients.

7) Proliferate availability of co-located services
   - Promote financial models that enable primary care providers to have behavioral health and dental services available on-site; and
   - Increase THW's in primary care setting and promote expansion into behavioral and dental locations.

MPCC will use these and other strategies to empower members to prioritize their own healthcare needs and concerns.

3. Transforming Models of Care

3. Patient-Centered Primary Care Home (PCPCH) core competencies 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.

MPCC has a robust PCPCH delivery system in which over 94% of members are assigned to clinics that have achieved a four or five star designation. MPCC will continue to promote PCPCH core competencies through the implementation of alternative payment methodologies that reward clinics based upon designation status. Using this approach, PCPCH's will have the opportunity to benefit from increased monthly capitation payments in addition to annual quality bonuses that are based upon designation status.

In addition to proliferating PCPCH-supportive alternative payment methodologies, MPCC will also explore increasing the fee schedule to enhance payments that align with PCPCH core attributes such as telephonic counseling, medication reconciliation, etc. The CCO firmly believes that the effective application of the Medical Home Model is a primary driver of clinical quality improvement and will strive to make PCPCH activities financially viable across the provider network.

Finally, in addition to deploying payment arrangements that provide direct compensation for PCPCH activities, MPCC will enhance the availability of shared resources that support the Medical Home Model. As an example, MPCC will make clinical wrap-around support services available to patients assigned to clinics where such resources would otherwise be unavailable. Under this arrangement, MPCC will hire clinical staff such as pharmacists, behaviorists, dieticians etc. that are co-located at various primary care locations across the network. This team will also work with primary care providers to provide services via referrals from across the network. MPCC believes making these types of shared resources available will enhance PCPCH performance and reduce disparities in care across primary care providers.

MPCC will also ensure DHS Medicaid-funded LTC Providers have an opportunity to participate in the CCO's decision-making process and will be empowered to raise concerns and propose interventions as appropriate. The CCO will provide administrative support to primary care providers looking to establish workflows and best practices that support improved care coordination across the continuum of care. Supports will include on-site training, learning collaborative, and the provision of pertinent data.

MPCC has reached out to FQHC's and other safety net providers to promote the payment structure and shared resources described above. All safety net providers have the opportunity to participate in the various programs made available to the primary care network. All FQHC's in

the MPCC service area are designated as tier 4 or tier 5 clinics, a fact which serves as a testament to MPCC's inclusive approach towards safety net providers.

4. Network Adequacy

4.a.1 MPCC will use multiple mechanisms to assess the adequacy of the Provider Network. The CCO will conduct frequent assessments of its patient population and provider network via geo mapping to ensure access is within allowable standards for time and distance. Geo-mapping will be stratified by provider type; PCP, specialty, dental, behavioral health mental health and Substance Use Disorder (SUD) providers.

MPCC will also perform quarterly network surveys of all contracted PCP, mental health and SUD providers to confirm current open/closed status for MPCC patients. This will be coupled with quarterly secret-shoppers calls to all PCP offices open to new patients to ensure timely access to health care services (based on urgency of clinical need). Offices outside of the allowable standard, or community standard, will be closed to new MPCC patients until the clinic demonstrates wait times adhere to established standards.

Annual Accessibility surveys will also be conducted on 10% of the provider network to assess provider network's ability to meet the needs of patients with Limited English Proficiency and those who are visual and/or hearing impaired. Additionally, 1% of the patient population will be surveyed quarterly using the access to, and satisfaction with, care questions mirrored from the CAHPS survey. Negative responses are captured as complaints and results are analyzed for trending and opportunities for improvement, education and network expansion needs.

Finally, MPCC will review all complaint data (including survey responses) as it pertains to access to care. Complaints regarding access to care will be investigated and escalated to contracting for opportunities to expand network access by contracting with out-of-area or non-contracted providers to ensure adequate, timely access to needed providers.

4.a.2 MPCC will establish capacity of its network using evidence based methodologies, historical penetration rates and industry standard patient/provider ratios. MPCC uses the 2017 national blended benchmark survey data from AMGA and SCA (1) which reports an average panel size for 50% of family medicine, internal medicine and pediatric medicine to be 1798, the plan then calculates the volume of panel that would reflect the current percent of the local population that is covered by OHP (24%) to be 431 Medicaid patients per provider. Additional consideration is given to the reported FTE status. MPCC provider network FTE status is, 80% of the providers report to be full time and 20% less than full time. PCP capacity for provider full time status is adjusted in calculation. With 296 PCP's in the intended MPCC network, the

percentage of provider reporting full vs part time, and including capacity query within the intended network, MPCC will have total capacity for 109,516 patients.

The PCP and specialty providers that MPCC intends to contract with span the entire service area to ensure geographically appropriate and timely access to care for members in all areas of the counties.

MPCC also intends to contract with 248 mental health and substance use disorder providers which span the service area which will ensure adequate capacity to these services. Historical use of the mental health system demonstrates a 7% penetration rate, at the reported capacity that would calculate to an average of 30 members per mental health/substance use disorder provider.

Lastly, MPCC will establish capacity for oral health providers utilizing the industry standard of 2,000-2,500 patients per provider. MPCC intends to contract with over 95 oral health providers. Historical penetration rate for oral health is 12% which would calculate to 137 patients per oral health provider at the reported capacity.

Sources:
(1) https://cokergroup.com/wp-content/uploads/2015/07/Using-Patient-Panel-as-a-Principle-Element-in-Primary-Care-Physician-Compensation_February-2018.pdf. Accessed: 02/11/2019
(2) http://files.kff.org/attachment/fact-sheet-medicaid-state-OR. Accessed: 02/11/2019.

4.a.3 MPCC will address network deficiencies by direct communication and coordination with its contracting department to locate additional capacity with non-contracted or out of area providers. Additionally, MPCC will coordinate and leverage the Provider Recruitment specialists within the three founding organizations to focus efforts on recruitment to the local area to increase capacity for MPCC patients.

4.a.4 MPCC will perform annual Accessibility surveys on 10% of the provider network to assess timely access to provider services (as defined by OAR) based on clinical need of the patient. Additionally, 1% of the membership will be surveyed quarterly using the access to, and satisfaction with, care questions derived from the CAHPS survey. Results will subsequently be analyzed for to identify trends and implement improvement activities.

MPCC will also perform secret-shopper calls each quarter to all PCP offices that are open to new patients. This process was designed to ensure timely access to health care services (based on urgency of clinical need). Offices outside of the allowable standard, or community standard, will be closed to new MPCC patients until the clinic demonstrates wait times within allowable/community standard.

Finally, MPCC will evaluate complaint data related to timeliness to care and address at the provider office level. Offices outside of the allowable standard, or community standard, will be closed to new MPCC patients until the clinic demonstrates sufficient improvement.

4.a.5 MPCC will monitor its dental provider network (general dentists and specialists) on a monthly basis to ensure the CCO has adequate capacity to serve OHP members from across the service area. MPCC will hold Network Provider meetings monthly to discuss additions (or deletions) to the network, any concerns or opportunities with respect to specific providers, and to review credentialing applications for new providers.

MPCC will perform annual Accessibility surveys on 10% of the provider network to assess timely access (as defined by OAR) to provider services based on clinical need of the patient. Additionally, 1% of the membership will be surveyed quarterly using the access to, and satisfaction with, care questions used in the CAHPS survey. Results will be analyzed to identify trends and implement interventions as needed.

4.a.6 MPCC will coordinate closely with the provider network to ensure members are not negatively impacted by capacity fluctuations. In the event of a provider leaving the plan, MPCC will determine impacted patient roster and proactively communicate with available network providers regarding network change and ensure capacity within the remaining network to accommodate additional MPCC patients within the access time allowances. Patients will be notified of the provider termination and available alternate providers within the network with capacity for new patients.

5. Grievance & Appeals

5. Marion Polk Coordinated Care Inc. (MPCC) has written policy and procedures in place to ensure compliance with the Grievance and Appeals procedures under which Members, Representatives, or Providers acting on their behalf may be able to appeal any Adverse Benefit Determination or file a complaint. MPCC does not delegate any portion of the Complaints process for physical health, behavioral health (Mental Health and Substance Use Disorder), oral health, and non-emergent medical transportation.

The complaints process will capture any expressions of dissatisfaction. It will assist in identifying issues related to access to care including non-emergent medical transportation, interpersonal relationships, quality of service, quality of care, Fraud Waste & Abuse, network adequacy for physical health/behavioral health/and oral health, and ensure appropriate review of prior authorized services by medical management.

MPCC will also monitor access complaints. The complaints coordinator will work with the assistance of other departments such as Provider Relations, Intensive Case Management, Contracting, and Compliance to ensure that there is adequate access to providers by type; PCP, specialist, dental, and behavioral health (Mental Health and Substance Use Disorder) and that providers are adhering to the Oregon Administrative Rules (OARS). Complaints regarding access to care will be investigated and escalated as needed. In instances where access issues have been identified, MPCC will work to expand the network by contracting with out of area or non-contracted providers to ensure adequate and timely access to providers.

MPCC will use several mechanisms to assess the adequacy of the provider network. MPCC will perform availability quarterly surveys at the provider level, annual accessibility surveys on 10% of the provider network. Additionally, 1% of the membership will be surveyed quarterly using the access to, and satisfaction with, care questions mirrored from the CAHPS survey. All negative responses will be captured as complaints and results will be analyzed for trending and opportunities for improvement, education, and network expansion needs. The provider network includes physical health, behavioral health (Mental Health and Substance Use Disorder), oral health, and non-emergent medical transportation.

MPCC will work closely with the NEMT brokerage to ensure that there is adequate access. This will include ensuring members arrive to appointments in a timely manner, assessing driver capacity, and ensuring proper interactions between the member and driver.

MPCC also utilizes consistent application of funding lines, Prioritized List criteria, McKesson InterQual criteria, and Up To Date for evidence based information for appropriate, consistent review of prior authorized services. All reviews and determinations are done by an individual with clinical expertise to address the member's medical needs or conditions. This may include a nursing staff or medical director.

Complaints including appeals will be monitored to ensure that appropriate criteria, funding lines, and OARs were appropriately applied. Complaints will also be monitored to ensure compliance with timelines. If an area of concern is identified the Complaints Department Supervisor will work with Medical Management Department and the Compliance Department to ensure compliance and consistency. Annually interrater reliability testing is completed or as needed for training purposes for all staff that review and make determinations.

6. Coordination, Transition and Care Management

6.a.1 MPCC will utilize a broad range of Intensive Case Management (ICM) programs to ensure members with Severe and Persistent Mental Illness (SPMI) and Fully Dual Eligible Members receive coordinated care. This will be accomplished by correct assignment of

responsibility and accountability, Individual Care Plans (ICP) and communication with all provider types and the member/member representative in a linguistically appropriate fashion. MPCC's communication plan includes the documentation and storage of mailings, phone calls, any meeting minutes, emails and notes from care coordination efforts with member, member representatives, DHS Medicaid-funded LTC providers, mental health crisis services, and home and community-based services. Information may be shared with any identified provider/organization that is involved in care coordination for identified MPCC members.

Types of information that may be shared may include, but is not limited to:

- Care Plans
- Medication fill history
- Case Management activity
- Health Risk Screening (HRS)
- Referral and Prior Authorization history
- Involvement in community resource programs

Communication methods with pertinent organizations involved in member health services and coordination via:

- Formal and informal meetings at varied entities
- Performance Health Improvement and/or Case Management software
- Electronic Health Record
- Secure fax, or
- United States Postal Service mailings, or
- Secure email, or
- Video conference, or
- Phone, or
- Other secure telecommunications as identified.

ICM processes and systems allows MPCC to assign a provider or organization, that is involved in members health and wellbeing, direct access to contribute to MPCC member care coordination management in real time. Providers/organizations that are assigned and actively involved in MPCC member individual care plan (ICP), can update, provide recommendations or view member health status, other providers that may be involved in the members care, community resources and programs that the member may be enrolled.

6.a.2 MPCC will work in partnership with Providers and community stakeholders to identify and develop new opportunities for access and coordination with social and support services including crisis management services, and Community prevention and self-management programs. These programs may be identified through community outreach, the Community

Advisory Council or submitted via the grant process. The newly identified programs will be added to the existing referral process in which MPCC provides several programs that facilitate partnership development by informing providers/organizations of services available to assist in care coordination, wellness support, empowerment and self-care opportunities; Intensive Case Management (ICM), Family Support Coordinators (FSC), Emergency Department Intervention Team (EDIT), Transition of Care Coordinators (TOCC), and Marion-Polk Obstetrics Mentoring Services (MOMs).

Information regarding new partnerships and referral options may be shared via the following communication methods:

- Attending community meetings
- Mailing educational materials
- Providing education directly to providers and staff at their place of practice
- Phone calls
- Video meetings/Webinars

6.a.3 MPCC will create provider and member education tools/materials to facilitate cultural and linguistically appropriate information regarding Care Coordination. The educational tools/materials will be provided to health care Providers to assist in explaining how care coordination can benefit the member and the responsibility of each part of the team for effective care coordination: plan, member and provider or community partners.

The educational tools/materials will be created with input from the MPCC CAC and Office of Equity and Inclusion to ensure the information is relative to our community and both culturally and linguistically appropriate.

6.a.4 MPCC has a robust analytics team and a variety of software platforms to identify and assist members with multiple concurrent conditions. MPCC will use these resources to create standing reports that identify members with multiple diagnoses who are receiving care at multiple locations. Members identified via this process will have wide-ranging assessment that takes utilization, medication history, provider notes and service location into account to determine if further case management would be beneficial.

MPCC also employs an extensive multi-disciplinary case management team to ensure members with multiple diagnosis receive appropriate and effective care. This team works draws from the expertise of geriatricians, physicians, RN's, pharmacists and behavioral health experts to coordinate care for vulnerable members. MPCC case managers use multiple platforms to monitor patient cohorts and share pertinent health information with providers.
MPCC works with its providers to ensure they are empowered to independently identify and treat members with multiple diagnosis. Resources and activities that support providers include

subsidies for EHR-based care-management tools, technical and informational support to ensure effective use of technology and the distribution of standing reports that identify members that would benefit from additional outreach and care coordination.

6.a.5 Intensive Case Management (ICM) oversight, including the confirmation of effective lines of communication are shared by MPCCs Medical Directors, Director of Medical Management Services and various CCO-support committees. MPCC member's Primary Care Provider (PCP) within a PCPCH, as the main point of health care, assumes an integral role and responsibility of Intensive Care Coordination (ICC) by directing the care coordination process and taking the lead in managing clinically related aspects of member care and the Individual Care Plan (ICP). The PCP participates in the Interdisciplinary Care Team (ICT) by reviewing the ICP and suggesting revisions, such as involvement in Community Developmental Disability Programs and brokerages. The PCP acts as the expert for determining the health care needs of MPCC members and contributes to the ICT by providing accurate diagnoses and evaluations. The PCP is responsible for ordering follow up testing, preventative health care services and making referrals to specialists as deemed necessary and most appropriate.

6.a.6 All adults with Serious and Persistent Mental Illness (SPMI) or functional impairments receive ICM supports as specified in outpatient designated treatment plans. Each county provides an array of residential, adult foster home and supported housing placements. MPCC will work with these providers to serve individuals living in LTC facilities managed by DHS and participate in care coordination activities. MPCC also has specialized teams in each county under the Adult Mental Health Initiative (AMHI) to promote more effective utilization of community-based residential facilities and promote the availability and quality of individualized community-based services and supports. Individuals eligible to transition to a lower level of care are provided with person-centered treatment planning, Transition of Care (TOC) assistance, ICM, peer support services and a broad array of other supports. MPCC anticipates that new services under the 1915(i) waivers will also be incorporated into the care coordination process.

MPCC has had great success promoting recovery and reducing costs through the use of peer mentors to support individuals improve their health and wellbeing needs. In addition, MPCC intends to spread this approach and enlist lay care providers or volunteers involved with LTC services. MPCC believes that it will be highly cost effective to launch this work with their cadre of experienced peer mentors.

6.a.7 MPCC recognizes that the effective use of Traditional Health Workers (THWs), peer mentors and intensive care coordination are vital resources to minimize health disparities. MPCC has used THW's since 2006, and has continued to expand THW programs. The MOMs program, which was the first program to use peer mentors associated with MPCC, uses peer support workers to coordinate and facilitate care not only in the health care system but across

all community systems serving high-risk populations. The goal of the MOMs program is to ensure that babies born to these mothers are clean and sober. In addition, the program focuses on developing home environments that are safe, nurturing, and sober for the member and her family. The program has seen a 99.9 percent success rate in babies being born clean and sober. Further, women are giving the support, and tools, they need to effectively parent and care for their children.

Additional MPCC THW-supported programs include:

- Emergency Department Intervention Team (EDIT)
- Family Support Coordinators (FSC)
- Transitions of Care Coordinators (TOC)
- Intensive Case Management (ICM)

MPCC has also partnered with numerous community organizations that provide THW-supported services to Medicaid recipients across the service area. Prominent services provided to MPCC members include for peer coaching, recovery support, self-care, wellness, and social support. Project ABLE offers a Trauma Survivors Project which links isolated individuals with peer mentors who provide telephone support and outreach and engagement with the recovery community. Consumer Care Partnerships forms consumer-facilitated wraparound teams to help adults with mental illness pursue goals based on their strengths and dreams. Consumers provide peer support in the Psychiatric Crisis Center waiting room, which has yielded marked improvements in the clients' experience of care. An annual retreat brings together participants from these programs for a powerful community-building experience.

MPCC has had great success promoting recovery and reducing costs through the use of peer mentors to support individuals with their health and wellbeing needs. MPCC intends to increase our use of THW for members with intensive care coordination needs and those experiencing health disparities. MPCC believes that it will be highly cost effective to launch this work with their cadre of experienced peer mentors.

6.a.8.a MPCC will implement a primary care assignment policy to ensure access to care for all enrolled members. Primary care assignment will be immediate upon enrollment, member notification will be sent to members via mail within 14 days of enrollment. MPCC will send health risk screenings (HRS) via mail to new enrollees within 14 days of enrollment, annually thereafter, and upon change in condition. Upon return these will be data entered into ENLI, case management software. Returned HRSs will be reviewed by MPCC to determine appropriate levels of care and services. MPCC providers may have access to Enli, a case management software system that enables the users to collect Health Risk Screening (HRS) information for each member. This system will be used to calculate a risk score, create an individualized care plan, and disseminate health information amongst members of the care team as well as

providers/organizations within the community that are involved in a member's healthcare. This risk score will be used to determine the appropriate outreach occurs within 30 days of each member's enrollment.

In addition to implementing Enli, MPCC will engage members in a comprehensive educational campaign designed to ensure that they are fully informed participants in the CCO. Educational outreach programs will take many forms, but the goal of such activities will be to familiarize members with the programs and services available to them and ensure they are invested and empowered in their health and wellbeing.

Finally, since the vast majority of CCO members are currently under the care of MPCCs provider panel, MPCC will have little difficulty utilizing members existing health information to ensure they receive appropriate levels of care upon transitioning into MPCC. MPCC will utilize existing programs and staff to assist members in the transition into MPCC.

6.a.8.b MPCC will ensure that providers are educated and aware of the contracted interpreter vendors to allow for culturally and linguistically appropriate health care. MPCC will encourage providers to utilize and access contracted interpretation vendors to conduct culturally and linguistically appropriate health screenings for members to assess their individual needs and identify potential need for higher level of care.

MPCC understands that comprehensive transition of care for all members is essential and will continue to develop programs and materials that reflect the cultural and linguistic needs of its members.

MPCC will record and publish providers with fluency in non-English languages and completion of cultural competency training

6.a.9.a MPCC will ensure appropriate transitions care for members facing admission or discharge from any service setting. MPCC will achieve this by the use of the Intensive Case Management (ICM), Transition of Care Coordinators (TOCC) and Interdisciplinary Care Teams (ICT).

The primary purpose of ICM, TOCC and interdisciplinary care team (ICT) is to encourage self-management and direct communication between patient/caregiver and their primary physician or specialist, rather than function as another Healthcare Provider. TOCC and ICM provide the tools to the patient/caregiver to help the patient self-manage his/her chronic conditions. ICT is composed of several partners who are directly involved in different touch points of the members health, making their collaboration with the member more seamlessly among the continuum of care, as well as activate client engagement, prevent gaps in care during transitions (planned and unplanned), and coordinate transitions and communication between

partners.

6.a.9.b MPCC plans to coordinate and communicate with Northwest Senior and Disability Services (NWSDS) the AAA, servicing MPCC service area. MPCC and NWSDS will work together to identify all members covered by both organizations, as well as those community members who are at risk of becoming Triple Eligible. As essential participants of the ICT, each entity will notify the other of transitions in a timely manner and develop individualized care plans with engagement from, at minimum the member, Case Manager (CM) and PCP, with a goal of participation of the entire team. The ICT will assess and coordinate the services, both social and medical, that the member needs while promoting member activation and engagement.

6.a.9.c For each planned and unplanned transition of care from any setting to any other setting, the following will occur and be documented and tracked in MPCC systems of record, which include but are not limited to Enli and CIM:

1. For planned and unplanned transitions from members' usual setting of care to the next setting, Intensive Case Management (ICM) must identify that a future transition may, or is expected to occur;
2. For planned admissions, ICM will be notified through the process of Prior Authorization (PA), which includes information from the members' usual practitioner (i.e. diagnosis, history, reason for admission);
    i. ICM may be notified of the request for pending PA service and use the information provided in the PA to start the transition process;
3. For planned discharges from facilities, ICM will recognize this transition is going to happen at the time of admission;
4. The expectation is the ICM will receive reports of admissions to long-term care facilities within one business day of the admission;
5. ICM will notify the patient's usual practitioner of a transition;
    i. This may occur by, but is not limited to;
        1. Secure email
        2. Phone
        3. EFax
6. Once a provider is notified of a transition, it is expected that that provider will follow up as needed with their patient;
7. If ICM discovers that the patient's usual practitioner wrote the order for the transition, then notification of that transition will not be sent;
8. If more than one transition has occurred when ICM is notified, for example if the patient is discharge before the nurse is notified the patient was admitted, then the nurse will perform intervention for the most recent transition;

9. Special Health Care Needs (SHCN) member admitted to a facility – CM will make weekly contact with the facility to ensure member has proper transition of care when ready to discharge
    a. Documentation of conversation with facility/entity CM/discharge planner will be made in the MMC section of the current open ICM case.
        i. If/when additional conversations take place with family, or other appropriate individuals, notation of conversation will be made in the current open ICM referral case.
10. To assist in appropriate discharge planning, and to reduce duplication of assessment and planning activities for the TOC, ICM and facility staff will work to provide the member and/or member representative help in understanding members healthcare needs, potential need for community resource or assistance programs, and understanding of health benefits, rights and responsibilities, including the right of the member to opt out of this service, or need for long term care (LTC) assistance.
    This includes, but is not limited to:
        a. Improved communication during transitions between providers, patients, and caregivers;
        b. Implement electronic medical records that include standardized medication reconciliation elements when able;
        c. Establish points of accountability for sending and receiving care, particularly for hospitalists, SNF (physicians practicing in skilled nursing facilities), primary care physicians, and specialists when feasible;
        d. Increase the use of case management and professional care coordination;
        e. Expand the role of the pharmacist in transitions of care when feasible;

11. ICM will continue working with member, if enrolled, or agreement to enroll in ICM services.

6.a.10.a MPCC ICM staff are made aware of a member's need for services, including those with SPMI receiving home and community-based setting, through an automated processes within the case management software or an active identification of a need (e.g. a call from a member's caregiver to customer service).

While processes may vary based on individual need, the ICM will first review available member specific data within the case management software and other databases (e.g. CIM-Community Integration Manager) for claims and authorizations requests.

ICM staff will attempt to contact the member and/or caregiver telephonically as the primary option. If ICM staff are unable to reach the member and/or caregiver in this manner they may rely on other forms of communication such as United States Postal Services mailings. Utilized forms of communication are documented within the case management software.

ICM staff assist the member and/or caregiver with the identification and prioritization of self-management goals and objectives, their preferences and specifically tailored needs of the beneficiary and roles of the member's caregiver(s).

ICM staff could include, but are not limited to:

- Doctors
- Nurses
- Social Workers
- Behaviorists
- Pharmacists
- Coordinator support staff
- Medical Assistants
- Certified Nursing Assistants
- EMT-P's
- Health Care Navigator's/Peer Support Mentors

ICPs are contained within the case management software and are generated using member specific information from a variety of sources including but not limited to: claims, the HRS, medical records and information gathered by ICM's and other ICT members and member and/or caregiver(s). The case management software serves as the central location for the documentation of care management and care coordination activities.

More than two outreach attempts via different methods will be attempted to engage members' in ICP and ICT activities. If ICM is unable to reach or engage a member in ICM, ICP creation and ICT activities, the member will be mailed a letter that provides ICM contact information and information regarding possible further outreach throughout the year should the members' condition change or at minimum, annually. If a member declines ICM, ICP creation and ICT, or any portion thereof, a letter will be mailed to the member indicating which activity, or all, that they declined, contact information for ICM and information regarding possible further outreach throughout the year should the members' condition change or at minimum, annually.

ICM staff will establish a schedule for follow up and will coordinate further ICT involvement as needed and identified. Follow up contact includes a discussion of the current ICP including if current goals are met or not met and if modifications need to be made as identified and as most appropriate. The ICP is modified based on the identification of changing needs of the member (e.g. a new goal or objective, new diagnosis, change in condition, transition of care, goals that have not been met) or requests by the member or other ICT members. At minimum, an ICP is modified upon annual HRS completion.

6.a.10.b MPCC uses information from the Health Risk Screening (HRS) to coordinate care for the member that reflects the member's special needs, such as intensive care coordination and DHS Medicaid-funded LTC services, and preferences. Such needs include, but are not limited to, community resources such as housing, food insecurities, dental care, end of life services, and transportation. MPCC utilizes the results of HRS's to develop an individualized care plan for each beneficiary. This care plan draws on various elements of the medical home and enables the Plan to develop, communicate, and act upon member individual preferences, goals and objectives. These goals include increasing beneficiary access to preventive health services, improving the coordination of care through an identified case manager and improving seamless transitions of care across healthcare settings.

In addition, MPCC utilizes data to identify individuals for critical risk factors that trigger intensive care coordination for high-risk members.

6.a.10.c MPCC will factor in relevant referral, risk assessment and screening information from the local type B AAA by including NWSDS case managers as part of the ICT. In addition, LTC providers have been part of the ICT and work closely with contracted LTC facilities on a regular basis. Communication, as described in 6.a.(1), will continue with deployment of a more robust communication system currently being developed.

6.a.10.d MPCC conducts an initial comprehensive Health Risk Screening (HRS) of all new members, and members identified as high risk via PERC codes, within 90 days of the effective date of enrollment and annually thereafter. New members will include both those who change from one CCO to another as well as those who are new to the CCO entirely. The Health Risk Screening will be sent via mail to each member to complete and return. If the first attempt to contact the member, for both the initial and annual assessment, is unsuccessful, one follow-up attempt will be made.

Upon receiving the completed HRA, a case management staff member reviews the HRS for medical, physical, behavioral and social needs. Those members identified as requiring intervention are assigned to case management, with the initial attempt to intervene occurring as soon as possible after receipt of the HRS. Documentation of intervention is then recorded in CIM under the appropriate category.

High-needs reassessment is done when significant changes in status occur. Varied methods of identifying changes and high-needs is done on an ongoing basis via, but not limited to:

- Care Plans
- Medication fill history
- Case Management activity

- Health Risk Screening (HRS)
- Referral and Prior Authorization history
- Involvement in community resource programs
- Provider referrals/prior authorizations
- Claims
- PreManage
- Transition of Care (TOC)
- Other methods as identified

6.a.10.e As part of the ICT, the relevant staff from NWSDS and Medicaid LTC providers will be encouraged to participate in the development of the individualized care plan. In addition, during transitions, care plans will be shared from the sending provider to the receiving provider to improve coordination and collaboration between providers and across systems. Care plans will also be shared with ICT members that are not centrally located in the hub, such as the primary care physician and home health care provider.

6.a.11 Through electronic data and communication tools, dental providers will be part of the care team. Oral health will be incorporated along with other wellness messaging interventions. Questions regarding oral health are part of the Health Risk Screening tool, ICM questions, as well as the TOCC program. Improved coordination and communication tools will streamline and facilitate appropriate dental referrals. MPCC will work with Capitol Dental Care with their program Virtual Dental Homes (VDH) piloted in 2015 which has since become a standard program. Capitol Dental Care VDHs can reach members that experience access issues related to income, migrant workers, transportation as well as other barriers to access. In 2018, Capitol Dental Care provided VDH care to over 800 children, within their schools, of which 53% had dental caries. MPCCs care coordination teams actively work with members to ensure that dental care is coordinated, and appropriate referrals and authorizations are in place for seamless care.

6.a.12 MPCC will coordinate referrals from oral health providers to physical or behavioral health providers. Oral health providers will be educated on the referral and coordination process.

6.b.1.a Through electronic data and communication tools, dental providers will be part of the care team. Oral health prevention will be incorporated along with other wellness messaging interventions. Questions regarding oral health are part of the Health Risk Screening tool, ICM questions, as well as the TOCC program. Increase in inquires with the member, and improved coordination and communication tools will streamline and facilitate appropriate dental referrals. MPCC will increase communication and education with PCP offices and community partners to further oral health initiatives to ensure a smooth transition of care within the continuum.

6.b.1.b MPCC will ensure that oral health questions are asked by multiple care coordination teams within MPCC. MPCC is able to identify and participate in coordinated efforts to ensure that proper referrals and authorizations are in place, thus removing any barriers to member's health care and wellbeing. MPCC will ensure that member materials clearly identify coverage for preventive oral health services and that the process to access that care is simplistic, applying a "no wrong door" approach to accessing oral health service. MPCC will ensure the provider network has adequate capacity across the geographical services area for preventive oral care to reduce potential urgent/emergent dental care. MPCC will engage with community partners to promote dental outreach for community education on the benefits of preventive oral health care.

6.b.2.a When MPCC approves a planned TOC, members are mailed a discharge checklist, which includes Plan contact information for any questions the member may have. Upon planned or unplanned hospitalization, MPCC is alerted to the hospitalization via phone, secure fax, secure email, PreManage or other means not mentioned. Once the TOCC is alerted of an admission to the hospital, the TOCC will visit case management staff within the facility, the member, and the member's representative or caregiver. Possible barriers to discharge or health care conditions are discussed and identified barriers are shared with organization staff. Together, the facilities case management staff, members PCP or PCPCH and TOCC will work to reduce barriers prior to discharge. The TOCC may provide community resources, education on member benefits, arrange transportation and/or appointments, facilitate referrals and authorizations to MPCC, and more. The TOCC then alerts ICM of the TOC. ICM will then make outreach to the member post discharge to promote members health and wellbeing. The member may be enrolled into other MPCC programs as need is identified.

6.b.2.b The process for PCPCH or PCP organizations to refer for hospital admissions or specialty services and coordination is to alert MPCC via, but not limited to:

- CIM - Referral and Prior Authorization software
- Performance Health Improvement and/or Case Management software
- Secure fax, or
- Secure email, or
- Video conference, or
- Phone, or
- Other secure telecommunications as identified

6.b.2.c MPCC will continue to maintain current relationships and develop new relationships with hospitals and specialty treatment clinicians. MPCC currently has written agreements to share access to data from various electronic medical record systems. In addition, MPCC has staff that focuses on hospital admissions (concurrent review RNs), discharge (Transition of Care Coordinators) and after-hospital follow up (Intensive Case Management). Hospitals will be required to send notification and share clinical documentation upon admission, ongoing clinical documentation is required to be sent every 3

days for admissions extending beyond 2 days.

MPCC realizes that a major step in promoting care coordination is the electronic health record (EHR). The EHR enables clinicians treating people in a variety of settings to exchange and continuously update a patient's clinical data and then present that information in logical clinical groupings that other clinicians can access easily. The key functions of an electronic health record system are health information and data storage, results management, order entry and management, decision support, electronic communication connectivity, patient support, administrative processing, and reporting and population health management Such an integrated system allows a physician to enter a patient's record number and view a menu showing his or her current medications, problem list, history of recent visits to health providers with submenus for notes from those visits, images and reports of diagnostic procedures, a functional status assessment and social service eligibility report, schedule of preventive services, allergies, contact information for all persons caring for the patient, names and contact information for family caregivers, guidelines for appropriate care, and clinical decision support.

MPCC continues to work with all community stakeholders to continue promoting the coordination of the EHR.

6.b.2.d When MPCC approves a planned TOC, members are mailed a discharge checklist, which includes Plan contact information for any questions the member may have. Upon planned or unplanned TOCs, MPCC is alerted to the TOC via phone, secure fax, secure email, PreManage or other means not mentioned. Once MPCC TOCC has been alerted of a TOC, the TOCC will visit case management staff, within the facility, the member, the member's representative and/or caregiver. Possible barriers to discharge or health care conditions are discussed. Identified barriers are shared with facility case management staff, PCP or PCPCH and MPCC staff. Together, the facility case management staff, PCP or PCPCH and TOCC will work on reducing barriers prior to discharge. The TOCC may provide community resources, education on member benefits, arrange transportation and/or appointments, facilitate referrals and authorizations to MPCC, and more. The TOCC then alerts ICM of the TOC. ICM will then make outreach to the member post discharge to promote additional members health and wellbeing. The member may be enrolled into other MPCC programs as need is identified.

6.c.1 MPCC will effectively provide health services to members receiving DHS Medicaid funded LTC services by including NWSDS case managers in the ICT for jointly managed members. As part of the ICT, both WVCH and NWSDS case managers will work together to ensure members receive care and services that are coordinated and based on best practice guidelines. This is a team approach is designed to ensure a high level of coordinated care and is in alignment with best practices.

6.c.2 MPCC will effectively provide health services to members receiving DHS

Medicaid funded LTC services by including NWSDS case managers in the ICT's for jointly managed members. As part of the ICT, both MPCC and NWSDS case managers will work together to ensure members receive care and services that are coordinated and based on best practice guidelines. This team approach is designed to ensure a high level of coordinated care. Currently ICM, EDIT, TOCC, and other previously identified programs bring coordinated healthcare directly to patients who live in alternative settings like Nursing Facilities (SNF and ICF), assisted living facilities, or foster homes. These teams develop a personalized healthcare plan based on a holistic assessments and/or interactions with the client and takes into consideration their physical and emotional needs and input from family, caregivers and physicians. By developing a personalized healthcare plan these programs may provide on-site visits to maintain member health as well as provide a higher level of healthcare and care coordination. Through regular monitoring and tailored response to clients' emotional and physical needs, the programs seeks to reduce healthcare emergencies and improve the overall quality of life. ICT's may also provide a mechanism to better incorporate innovations, use of flex funds and grant proposals to positively impact member and community wellbeing.

6.d.1 MPCC utilizes pre-service and concurrent review as a main source of authorization for acute and ambulatory authorization processes. Acute care often requires concurrent or retrospective analysis, non-urgent or ambulatory levels of care can be reviewed prospectively. For instance, preauthorization requirements for some non-urgent care requires procedures and treatments that support development of a holistic and patient centered care plan using best practices. Prospective and concurrent review for diverse populations will be scrutinized to ensure that care coordination and ICT is involved at the earliest opportunity to allow for a seamless TOC for the best possible outcome for members and their care team.

6.d.2 MPCC utilizes a variety of mechanisms to identify over- and under-utilization. These mechanisms include individual case reviews to examining distribution of treatment, procedures, and preventative services as well as data analysis on the utilization and penetration rate of services categories by demographic factors such as rate group, age, ethnicity and primary language spoken.

7. Accountability

7.a MPCC has a robust quality measurement and reporting system designed to ensure the organization and its providers adhere to contractual requirements. Current contractual arrangements between WVCH and MPCC member organizations include significant CCO Incentive Metric performance components, which have engendered comfort towards outcomes-based payment arrangements within the provider community. Providers are accustomed to receiving and acting upon monthly reports that outline performance on prominent indicators; MPCC will build upon this existing reporting structure by further leveraging alignment across prominent state and federal reporting requirements such as CPC+, CCO Incentive Metrics, Medicare Stars etc.

MPCC's quality and reporting initiatives are further bolstered by a strong Clinically Integrated Network (CIN) that is dedicated to harmonizing measurements, strategies and incentives across payers. Participation in the CIN enables MPCC providers to identify and promote measures that have the greatest impact on patient health while providing a forum for collaboration on quality improvement initiatives. Ultimately, the CIN will work to expand the standardization of contractual performance requirements and establish a fair and consistent mechanism for provides to resolve performance issues.

7.b MPCC does not anticipate participation in external quality measurement and reporting programs in the immediate future.

7.c All MPCC providers are held to explicit performance expectations and subject to extensive monitoring of CCO Incentive Metric performance. Providers are expected to meet or exceed established CCO metric improvement targets and participate in MPCC quality improvement activities as needed. The MPCC Transformation and Quality (TraQ) Committee is charged with overseeing network-wide metric performance and will conduct regular outreach to organizations that fail to meet performance expectations.

Initial outreach to low-performing organizations is not punitive, but rather viewed as an opportunity for MPCC to better understand the unique needs of both the practice and its members. After in-depth consultation with the MPCC Medical Director and Quality Department staff, the CCO will provide a menu of resources designed to address the deficiencies identified. Potential resources include, but are not limited to the following:

- Review of clinic workflows and intervention assistance
- Training to enhance accuracy of documentation within clinic information systems
- Supporting clinic with member outreach and engagement
- Devising or enhancing member materials to ensure cultural and linguistic appropriateness
- Providing assistance in the collection, analysis and operationalization of data to improve performance
- Identification of other necessary CCO supports

If, following MPCC outreach and subsequent support, a practice fails to sufficiently improve performance, the CCO will issue a formal corrective action plan that includes steps for the practice to take in order to remain in good standing with the organization.

7.d MPCC providers will have independent access to numerous analytical platforms that monitor performance on key indicators from a variety of sources. These resources range from claims-based population health management solutions such as Enli to cloud-based platforms like Eagle Dream that draw upon clinical, financial, claims, and patient-derived data sources. MPCC strongly believes that making these tools available to providers will enhance the

clinician's ability to design, implement and measure quality improvement activities that meet the unique needs of their population.

The network will be further supported by a robust CCO analytics department that assists with the collection and interpretation of information, while also providing regular performance reports directly to practices. Finally, all MPCC providers will have an opportunity to participate in the TraQ and its various subcommittees, which serve as a forum for presenting, reviewing, and discussing information on a wide-range of pertinent quality improvement topics.

8. Fraud, Waste and Abuse Compliance

8.a MPCC and its delegated entities are committed to fighting Fraud, Waste and Abuse and follows strict guidelines in the event of any reported or suspected cases of Fraud, Waste or Abuse. Marion Polk Coordinated Care will have Fraud, Waste and Abuse and False Claims Act training upon hire and then yearly thereafter for all staff, members of the Board of Directors and delegated entities. MPCC will adhere to a Code of Conduct for all staff with multiple avenues for reporting suspected Fraud, Waste and Abuse.

Grievances are monitored for potential Fraud, Waste and Abuse as well as auditing and monitoring processes in place which include plan function audits, up coding audits and investigative services not rendered audits.

All staff, members of the Board of Directors, providers and downstream entities are screened against the OIG/LEIE/SAM systems upon hire and monthly thereafter. Monthly reports are also received from the PBM showing Fraud, Waste and Abuse efforts and any recoupments they may have obtained.

8.b Marion and Polk Coordinated Care will monitor and audit its Provider Network, Subcontractors and delegated entities for potential Fraud, Waste and Abuse activities by performing audits on plan functions, up coding and investigative services not rendered. Marion Polk Coordinated Care will also monitor and audit by investigating all reports of suspected Fraud, Waste and Abuse. Marion Polk Coordinated Care will not only have avenues for reporting but will also have clear enforcement and discipline policies.

9 Quality Improvement Program

9.a The MPCC governance structure has been designed to maximize the application of key quality improvement principals, evaluate performance and identify improvement opportunities. The organization recognizes the importance of promoting a culture that values the use of quantitative and qualitative information to monitor and evaluate performance and

will use those principals to guide workflow improvements, adopt best practices, and enhance system-wide efficiency.

Data is the cornerstone of the MPCC QI process and an essential resource for the CCO to ensure compliance with established standards. In recognition of this, MPCC will promote data-driven resources and strategies at all levels of the organization and across the provider network. Primary Care Provider's serving MPCC members will have access to a wide-array of resources that improve Member outcomes. These resources include the various analytic platforms available to providers affiliated with MPCC's member organizations. Pertinent platforms include:

- *Eagle Dream Health*: A modular, cloud-based platform that enables health plans and providers to draw upon clinical, financial, claims, and patient-derived data sources. This information will assist in the development of data-driven clinical strategies that improve the quality of care, reduce cost, and enhance health outcomes.
- *Emergency Department Information Exchange (EDIE):* Provides real time alerts that allow ED staff to share pertinent case management information with primary care providers. MPCC will promote continued and expanded utilization of EDIE to enhance care coordination across the CCO's service area. Most MPCC primary care providers are already using EDIE to develop patient cohorts and provide case management as appropriate
- *PreManage:* A product that compliments EDIE to facilitate the exchange of information between hospitals and providers. MPCC will leverage this tool to ensure hospital event information is share in real-time with the CCO and providers alike.
- *Healthy Planet:* A population management tool that includes real-time and predictive analytics, role-based daily metric dashboards and enhanced interoperability. A number of large clinics serving MPCC members utilize healthy planet to drive care coordination and improve health outcomes.

These platforms supplement the existing policies and practices used by MPCC primary care providers to improve Member outcomes. MPCC will work with high-performing clinics to identify and disseminate best practices and facilitate information sharing across the primary care network.

In addition to the aforementioned resources that enable providers to independently use data to assess and improve the quality of CCO services, MPCC will distribute a wide-range of supplemental data supports that further promote the organization's Transformation and Quality Strategy. Examples include:

- Performance Metric Monitoring
- Population Health Management
- Risk Stratification
- Patient Experience Survey Results
- Health Complexity

9.b MPCC member organizations have a long history of promoting wellness and health improvement activities amongst patients and staff. Existing services include:

- Establishing Tobacco-Free Campuses
- Extensive Tobacco Cessation Benefits
- Healthy Living Courses

MPCC also provides a number of wellness resources via the Community Health Education Center (CHEC) at Salem Heath. The CHEC provides community members and MPCC staff with access to wide range of resources to help them manage their health conditions and maintain a healthy lifestyle. Offerings at the CHEC include, but are not limited to, the follow:

- Classes covering areas such as childbirth/parenting, fitness, diabetes education, senior health, nutrition, and wellness
- Community resource library
- Community Kitchen with cooking classes taught by dieticians and chefs
- Meeting rooms for support groups and community health organizations
- Car seat checks and clinics

9.c MPCC has extensive experience using data to guide quality improvement activities. MPCC's member organizations have played an integral role in the development of WVCH's performance monitoring and improvement programs, which have served as the foundation for that CCO's exemplary performance on OHA metrics. Moving forward, MPCC will continue to make CCO accountability metrics an organization priority. The CCO accountability metrics are standing items for action and review at MPCC committees and incorporated into the evaluation plans for most projects.

The organization also has the benefit of drawing from existing staff members with longstanding experience using data to evaluate CCO performance. This, coupled with the robust data collection platforms listed elsewhere in this section, to ensure quality care is adequately measured.

9.d Referral and prior authorization requests go through Medical and Utilization Management department, are time stamped and recorded in the Community Integration (CIM) software system, which permanently records the request and actions. Hospitalizations and skilled nursing stays are tracked. Requests, dependent upon many variable factors, which alert staff that a member may require further assistance, will advise other programs within MPCC, such as but not limited to: MOMs, TOCC, EDIT and ICM.

10 Medicare/Medicaid Alignment

10.a No, MPCC is not under Enrollment and/or Marketing sanctions by CMS.

10.b MPCC is affiliated with ATRIO Health Plan, which provides services as a Medicare Advantage plan, to effectively integrate and coordinate health care and care management for Fully Dual Eligible Members.

11 Service Area and Capacity

11.a Please see RFA4690-MPCC-Att7-Service Area Table.

11.b MPCC has requested to serve less than the full county for Yamhill, Linn, Benton and Clackamas. The zip codes requested are the result of contiguous zip codes that cross the Marion and Polk county boarders. The members in these zip codes are imbedded in the Marion and Polk communities and have established relationships with providers in Marion and Polk County.

12 Standards Related To Provider Participation

12.a DSN Provider Report Template provided within submission: RFA4690-MPCC-Att7-DNS.

12.b MPCC provider network will encompass a broad range of providers. All of the network providers have qualifications and sub-specialty to serve patients with special health care needs, including elderly, disabled, children/youth in substitute care, patients with high health care needs, multiple chronic conditions, mental health issues or substance use disorder. The majority of the primary care clinics that MPCC will be contracting with are Tier 3 or 4 PCPCH facilities. The clinics have integrated behavioral health providers, dental health provider and case management/care coordinators that allow them to provide coordinated care to patients with special healthcare needs across the health care continuum.

MPCC recognizes, by review and data analysis of the CHA, the needs of the community as it relates to patients noted above and leverages that information to ensure PCP and specialty services are available to meet the community needs. For instance, due to the prevalence of patients with high ACE scores, PCP providers are provided additional education opportunities to learn about the impact of ACEs and how to successfully engage patients with high ACE scores.

12.c Publicly Funded Health Care and Service Programs Table has been included with RFA submission: RFA4690-MPCC-Att7-Publicly Funded Health Care and Service Programs Table.

12.c.1 MPCC held Initial strategic meetings with both Polk and Marion counties in February 2019. Integration and coordination concept discussions which included presentation of the draft Organization Agreement have taken place. MPCC will continue to engage the counties and publicly funded providers as key community contributors of the new CCO

Network model.

12.c.2 WVP Health Authority will continue their work with Marion and Polk County Health Departments and mental and substance use disorder treatment programs. MPCC intends to obtain an Organizational Agreement with Marion and Polk county mental health departments that encompasses all requirements of ORS 414.153. Language will be similar to the contractual agreement WVP Health Authority created for previous work ensuring contract language is compliant with the ORS requirements. With relationships already established, and processes in place that meet the requirements that all parties are familiar with, MPCC expects a smooth transition; including the process of obtaining new agreements.

12.c.3 MPCC currently has a Memorandum of Understanding with Marion and Polk County which represents the County's commitment to collaborate with MPCC in the development of a plan for shared responsibility for the full continuum of health care services in the Marion/Polk region.

12.d MPCC is experienced in delivering culturally relevant Coordinated Care Services for the AI/AN population through the established relationships it holds with its current partners that it brings forward to the new CCO. MPCC is excited to expand these services and opportunities to serve this population.

12.e.1 Grand Ronde Health and Wellness Center is an Indian Health Services location and will be a contracted Primary Care office with MPCC. In addition, while not contracted, MPCC will continue the current process of allowing care to be delivered by and coordinate care with Chemawa Indian Health Center.

12.d.2 WVP Health Authority, a MPCC principal partner, has established relationships with Indian Health Programs in Oregon whose tribe's areas of interest extend beyond the reservation or governmental center and within Marion/Polk counties. WVP Health Authority offers assistance and acts as a liaison to the healthcare, dental, vision, behavioral/ chemical health, and pharmacy needs of Chemewa Indian School, Confederated Tribes of Grand Ronde, and Confederated Tribes of Siletz. WVP Health Authority provides contracting, credentialing, claim assistance, problem resolution and collaboration and provider support. MPCC understands Tribes with membership in Marion/Polk counties have valuable input and appreciates the value of Tribal consultation. MPCC will continue to build on these existing relationships.

MPCC referral process for patients accessing care with a non-participating IHS or Tribal 638 facility will mirror the process for patients requesting to access care with any other out of panel provider. MPCC will account for the unique needs of tribal patients and the specialized care available in an IHS facility. MPCC will facilitate coordination of care and services for patients accessing any IHS or Tribal 638 facility.

MPCC process for referrals or authorizations originating from a non-participating IHS or Tribal 638 facility for patients facility will mirror the process for all referral and authorization requests originating from an out of panel provider. MPCC will account for the unique needs of tribal patients and the specialized care available in an IHS facility. MPCC will facilitate coordination of care and services for patients accessing any IHS or Tribal 638 facility.

12.f.1 Currently the formulary is periodically reviewed to ensure adequate representation of medications to treat conditions that are found on funded lines of the prioritized list. Utilization management criteria is updated to reflect the most current Guideline Notes that are approved by the HERC. Medications that are coded to process as non-formulary or have UM edits require review at the plan level. Part of the review process is to evaluate that the condition the medication is intended to treat is a condition that is found on a funded line. For those conditions that are not funded, a review of the submitted documentation is done to evaluate for relevant comorbid conditions or exceptional needs of the impacted member. In cases when a trend is noted to reveal medications routinely approved for non-funded conditions meeting the comorbid rule, this is assessed and reviewed by the Pharmacy and Therapeutics committee for potential update.

12.f.2 The pharmacy department currently administers a closed formulary. Pharmacy staff codes most changes internally through the Pharmacy Benefit Manager's electronic system which is updated every week. This allows us to be nimble when there are new generics and line extensions available. Providers may submit a prior authorization for any non-formulary medication for review.

Current management of the formulary is routinely performed by pharmacist staff to ensure adequate coverage of available pharmaceutical products from the different drug classes, including OTC products. High cost medications and controlled substances do require prior authorization to ensure use for a funded diagnosis, FDA approved use, and medical appropriateness. A majority of the formulary products are available to members without utilization management edits. There are also prospective DUR edits in place for safety that can be overridden at the Point of Service (POS) by dispensing pharmacists.

All utilization management edits and associated Prior Authorization criteria are reviewed and approved by the Pharmacy and Therapeutics Committee. This committee is composed of local providers which meet on a monthly basis. Utilization controls are implemented in the form of Quantity Limits, Age Limits, Step Therapy requirements and Prior Authorizations. These will vary depending on the drug and is dependent on FDA approved dosing of the medication, available efficacy and safety data, and medical appropriateness of the therapy.

The Pharmacy and Therapeutics committee meets regularly to discuss updates to the existing formulary. Materials prepared for presentation to the P&T committee are prepared internally by clinical pharmacists then reviewed by committee members. All formulary changes are approved by the committee. This committee meets most months of the year. Information included for review is pulled from the Oregon Pharmacy and Therapeutics committee documents, as well as, published peer reviewed clinical studies, major national guidelines, NICE, clinical guideline databases, and internal and external reporting devices. There is currently no plan in place to subcontract this work.

12.f.3 MPCC has agreed to contract with MedImpact a Pharmacy Benefit Manager with an adequate pharmacy manager to serve the local Medicaid population. The limited pharmacy network has over 54,000 chain and independent pharmacies nationwide. Currently, Walgreens is excluded from the network to ensure the highest financial performance. In Oregon, CCO members have access to over 600 pharmacies, 587 of which are enrolled in the State Medicaid program per the State's last posting. Locations of the pharmacies meet the access needs of the CCO.

The plan will make adequate outreach to the provider network and impacted members regarding formulary changes per current OAR requirements. Notifications are also posted to the public website and Point of Service (POS) messaging is placed for notification at the pharmacy level.

12.f.4 Through MedImpact, the contracted network pharmacies are electronically linked for real-time claims adjudication. MedImpact participates actively in the National Council for Prescription Drug Programs (NCPDP) to ensure compliance with industry standards for use of real-time, point-of-service technology across health care segments. Information captured with claims submission includes the necessary clinical and historical data elements for which a health plan may use for case management, formulary management and quality initiatives such as diabetic and asthma medication adherence. In addition, the information captured at the pharmacy is used to create the monthly encounter data files sent to the State.

Electronic coordination of benefits (eCOB) occurs at the point of sale as well. The purpose of an eCOB program is to allow pharmacies to seamlessly process secondary coverage claims at the point of service. The eCOB process is as follows: The pharmacy electronically transmits the claim to the primary payer. The primary payer will return an electronic confirmation of charges approved for payment and the remaining unpaid balance. The pharmacy then transmits the remaining charges electronically to the secondary payer. The secondary payer approves payment then the secondary electronic claim is processed and the pharmacy is paid.

For eCOB to work most effectively, the health plan provides the appropriate COB eligibility

information and network pharmacies must be willing or contractually obligated to participate. The ability for a pharmacy to participate can be dependent on the capabilities of the pharmacy's claim submission software. The eCOB program is fully compliant with NCPDP 5.1 standards for claim submission; however, some pharmacies are still unable to participate due to constraints.

Network pharmacy providers are reimbursed via a bi-weekly cycle.

12.f.5 Pharmacy staff have the capacity to process Prior Authorizations for all medications covered under the OAR language for outpatient medications (included Physician Administered Drugs (PADs)) within the required timeframe. The most recent audit showed timely processing for all requests greater than 99%. Prior Authorization requests can be submitted online or via fax at any time of the day. Staff addresses requests during extended business hours during the week and has adequate coverage over weekends and holidays to meet all required timeframes.

MPCC Pharmacy staff will handle all member and provider calls as well as Prior Authorizations. MedImpact handles pharmacy calls 24/7. All member and providers are directed to the plan. MedImpact may enter clinical or operational authorizations into the system only under the direction from Authorized Personnel at the health plan. These individuals are authorized to approve anything that falls outside the standard procedures during and after plan business hours when calling MedImpact's Contact Center for assistance. Any individuals making a request that are not identified as Authorized Personnel will be advised to have an Authorized Personnel contact MedImpact for assistance.

Clinical Authorizations include the following:

- Clinical-Age Restrictions
- Clinical-Medical Exceptions
- Clinical-Non-Formulary
- Clinical-Prior Authorization Required
- Clinical-Quantity Restrictions
- Clinical-Physician/Specialty
- Clinical-Step Care Therapy
- Clinical-Excluded Drugs
- Clinical-DAW Difference
- Clinical-Co-pay Exceptions

MedImpact does not handle Clinical Authorizations; however, MedImpact accommodates requests for the backdating of authorizations up to 30 days. Backdating requests for more than 30 days are not applicable.

For Emergencies, MedImpact will enter a five-day override, during or after the plan's business hours, if the pharmacy states that it is for an emergency. The override may include quantity restrictions, as long as there is no lifetime or yearly limit on the medication and the quantity does not exceed the limit allowed per month as defined in the member's benefit. A five-day supply may be approved for an emergency supply if a claim rejects stating the pharmacy or physician is not enrolled in the State Medicaid Program.

Specific to Natural Disasters, MedImpact will enter a one-time refill-too-soon override, per medication, if the pharmacy states the member has had to evacuate due to a disaster.

12.f.6 Retail 30 Brand Effective Rate Guarantee: AWP - 18.75%
Retail 30 Generic Effective Rate Guarantee: AWP - 81.25% (2020), AWP - 81.50% (2021)

Retail 90 Brand Effective Rate Guarantee: AWP - 21.00%
Retail 90 Generic Effective Rate Guarantee: AWP - 81.00%

Mail Order Brand Effective Rate Guarantee: AWP - 23.50%
Mail Order Generic Effective Rate Guarantee: AWP - 85.25% (2020), AWP - 85.50% (2021)

Specialty Pharmacy Effective Rate Guarantee: AWP - 22.00% (Includes Brand and Generic claims)

The dispensing fees associated with each category or type of prescription (for example: generic, brand name, mail order, retail choice 90, specialty).

Retail 30 Brand and Generic Dispensing Fee: $0.70
Retail 90 Brand and Generic Dispensing Fee: $0.00
Mail Order Brand and Generic Dispensing Fee: $0.00
Specialty Pharmacy Dispensing Fee: $0.00

$0.47 per approved, paid electronically submitted claim, plus a performance-based administrative fee equal to 60% of network performance above the aggregate guaranteed Retail and Specialty pharmacy network discounts. The latter administrative fee is reported quarterly and reconciled annually.

12.f.7 Currently there is no formal arrangement between MPCC and local FQHCs in the processing of 340B claims. Therefore, a processes to evaluate the impact is not currently

applicable. The local FQHCs have adequate representation at the Pharmacy and Therapeutics committee meetings. Pharmacy staff has also provided formulary and utilization management information to local FQHCs that offer programs for our members through their clinics (e.g. HCV treatment, SUD treatment) to allow for efficient implementation and streamlines processes for member treatment.

Through the PBM, MedImpact, there is capacity to process 340B claims and accurately report them to the state if there is opportunity for MPCC to have a formal arrangement with the FQHCs regarding pharmacy claims.

12.f.8 Currently a MTM pharmacist that works closely with local primary care providers, both remotely and in clinic, to manage members. The MTM pharmacist manages member through face-to-face appointments often in tandem with the member's primary care provider visit.

Any member may be referred to the MTM pharmacist for consultation by a participating provider, case manager, or staff member (e.g. transition of care coordinator).In addition, high risk members are identified by the pharmacist based on:

- High utilization of chronic medication
- High risk disease states
- High hospital utilization
- High Emergency Department utilization

The MTM pharmacist provides comprehensive medication review with the following objectives:

- Improvement in medication adherence
- Increase in member self-management
- Evaluation for adverse drug reactions, toxicity, in addition to drug-drug and drug-disease state interactions, barriers to adequate disease state management through pharmacotherapy, evidence-based medical appropriateness of medication therapy
- Minimize medication waste
- Minimize member pill burden
- Decrease member and health plan costs

MTM services for all members include:

- Comprehensive Chart Review
- Complete medication review
- Detailed member plan
- Follow-up appointments as appropriate
- Providers all receive a comprehensive SOAP note with recommendations as appropriate
- Recommendations for additional WRAP around services as appropriate (nutrition, LCSW, etc.)

Additional services available to providers by the MTM pharmacist include:

- Drug and disease specific provider education
- Pharmacist participation in clinic case management meetings
- Available resource for drug information
- The pharmacist is able to act as a liaison between the Primary Care Provider and specialists to create the most optimized medication plan for participating members

The Pharmacy Benefit Manager also has a MTM program:
MedImpact utilizes a pharmacist-based call center to provide a comprehensive medication therapy management program. The objectives of this program are to improve medication adherence, lower costs, fill gaps in care as established by national consensus guidelines, and address medication safety concerns for those member enrolled in the program.

MedImpact's Medication Therapy Management (MTM) Program is a high-touch patient-centered program designed to manage medication therapy and optimize population health outcomes. The program analyzes claims data to identify potential drug-related problems (DRPs) in the following areas:

- Adherence
- Gaps in Care/Treatment Guidelines
- Medication Safety
- Cost Savings

MTM program members will be determined based on a set of criteria established by the health plan. Once members are enrolled in the program, potential DRPs are triaged for resolution opportunities through targeted patient, provider and/or caregiver outreach. MedImpact's MTM program services include:

- Welcome Letters – Explain the benefits of the program.
- Daily Medication Surveillance – Every time the member fills (or should fill) a prescription for a chronic medication, they will be assessed for a potential DRP.
- DRP Resolution – Every DRP identified will be addressed through proactive outreach to member and/or provider. Member outreach is by phone or mail, and prescriber outreach is primarily conducted by fax.
- Comprehensive Medication Reviews (CMR) – Based on health plan needs, MedImpact will guarantee a CMR completion rate percentage.
    - Reporting – Client will have access to, or receive, the following reports:
        - Client Portal – A web-based tool that Client can access at any time.
        - Dashboard Report – Delivered monthly; provides a high-level graphical summary of MTM activities.
        - Beneficiary Detail Report – Delivered monthly; provides a list of the members that are in the Commercial MTM Program.

- CMR Detail Report – Includes the MTM provider's SOAP notes.
- Outcomes Report – Delivered six to eight months after program implementation and quarterly thereafter; provides cost savings based on claims analysis.

12.f.9 MPCC's PBM partner, MedImpact, has an electronic solution to furnish providers with valuable formulary, benefit and medication history information to support prescribing accuracy and efficiency. As the result of CMS's requirements for providers to access EMRs and/or e-Prescribing applications, MedImpact developed MedPrescription®. MedPrescription provides physicians and other healthcare providers with "pre-prescribing" services. These services include patient-specific prescription eligibility, medication history and basic formulary information for consenting patients in both inpatient and outpatient settings. The exchange of pre-prescribing essential intelligence between physicians and MedImpact enables physicians to write an informed prescription at the point of care. A study funded by HHS' Agency for Healthcare Research and Quality found that e-prescribing systems that allow prescribers to select lower cost or generic medications can save $845,000 per 100,000 patients. Furthermore, such systems could reduce prescription drug spending by up to $3.9 million per 100,000 patients per year. Studies also indicate that about 70 percent of the safety and savings from e-prescribing result from the "pre-prescribing" components of e-prescribing. MedPrescription provides these pre-prescribing components.

MedPrescription interfaces with Surescripts, MedImpact's e-prescribing connectivity vendor, to deliver these valuable pre-prescribing services to physicians of contracted clients. Physicians can access patient-specific information securely using their practice's e-prescribing technology of choice. The e-prescribing technology has to have passed the certification requirements of the e-prescribing connectivity vendor. MedPrescription's IT flexible infrastructure supports any connectivity vendor provided the vendor conforms to industry standards.

12.f.10 Marion Polk Coordinated Care Inc. will have the capacity to publish the formulary and prior authorization criteria to the public website.

12.g.1 MPCC will obtain contracts with all local hospitals, ensuring appropriate access to services. Monitoring is done through several avenues, including but not limited to contractual requirements, utilization management and trending appeals and grievances.

When medically necessary, letters of agreements are executed with out of state facilities, ensuring members receive services in the absence of local resources. Examples are Stanford, Mayo Clinic, among others.

All access is monitored via contractual arrangements, utilization managed and trending of appeals and grievances.

12.g.2 All members receive educational materials, outlining the appropriate use of services via the member handbook upon enrolling in the CCO.

Utilization is tracked via claims mining, referrals, intensive case management and utilization management. If inappropriate usage of these services is identified members are referred to MPCC's Emergency Department Intervention Team (EDIT) for assignment of mentors, who work with members on education, transportation and any other identified barriers that will enable members to access emergency services when appropriate.

MPCC is also working with local hospitals for appropriate triage services and redirection if medically appropriate.

12.g.3 Claims for DRG hospitals are ran through a CMS grouper and pricer. Adjustments are made to claims according to CMS guidelines.

Quarterly reports are generated identifying claims with Provider Preventable Conditions. These reports are reviewed by compliance and clinical staff as needed.

12.g.4 MPCC Hospital Readmission policy ensures review of all readmissions for members. When a readmission is identified upon claims submission, the readmission claim will be denied based on exclusion criteria, with an indication to combine with the initial admission claim. Notification of a readmission billing will be sent to MPCC UM staff for review and monitoring. MPCC has several departments and programs (CIM, PreManage, etc.) that monitor data sources for admissions. The initial goal of discharge is to assist members with barrier reduction and/or elimination prior to discharging from an organization. This starts with TOCC's visiting members within an organization and with their agreement, facilitating possible barrier identification. The TOCC then works with member, CM staff within the organization, MPCC departments to obtain all necessary supplies, supports, community resources, and etcetera. The TOCC then collaborates with necessary MPCC staff and departments, who may then follow member and provide further care coordination activities.

MPCC will coordinate with facilities with outlier readmission percentages to improve the effectiveness of discharge planning and reduce readmissions.

12.g.5 MPCC has several internal programs and departments that work to decrease unnecessary hospital utilization such as EDIT, ICM and TOCCs.

The EDIT program has been in place for seven years. EDIT peer mentors work with members identified as using the emergency department more than three times within three months, 6 times within 6 months and 10 times in a 12 month period.

Well vetted hospital discharges start with TOCC's visitation to members within an organization and with their agreement, facilitating possible barrier identification. The TOCC then works with the member, CM staff within the organization and MPCC departments to obtain all necessary supplies, supports, and community resources. The TOCC then collaborates with necessary MPCC staff and departments, who may then follow member and provide further care coordination activities.

The ICM will work with EDIT and TOCC as well as the members PCP, member and member representative to identify and remove any additional barriers to decrease unnecessary hospital utilization.

MPCC is also engaged with local hospitals to identify and support innovative strategies from the hospitals perspective including but not limited to triage services and redirection if medically appropriate.

12.g.6 MPCC will share ICP and care coordination activities with any plan or provider that is involved with member health care needs. See section 7.6 for shared communication methods. The same efforts in (4) above are taken with Fully Dual Eligible MPCC members. MPCC will coordinate with facilities with outlier readmission percentages to improve the effectiveness of discharge planning and reduce readmissions for Medicare Advantage patients.

Marion Polk Coordinated Care℠

RFA Community Engagement Plan Narrative

Formatting aligned with RFA Community Engagement Plan Reference Document

1. General Component

1.1-1.2 Please see Community Engagement Table 1 and 2: RFA4690-MPCC-Att10-Community Engagement Plan Required Tables.

1.3 The composition and structure of the MPCC Community Advisory Council (CAC) ensures that members, health care providers and other stakeholds are able to provide input that informs CCO decision-making. MPCC CAC members will be selected by a committee comprised of an equal number of representatives from Marion and Polk counties and members of the governing body of the CCO. The composition of the CAC will adhere to the following guidelines:

- Designate a current OHP recipient or family member serving as CAC Chair; and
- Ensure CAC members include representatives from the community and the Marion and Polk county governments, with consumer representatives constituting a majority of the membership; and
- Include a representative from a primary care office serving OHP members

The CAC Chair will also serve on the CCO Board and have the authority to appoint a CAC representative to attend and participant in any CCO standing committee. The CAC will issue written and verbal reports to the MPCC governance board regarding CAC activities and concerns. This process empowers the CAC to both provide the MPCC Board with direction when appropriate and request feedback on critical issues.

1.4 In order to elevate the member voice in CCO decision making, the CCO will have current and past OHP members on both the board and the CAC. MPCC will also conduct focus groups and utilize tools such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) to ensure OHP members have a prominent role in the CCO's decision making process.

1.5.a Through careful study of the Marion-Polk Community Health Needs Assessment, use of the MAPP (Mobilizing for Action through Planning and Partnerships) process, and better understanding of how social determinants of health and health disparities impact delivery of and access to care, MPCC will regularly assess barriers faced by OHP members. Anticipated barriers are based on the "Forces of Change Assessment" conducted as part of the Community Health Needs Assessment, which identified eight areas that impacted local health. These were (in alphabetical order):

- Access to health care which includes finding a provider, being able to schedule an appointment in a timely manner, find child care during the appointment and having the means to get there (see transportation below)
- Behavioral Health Support includes lack of providers, coordination of care resources and community stigma all contribute to this social issue.

- Economic Stability: roughly 25% of children in Marion County live in poverty, compared with 20% statewide. This statistic becomes even more staggering when broken down by race. Black, American Indian and Native Hawaiian/Pacific Islanders see 30+% living below the federal poverty, and Latinos are close behind at 26.3%.
- Education impacts language access, literacy, and employability. While the unemployment rate statewide is low, it is higher in Marion and Polk counties. Poverty directly aligns with educational level. Of those living in Marion and Polk counties with less than a high school diploma, 25% of them are living in poverty, vs. 13% with a high school diploma.
- Food insecurity impacts a person's ability to manage chronic conditions, such as diabetes. 23% of Marion county households received SNAP or cash benefits and 57% of those had children under the age of 18. Forty percent of the service area live in a food desert.
- Housing continues to be a challenge with low rental vacancy rates, and high costs relative to income, making housing unaffordable to many. The rate of homelessness is increasing. Nearly 2,000 students grades K-12 were homes in 2018.
- Substance Abuse: whether its binge drinking, using tobacco or marijuana, or illicit drugs and opioid addiction, substance abuse continues to plague Marion and Polk counties. Health disparities play a role in drug use, as higher rates of tobacco use and opioid overdoses are seen among African Americans and American Indians.
- Transportation is a concern within the urban and suburban areas of Marion and Polk counties, but also is a significant barrier in the very rural areas of the region.

1.5.b MPCC will tap into current successes experienced by the member organizations, which include expanding access and availability of Peer Mentors and Navigators. The role of these Traditional Health Workers (THWs) will be to engage the member in their own care, identify potential barriers and work together to coordination the patient experience before, during and after care. Patients will be further connected with non-health care related resources as appropriate.

This process will include an initial interview with a THW. The patient will be assessed and based on need and risk factors, assigned to a scale of low to intensive care management. The THW will identify barriers and connect the patient with available resources. If identified as intensive care management, the THW will continue to walk alongside the member to ensure a positive patient experience, reevaluate barriers and continue to assist in connecting to resources until the patient feels barriers have been adequately addressed and they are able to manage on their own.

Trauma informed care deserves a special mention here, along with culturally competent providers and staff. Many OHP members have experienced adverse childhood events that have shaped their current lifestyle behaviors. Having providers who are well versed in providing

trauma informed care as well as being culturally competent will go a long way to influence positive patient outcomes.

MPCC will address anticipated barriers in several ways. MPCC will support requests through the Health Related Service Program to address food insecurities. MPCC will ensure adequate capacity of NEMT providers in rural areas to allow adequate access to providers. MPCC will leverage the Provider Recruitment departments in the partner organizations to recruit and retain providers in rural areas of our service area, and identify possible specialty rotation to ensure adequate access to specialty providers for those in rural areas.

1.6 MPCC will develop a number of metrics to evaluate patient experience, health outcomes and cost containment. These metrics will be reviewed on an ongoing basis at the appropriate MPCC committees, who will then design and implement quality improvement strategies to address the issues identified. A significant number of the issues and interventions identified through this process will be reviewed by the MPCC CAC and disseminated to the public via direct member communication, CAC meetings, and community forums.

2. CAC Component

2.1.a Initial strategies for CAC recruitment are already underway. MPCC will look to providers and community advocates to identify members interested in serving on the CAC. Recruitment activities will include outreach at community events, working with existing primary care patient councils, leveraging contacts with existing community services organizations and multi-media advertising. This comprehensive approach will ensure the MPCC CAC adequately represents both the CCO's population (MPCC members) and the community at-large. Representation of current and former OHP members will take precedence, but also prioritized will be those who serve the same population and can partner with MPCC to insure the highest level of quality and coordination of care.

2.1.b. MPCC does not have any existing CACs.

2.1.c MPCC will encourage diverse participation on its Board and CAC by working with OHP members to develop strategies for removing barriers to member engagement. The CCO recognizes that transparency relating to the expectations of members and investing in capacity building for all board and committee members (i.e. health equity, diversity and inclusion, unconscious bias, etc.) is critical to success. MPCC will work to ensure funding and resources are available to support the needs of specific CAC members. Additionally, all MPCC member communications will utilize approaches that are culturally and linguistically appropriate, e.g. offering materials in plain language, written at a 6th grade reading level or below; providing professional translations of all meeting materials or alternate formats if appropriate; limiting use

of health care related jargon and acronyms; providing resources for transportation and child care, etc. Each board and CAC meeting will begin with time for public comment.

2.1.d Should more than one contract be granted in the region MPCC intends to serve, MPCC will work closely to avoid overtaxing the community. There is already significant collaboration in this region in developing and implementing the CHA/CHP and MPCC member organizations are deeply embedded in this work. Even with an additional CCO, this is unlikely to change. MPCC will look to community stakeholders for feedback on the best way to manage this.

3. Description on CHA/CHP Component

3.1.1-3.3.1 Please see community engagement tables 3, 4 and 5.

3.3.2 MPCC founding organizations have made significant contributions to existing CHA/CHPs in Marion and Polk counties. WVP Health Authority has led the development of past CHA/CHPs on behalf of Willamette Valley Community Health (WVCH). This process leveraged broad partnerships that included participation from area hospitals, community service entities, the WVCH CAC, primary care representatives, local public health agencies, behavioral health providers, and members of the community at-large. Additional community organizations that worked with WVP Health Authority to develop existing service area CHA/CHPs include:

- Marion and Polk Early Learning Hub
- Community Action Agency
- Catholic Community Services
- Oregon Childhood Development Coalition (OCDC)
- Family Building Blocks
- Capitol Dental

3.3.3 The primary gap between existing relationships with the identified organizations is the forthcoming dissolution of WVCH. However, while WVCH will no longer be operating, the entities and community partnerships that were used to develop the existing CHA/CHP remain strong. MPCC will draw upon the experience of its founding partners to advance the development of an updated CHA/CHP.

3.3.4 MPCC will work to strengthen existing partnership with individuals and entities that participated in previous CHA/CHP iterations while also conducting outreach to expand community participation. Over the course of the year, MPCC will convene pertinent stakeholders to secure participation in the development of the CHA/CHP and preemptively identify issues that might hinder the process. The CCO fully anticipates meeting all deadlines and requirements associated with the CHA/CHP.

3.4 Please see community engagement table 5.

3.5 Please see Attachment 10 part C.1.a.

MARION POLK COORDINATED CARE, INC - 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)			
Current OHP members	Individuals to be determined	Current OHP members will serve as part of the board and community advisory committee. Representation of both current and past OHP members will lend critical insight into the patient experience, will provide cultural context; creates advocacy	MPCC will look to providers and community advocates initially to identify members interested in serving on the board and community advisory committee, with an ear to filling a variety of cultural competencies and ensuring diverse representation.
Past OHP members	Individuals to be determined		

		opportunities and allows for relevant and timely feedback regarding transformation efforts.	Additional members will be invited to take part in forums led by the CAC and will be able to offer feedback through patient surveys.
Community-based organizations that address disparities and SDOH-HE (list in first column below)			
Organizations addressing access to health care	NW Family Services, Salem Free Clinic; Guadalupe Clinic	NW Family Services houses Project Access (access to specialty care for uninsured or underinsured individuals) and low/no-cost breast cancer screenings among other programs. Salem Free Clinic provides free medical and dental care to uninsured individuals in Salem and Dallas and has been an excellent partner in encouraging those eligible to sign up for OHP.	Partnerships are already in place and the missions align. In addition to a referral stream for those eligible but not yet signed up for OHP, MPCC will look for ways to partner, creating clinical pathways, accessing care in a more timely manner and improving the overall patient experience. These organizations will be included in the overall strategy development for the CHA, CHP and healthcare delivery.
Organizations addressing early childhood development	Family Building Blocks, Head Start; Liberty House United Way, Marion County Early Learning Hub, Oregon Childhood Development Coalition (OCDC)	All the organizations listed here are critical to keeping children safe and families together. Each serves a slightly different need, but all play an important role in removing barriers for OHP patients as they navigate life.	Relationships are established. MPCC will invite these organizations to part of a larger conversation around prevention, immunizations, early learning, and resiliency. Excellent opportunities exist to partner with these organization to optimize coordination of care and services related to addressing SDOH and health disparities. These organizations will be

			included in the overall strategy development for the CHA, CHP and healthcare delivery.
Organizations acting as advocates for cultural competency, ethnically vulnerable and other underserved populations	Mano a Mano Willamette Valley Health Equity Coalition NW Family Services Salem Free Clinic CASA, Early Learning Hub, OCDC, Interface Network	Marion and Polk counties have several groups which advocate for health equity. Partnership with these and other organizations which offer insight into culturally competent treatment will be critical to engage minorities	Relationships are already in place. Further discussion and planning will occur as MPCC builds its network of culturally competent providers. The CAC will consider contributors to health disparities and recommend solutions. Beyond representation on the committee, these stakeholders are an excellent springboard for expanding the THW network of care. These organizations will be included in the overall strategy development for the CHA, CHP and healthcare delivery.
Organizations addressing parenting skills, resiliency, and community support	Family Building Blocks; Fostering Hope Initiative (led by Catholic Community Services); WEAVE (We Are All Village Elders), Early Learning Hub, OCDC	Family Building Blocks was addressed above in early childhood development; they along with the Fostering Hope Initiative and WEAVE looks to build a network of support within neighborhoods: providing childcare, transportation assistance, and reducing social isolation	FBB partnership has been established; MPCC will designate staff to attend Fostering Hope and WEAVE to see how this work impacts members and what partnership opportunities exist. These organizations will be included in the overall strategy development for the CHA, CHP and healthcare delivery.

Organizations addressing SDOH such as housing, economic stability, social and community issues	County Service Integration Teams, Homeless Task force, Marion Polk Food Share, Mid-Willamette Valley Community Action Agency, Union Gospel Mission, Salvation Army, Habitat for Humanity, Family Building Blocks, OCDC, Health and Housing Workgroup, Oregon Continuum of Care and more.	Local social service agencies address SDOH and share many of the same clientele as the CCO. Service Integration teams bring all the involved parties to the table to coordinate services and reduce duplication. Salem Health partially funds the Service Integration Teams in Marion and Polk counties. These partners are critical to meeting the SDOH needs of the OHP population.	MPCC member organizations work closely with these agencies, as well as the local government entities that support them. Salem Health is participating in a medical respite program with Salem Housing Authority. A sobering center is being discussed among a partnership of city and county government, law enforcement and several social service agencies. Housing remains an issue to which all parties will be drawn. MPCC will partner with these agencies and more to seek social solutions that result in the best possible outcome for patients.
Providers, physical health, including culturally specific providers as available (list in first column below)			
Primary Care providers	Salem Health Medical Group providers, Salem Clinic Providers, WVP Health Authority Providers, Mid-Valley IPA Providers and other providers in service area	Fully engaged providers of both physical, oral and mental health are critical to the fully integrated care model which MPCC is proposing. To this end, providers will be part of the board, CAC, and clinical committees.	Member organizations of MPCC make up 88% of primary care in the service area, so relationships are well established. Providers will be invited to play an active role, sought after for their input in clinical pathway and best practice development and roll out as well as overall health care delivery strategy.
Specialty care providers	Salem Health Medical Group providers, Salem Clinic Providers, WVP Health Authority Providers, Mid-Valley IPA Providers; other providers in service area		

Federally qualified health centers	NW Human Services;		
Pediatric Clinics	Salem Pediatric Clinic; Childhood Health Associates, Woodburn Pediatric Clinic		
Hospitalists	Salem Hospital, Santiam Hospital		
Providers, behavioral health, including culturally specific providers as available (list in first column below)			
Marion and Polk County	County Public Health Departments	Fully engaged providers of both physical, oral and mental health are critical to the fully integrated care model which MPCC is proposing. To this end, providers will be part of the board, CAC, and clinical committees.	MPCC member organizations already work closely with behavioral health providers on a number of initiatives now, including standards of care for opioid overdose patients brought to the ED Protocol (HB 4143) Neonatal Opioid Withdrawal Syndrome Task Force and Alcohol Abuse Task Force. Providers will be invited to play an active role, sought after for their input in clinical pathway and best practice development and roll out. As needs are prioritized, MPCC will continue to work closely with County and Community providers to ensure the best outcome for the patient.
Community Providers	Community Providers throughout service area		
Providers, oral health, including culturally specific providers as available (list in first column below)			
Dentists, FQHC with dental services	Local dental providers, Salem Free Clinic Dental Clinic, NW Human Services, Capitol Dental	Fully engaged providers of both physical, oral and mental health are critical to the fully	Providers will be invited to play an active role, sought after for their input in clinical pathway

Emergency Dental Services	Medical teams (traveling vans), Capitol Dental	integrated care model which MPCC is proposing. To this end, providers will be part of the board, CAC, and clinical committees.	and best practice development and roll out. MPCC will build and maintain relationships with local dental entities in the service area to ensure the best outcome for the patient and full engagement and commitment on the part of the providers.
Oral health advocacy groups	Oregon Dental Association Mission of Mercy , Capitol Dental		
Social services serving dental needs	Boys and Girls Club		
Providers, long term services and supports, including culturally specific providers as available (list in first column below)			
Nursing homes	Avamere, French Prairie		
Providers, traditional health workers, including culturally specific providers as available (list in first column below)			
Peer Support groups for substance abuse and addiction	County Coalition to address Pain & Addiction Youth Era Oregon Family Support Network MOMS program Marion County Medically Assisted Treatment programs ROCC Project ABLE	Peer support and other traditional workers will play a critical role in the transformation of care. Each entity listed here offers peer support, individuals with lived experience and cultural competence not available within a conventional clinic setting.	There are several community organizations or support groups already in place in the service area and as health care strategy is further developed, these providers will be invited to play an active role, sought after for their input in clinical pathway and best practice development and roll out as well as overall health care delivery strategy.
Providers, health care interpreters (list in first column below)			
Interpreters	National Interpreting Services, Global Interpreters USA, Guerra/Guerra Interpretations, Lavo Translations, Linguava Interpreters, Oregon Certified Interpreter's Network, Passport to Languages,	A variety of interpreting services are used to ensure members requiring interpretation receive it in a timely manner.	

	Professional Interpreters, Stars Interpreters, Willamette Sign Language		
Early learning hubs (list in first column below)			
Early Learning Hub of M/P counties	Early Learning Hub of Marion and Polk Counties	The Early Learning Hub is an important partner to OHP members with young children. Their initiatives expand beyond health care but address many of the SDOH and resiliency components that contribute to health disparities. They are a critical partner to have at the table.	MPCC member organizations already work closely with the ELH and will continue to do so. Input from this group regarding SDOH-HE spending initiatives will be extremely valuable. The ELH will also be included in the overall strategy development for the CHA, CHP and healthcare delivery.
Local public health authorities (list in first column below)			
County health and human services	Marion County and Polk County Public Health Departments	Polk county manages all of the mental health care for OHP members living in that county and Marion County has extensive programming for crisis and safety net programs as well. The counties take the lead on the Community Needs Assessment and Community Improvement Plan.	MPCC member organizations are already involved in multiple task forces and committees led by Marion and Polk county public health departments which address public health issues, safety net programs, community education, and SDOH. These include ED Diversion, LEAD program, Communicable Disease Task Force, Opioid Overdose ED Protocol (HB 4143), Sexual Assault Response Team, Domestic Violence Council, Child Abuse Prevention Team, Justice Reinvestment Council,

			Neonatal Opioid Withdrawal Syndrome Task Force, Maternal Child Health Coalition, Child Fatality Team, Alcohol Abuse Task Force, Mobile Crisis Services, Psychiatric Crisis Services and Health Advisory board. MPCC will work closely with local public health authorities through these committees and other partnership opportunities to improve outcomes for the patient.
Local mental health authorities (list in first column below)			
County Mental Health Departments	Marion County; Polk County	Polk county manages all of the mental health care for OHP members living in that county and Marion County has extensive programming for crisis and safety net programs as well. The counties take the lead on the Community Needs Assessment and Community Improvement Plan. MPCC member organizations are also active in the Mid-Valley Suicide Prevention Coalition and Marion County's Zero Suicide initiative and Marion County has its Psychiatric Crisis Center on the Salem Hospital Campus.	MPCC member organizations are already involved in multiple task forces and committees led by Marion and Polk county public health departments which address public health issues, safety net programs, community education, and SDOH. These include ED Diversion, LEAD program, Communicable Disease Task Force, Opioid Overdose ED Protocol (HB 4143), Sexual Assault Response Team, Domestic Violence Council, Child Abuse Prevention Team, Justice Reinvestment Council,

			Neonatal Opioid Withdrawal Syndrome Task Force, Maternal Child Health Coalition, Child Fatality Team, Alcohol Abuse Task Force and Health Advisory board. MPCC will work closely with local public health authorities through these committees and other partnership opportunities to improve outcomes for the patient.
Other local government (list in first column below)			
Local city and county governments	City of Salem Salem Housing Authority EMS Salem Fire Department Salem Police Department Marion County Sheriff Polk County Sheriff	City government, including law enforcement and emergency responders are important partner in the delivery of care. Areas where MPCC members organizations are already working with local government include emergency preparedness Medical Respite through Salem Housing Authority, quarterly meetings between ED and EMS teams, work to open a Sobering Center in Salem; Marion County mental health evaluators in the ED, partnering with police to promote suicide prevention and supplying officers with narcan to treat opioid overdoses in the field.	Regular meetings and relationships are established with these providers and will continue, including solicitation of feedback for improvements to the delivery of care for OHP members.

Tribes, if present in the service area (list in first column below)			
Grand Ronde and Chemawa Tribes		These tribes have primary care clinics in the MPCC service area and will serve OHP recipients.	Tribal clinics will be invited to participate in the MPCC Community Advisory Council and other CCO committees. The organization will conduct outreach to enhance communication and improve partnerships with these groups.
Regional Health Equity Coalitions, if present in the service area (list in first column below)			
Health Equity Coalition of Marion County	Willamette Valley Health Equity Coalition	This group is still in the formative stages, but Salem Health has been actively participating in its development. In order to increase cultural competencies and address health disparities this will be an important partnership.	The Coalition will be invited to be part of regular CCO community forums as well as a position on the CAC. Their feedback and input will be used to inform strategies to address health equity.
Add additional stakeholder types here (list in first column below)			
State Government	Department of Human Services; Oregon Health Authority	Work is currently underway to increase awareness around suicide prevention and reduce stigma. Salem Health is actively participating in OHA's Zero Suicide Initiative and will allow this work to inform care delivery throughout MPCC. DHS is a partner with ED staff and others in efforts to provide care	MPCC staff will seek guidance from these state organizations as to best practices when caring for vulnerable populations such as children in state custody and children in psychiatric crisis. Close partnerships will be needed to ensure the best outcomes for the patient.

		to children in the foster care system.	
Marion Polk Medical Society	MPMS	Marion Polk Medical Society is a conduit to local providers and can assist MPCC in developing relationships, recruiting providers, soliciting feedback and more.	MPMS will be invited to take part in the strategic development through the Community Advisory Committee, Clinical Committee or community forums.
Educational Institutions	K12 School Districts Willamette University; Western Oregon University, Chemeketa Community College; Linfield, Pacific University, George Fox University	Partnerships with local educational institutions are important for workforce development, continuity of care and greater impact of social issues such as immunizations and suicide prevention. Schools are gathering places for families and they feel comfortable there. Partnering with our K12 schools and higher learning will increase access and provide keener insight into the needs of our members.	Educational partners, including classroom teachers, instructional assistants and others who work directly with families, will be invited to provide feedback for improving the health care delivery system. Salem Health currently operates a school based health center at Central High School and has a district wide suicide prevention project underway with Salem-Keizer Public Schools. Many opportunities exist to streamline care and MPCC will work closely with schools to do so.
Faith based community	Salem Leadership Foundation, Young Life, Family Promise (formerly Interfaith Hospitality network)	The faith based community is often overlooked, but churches, synagogues and fellowship groups are excellent ways of accessing underserved populations that may feel their culture is misunderstood or	Each of the named entities works to address SDOH and strengthen communities. Working together to identify barriers to health that are specific to cultural or ethnic background will be a focus.

		undervalued. In order to increase outreach and better understand cultural differences among our members, the faith based community must be among our partners.	This community is an excellent source of volunteers, peer mentors and those with lived experience too, so will also lead to a more robust THW model.
Community Advocacy Groups	Neighborhood Associations; Salem Community Vision; Service Integration Teams	There are multiple community advocacy groups unique to neighborhoods and towns. Involving these voices as a way to improve the overall health of the population as well as better understand niche needs of certain areas will be important to the success of the CCO.	Community forums will be offered in various geographic locations, not only in the single urban center of the focus area. Using other network partners, such as Service Integration Teams, social services agencies and the faith based community, MPCC will ensure linkage to rural communities on a regular basis and reflect their voices as health care strategies are developed and evaluated.

Table 2: Major activities and deliverables for which the CCO will engage the community	
All applicants must complete this full table.	
Part 2a. List and describe the five to eight major projects, programs and decisions for which the CCO will engage the community.	**Part 2b.** Identify the level of community engagement for each project, program and decision. Answers* must be 1) inform/communicate, 2) consult, 3) involve, 4) collaborate, or 5) shared decision-making. Applicant may include more than one level of engagement for each project, program or decision to account for differences among stakeholder groups.
Housing	Shared decision making
Food Insecurity/Food Deserts	Consult and Involve
Preventative Health (Screenings, immunizations, prenatal care, managing pre-diabetes, etc.)	Inform; Consult
Mental Health	Inform; Consult; Involve and Collaborate (continue work on teen suicide prevention)
Substance abuse	Inform

*

1. **Inform**: Provide the community with information to assist in their understanding of the issue, opportunities, and solutions. Tools include fact sheets, published reports, media releases, education programs, social media, email, radio, information posted on websites, and informational meetings.
2. **Consult**: Obtain community feedback on analysis, alternatives, and/or decisions. Tools include issue briefs, discussion papers, focus groups, surveys, public meetings, and listening sessions.
3. **Involve**: Work directly with the community throughout the process to ensure that community concerns and aspirations are understood and considered. Applicant provides feedback to the community describing how the community input influenced the decision. Tools include meetings with key stakeholders, workshops, subject matter expert and stakeholder roundtables, conferences, and task forces.
4. **Collaborate**: Partner with the community in each aspect of the process, including decision points, the development of alternatives and the identification of a solution. Tools include advisory committees, consensus building, and participatory decision making.
5. **Shared decision-making**: To place the decision-making in the hands of the community (delegate) or support the actions of community initiated, driven and/or led processes (community driven/led). Tools include delegated decisions to members of the communities impacted through steering committees, policy councils, strategy groups, Community supported processes, advisory bodies, and roles and funding for community organizations.

Table 3: Engagement with other agencies in the service area that have responsibility for developing community health assessments and community health improvement plans					
All applicants must complete this full table. Applicants may add rows as needed.					
Part 1. Applicants with an existing CCO CHA and CHP will submit their most recent CHA and CHP with the community engagement plan.					
Part 2. List of all local public health authorities, non-profit hospitals, other CCOs that share a portion of the service area, and any federally recognized tribe in the service area that is developing or has a CHA/CHP. Add additional rows as needed.	**Part 3.** The extent to which each organization was involved in the development of the Applicant's current CHA and CHP. Answers* must be a) competition and cooperation, b) coordination, c) collaboration, or d) not applicable (NA).**	**Part 4.** For any organization that is a collaborator for a shared CHA and shared CHP priorities and strategies, the applicant will list the shared priorities and strategies.**	**Part 5.** For any organization that is not a collaborator for a shared CHA and shared CHP priorities and strategies, the applicant will describe the current state of the relationship between the applicant and the organization(s), including gaps.	**Part 6.** For any organization that is not a collaborator for a shared CHA and shared CHP priorities and strategies, the applicant will describe the steps the applicant will take to address gaps prior to developing the next CHA and CHP, and the dates by which the applicant will complete key tasks.***	**Part 7.** Applicants **without an existing CHA and CHP or that intend to change their service area** will demonstrate that they have reviewed CHAs and CHPs developed by these other organizations. List the health priorities from existing plans.
Local public health authorities (list in this column below)					
NOTE: Applicant is a new CCO without an existing CHA and CHP, two of the three member organizations (Salem Health Hospitals and Clinics and WVP Health Authority have extensive experience developing both, having been a collaborator on the CHA and CHP currently being used in the service area.					
Marion County	N/A	N/A			Salem Health and WVP Health Authority, two of the three member organizations of MPCC, were actively involved in the development of the 2015 full Community Health Assessment as well as

					the annual updates that have occurred since, including the most recent update and recommendations for 2019. While the counties lead the effort, there are dozens of community partners involved in the assessment, community stakeholder meetings and review of the data. Salem Health along with the other hospitals in the service area, contribute to the decision regarding the final identified health priorities. In 2019, the teams agreed to focus on housing, behavioral health and substance abuse. In the 2018 CHP action plan, Marion County was specifically focused on Prenatal Care, Obesity Prevention, Tobacco Use and Depression

					Screening. Marion County worked with a Prenatal Care Partner workgroup to engage providers, pregnant women and the community at large. In Obesity prevention, Marion County partnered with Salem Health to provide CATCH training (healthy eating and behavior training for grades K-4) and promote Safe Routes to School. Partnership with Woodburn Health Initiative to offer exercise options for community members. In the area of tobacco use, Marion County worked with the city of Silverton to strengthen the licensing of tobacco retailers, promote worksite wellness related initiatives and lobbied for an increase in the

					minimum age to purchase cigarettes. Other partnerships include OSU Extension, Woodburn Pediatric Clinic, Marion Polk Food Share, American Diabetes Association, WVCH and WVP Health Authority.
Polk County	N/A				Polk County works in cooperation with Marion county to develop the community health needs assessment and community health improvement plans. While the counties lead the effort, there are dozens of community partners involved in the assessment, community stakeholder meetings and review of the data. Salem Health along with the other hospitals in the service area, contribute to the

					decision regarding the final identified health priorities. In 2019, the teams agreed to focus on housing, behavioral health and substance abuse. Polk County has not published their CHP results from 2018 at the time of this application, but their work mirrored Marion County's, focusing on reducing tobacco use, especially in teens; increasing access and awareness for pregnant mothers to get care in their first trimester, reducing obesity and screening for depression. Other partnerships include OSU Extension, Woodburn Pediatric Clinic, Marion Polk Food Share, American Diabetes Association, WVCH and WVP Health Authority.

Non-profit hospitals (list in this column below)					
Salem Hospital	N/A				Depression: Added suicide risk assessment of all patients admitted to ED and referred to mental health services if score was moderate, mental health evaluator sees patient in the ED immediately if score is high; screen all outpatients at clinics for depression using PHQ-9; added depression screening to community health "Know Your Numbers" screenings; increased Mental Health First Aid and Question, Persuade, Refer trainings for community members at no cost. Over 2,000 community members trained since July 2018. Tobacco use: tobacco screening of all out

					patients and referral to tobacco cessation classes in collaboration with WVP; screen in patients for tobacco use and referral to tobacco cessation classes; worked with City of Salem to extend smoke free campus to city owned sidewalks and parkways; offered free lung cancer screenings through Salem Cancer Institute; Obesity: Healthy cooking classes hosted at Community Health Education Center (CHEC), Weight Management Classes at CHEC, Funding Triple Play (Mind, Soul, Body) at Boys and Girls Club; Community Screenings for pre-diabetes and support to local physical activity clubs such as

					"Just Walk" and support groups.
West Valley Hospital	N/A				Depression: Added suicide risk assessment of all patients admitted to ED and referred to mental health services if score was moderate, mental health evaluator sees patient in the ED immediately if score is high; screen all outpatients at clinics for depression using PHQ-9; added depression screening to community health "Know Your Numbers" screenings; increased Mental Health First Aid and Question, Persuade, Refer trainings for community members at no cost. Over 2,000 community members trained since July 2018. Tobacco use: tobacco screening of all out patients and referral

					to tobacco cessation classes in collaboration with WVP; screen in patients for tobacco use and referral to tobacco cessation classes; Know Your Number screening events for community members; Wellness Activities for employees; training of elementary teachers in Polk county in curriculum for healthy behaviors
Santiam Hospital	N/A				Held community screening events for breast, prostrate, colon and lunch cancer; promote healthy behavior change to community through local events and “Living Well” workshops
Legacy Silverton Medical Center	N/A				Participated in depression screening for patients at their outpatient clinics. Offered Worksite

					Wellness classes for employees.
Current coordinated care organizations, as of 2019 (list in this column below)					
Willamette Valley Community Health (WVCH)	N/A				WVCH worked in cooperation with Marion and Polk counties, all four hospitals in the region, and numerous other partners to coordinate their CHP. Priorities in 2015-18 were prenatal care, depression, obesity and tobacco use. WVHC attempted to engage their primary care providers in depression screening by providing training and improving connections with mental health providers. WVCH focused on communication with the local health departments and Oregon Mothers Care to increase the

					number of pregnant women seeking care in their first trimester. In obesity, WVCH worked to develop a reimbursement mechanism that would allow nutrition and physical activity guidance to be a billable service. They also planned to develop a tool kit including resources available to those looking to lose weight. In tobacco use, WVCH planned to survey the community regarding tobacco cessation services and use the results to "craft a comprehensive and coordinated approach to tobacco prevention and cessation". The published CHP is not dated and does not have outcomes regarding whether any of these tactics were implemented or if the goals were met.

Federally recognized tribes that have or are developing a CHA/CHP (list in this column below)					
NA					

*

a) Competition and Cooperation: Loose connections and low trust; tacit information sharing; ad hoc communication flows; independent goals; adapting to each other or accommodating others' actions and goals; power remains with each organization; resources remain with each organization; commitment and accountability only to own organization; relational time frame short; low risk and reward.
b) Coordination: Medium connections and work-based trust; structured communication flows and formalized project-based information sharing; joint policies, programs and aligned resources; semi-interdependent goals; power remains with parent organizations; commitment and accountability to parent organization and project; relational time frame medium and based on prior projects; medium risk and reward.
c) Collaboration: Dense interdependent connections and high trust; frequent communication; tactical information sharing; systems change; pooled and collective resources; negotiated shared goals; power is shared between organizations; commitment and accountability to network first, community and parent organization; relation time frame long (3 years or more); high risk and reward.
d) Not applicable

**If the applicant does not have a current CHA and CHP, the applicant will enter not applicable (NA).

***Engagement activities must begin by March 31, 2020 and applicant will report on progress through the June 2020 CCO CHP progress report.

Table 4: Engagement with social determinants of health and health equity (SDOH-HE) partners for CHA and CHPs Applicants may add rows as needed.		
All applicants must complete Part 1.	**Applicants <u>with an existing CHA and CHP</u> must complete Parts 2, 3 and 4. Applicants <u>that intend to change their service area</u> must also complete Parts 2, 3, and 4.**	**Applicants <u>without an existing CHA and CHP or that intend to change their service area</u> must complete Parts 2a and 4a.**

MARION POLK COORDINATED CARE, INC - RFA COMMUNITY ENGAGEMENT PLAN TABLES

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.					
Grand Ronde				unknown	Invite tribe representatives to review priorities and submit feedback through written survey and community forum by 3/31/20 invite to be part of review and evaluation annually each year no later than June 30
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					
Local government, including counties					
Marion County Health Department				The organization was explicitly involved in developing one or more CHAs or CHPs	Meet with county representatives, review priorities and confirm support for identified areas of

					focus no later than 3/1/20
Polk County Health Department				The organization was explicitly involved in developing one or more CHAs or CHPs	Meet with county representatives, review priorities and confirm support for identified areas of focus no later than 3/1/20
City of Salem				Unknown	Invite city representatives to review priorities and submit feedback through written survey and community forum by 3/31/20
Salem Housing Authority				The organization was explicitly involved in developing one or more CHAs or CHPs	Invite SHA representatives to review priorities and submit feedback through written survey and community forum by 3/31/20
City of Dallas				The organization was explicitly involved in developing one or more CHAs or CHPs	Invite city representatives to review priorities and submit feedback through written survey and community forum by 3/31/20

City of Keizer				Unknown	Invite city representatives to review priorities and submit feedback through written survey and community forum by 3/31/20
City of Monmouth				Unknown	Invite city representatives to review priorities and submit feedback through written survey and community forum by 3/31/20
City of Independence				Unknown	Invite city representatives to review priorities and submit feedback through written survey and community forum by 3/31/20
City of Stayton				The organization was explicitly involved in developing one or more CHAs or CHPs	Invite city representatives to review priorities and submit feedback through written survey and community forum by 3/31/20

City of Scotts Mills				The organization was explicitly involved in developing one or more CHAs or CHPs	Invite city representatives to review priorities and submit feedback through written survey and community forum by 3/31/20
City of Silverton				The organization was explicitly involved in developing one or more CHAs or CHPs	Invite city representatives to review priorities and submit feedback through written survey and community forum by 3/31/20
City of Mt. Angel				The organization was explicitly involved in developing one or more CHAs or CHPs	Invite city representatives to review priorities and submit feedback through written survey and community forum by 3/31/20
City of St. Paul				The organization was explicitly involved in developing one or more CHAs or CHPs	Invite city representatives to review priorities and submit feedback through written survey and community forum by 3/31/20

City of Woodburn				The organization was explicitly involved in developing one or more CHAs or CHPs	Invite city representatives to review priorities and submit feedback through written survey and community forum by 3/31/20
City of Sublimity				The organization was explicitly involved in developing one or more CHAs or CHPs	Invite city representatives to review priorities and submit feedback through written survey and community forum by 3/31/20
City of Turner				The organization was explicitly involved in developing one or more CHAs or CHPs	Invite city representatives to review priorities and submit feedback through written survey and community forum by 3/31/20
City of Falls City				unknown	Invite city representatives to review priorities and submit feedback through written survey and community forum by 3/31/20

Law Enforcement				unknown	Invite city representatives to review priorities and submit feedback through written survey and community forum by 3/31/20
Emergency Responders				unknown	Invite city representatives to review priorities and submit feedback through written survey and community forum by 3/31/20
Organizations that address the four key domains of social determinants of health* (list in this column below).					
Mid-Willamette Valley Community Action Agency				The organization was explicitly involved in developing one or more CHAs or CHPs	Solicit names from entities for CCO board and CAC by 10/31/19; Review current county priorities and progress made, evaluate and solicit recommendations for next steps specific to their work by 2/15/20; invite to be part of

					review and evaluation annually each year no later than June 30
Union Gospel Mission				The organization was explicitly involved in developing one or more CHAs or CHPs	Solicit names from entities for CCO board and CAC by 10/31/19; Review current county priorities and progress made, evaluate and solicit recommendations for next steps specific to their work by 2/15/20; invite to be part of review and evaluation annually each year no later than June 30
Service Integration Teams				The organization was explicitly involved in developing one or more CHAs or CHPs	Solicit names from entities for CCO board and CAC by 10/31/19; Review current county priorities and progress made, evaluate and solicit recommendations for next steps specific to their work by 2/15/20; invite to be part of review and evaluation annually each year no later than June 30
Boys and Girls Club				unknown	Solicit names from entities for CCO board

					and CAC by 10/31/19; Review current county priorities and progress made, evaluate and solicit recommendations for next steps specific to their work by 2/15/20; invite to be part of review and evaluation annually each year no later than June 30
Catholic Community Services				The organization was explicitly involved in developing one or more CHAs or CHPs	Solicit names from entities for CCO board and CAC by 10/31/19; Review current county priorities and progress made, evaluate and solicit recommendations for next steps specific to their work by 2/15/20; invite to be part of review and evaluation annually each year no later than June 30
Marion Polk Food Share				The organization was explicitly involved in developing one or more CHAs or CHPs	Solicit names from entities for CCO board and CAC by 10/31/19; Review current county priorities and progress made, evaluate and solicit

					recommendations for next steps specific to their work by 2/15/20; invite to be part of review and evaluation annually each year no later than June 30
United Way of the Willamette Valley				The organization was explicitly involved in developing one or more CHAs or CHPs	Solicit names from entities for CCO board and CAC by 10/31/19; Review current county priorities and progress made, evaluate and solicit recommendations for next steps specific to their work by 2/15/20; invite to be part of review and evaluation annually each year no later than June 30
Salvation Army				The organization was explicitly involved in developing one or more CHAs or CHPs	Solicit names from entities for CCO board and CAC by 10/31/19; Review current county priorities and progress made, evaluate and solicit recommendations for next steps specific to their work by 2/15/20; invite to be part of review and evaluation

					annually each year no later than June 30
Family Building Blocks				The organization was explicitly involved in developing one or more CHAs or CHPs	Solicit names from entities for CCO board and CAC by 10/31/19; Review current county priorities and progress made, evaluate and solicit recommendations for next steps specific to their work by 2/15/20; invite to be part of review and evaluation annually each year no later than June 30
Liberty House				The organization was explicitly involved in developing one or more CHAs or CHPs	Solicit names from entities for CCO board and CAC by 10/31/19; Review current county priorities and progress made, evaluate and solicit recommendations for next steps specific to their work by 2/15/20; invite to be part of review and evaluation annually each year no later than June 30
Salem-Keizer School District				The organization was explicitly involved in	Invite district representatives to review priorities and

				developing one or more CHAs or CHPs	submit feedback through written survey and community forum by 3/31/20; invite to be part of review and evaluation annually each year no later than June 30
Early Learning Hub of Marion County				The organization was explicitly involved in developing one or more CHAs or CHPs	Invite district representatives to review priorities and submit feedback through written survey and community forum by 3/31/20; invite to be part of review and evaluation annually each year no later than June 30
Central School District				The organization was explicitly involved in developing one or more CHAs or CHPs	Invite district representatives to review priorities and submit feedback through written survey and community forum by 3/31/20 invite to be part of review and evaluation annually each year no later than June 30

Dallas School District				The organization was explicitly involved in developing one or more CHAs or CHPs	Invite district representatives to review priorities and submit feedback through written survey and community forum by 3/31/20 invite to be part of review and evaluation annually each year no later than June 30
Woodburn School District				The organization was explicitly involved in developing one or more CHAs or CHPs	Invite district representatives to review priorities and submit feedback through written survey and community forum by 3/31/20 invite to be part of review and evaluation annually each year no later than June 30
North Santiam School District				The organization was explicitly involved in developing one or more CHAs or CHPs	Invite district representatives to review priorities and submit feedback through written survey and community forum by 3/31/20 invite to be part of review and

					evaluation annually each year no later than June 30
Santiam Canyon School District				The organization was explicitly involved in developing one or more CHAs or CHPs	Invite district representatives to review priorities and submit feedback through written survey and community forum by 3/31/20 invite to be part of review and evaluation annually each year no later than June 30
Silver Falls School District				The organization was explicitly involved in developing one or more CHAs or CHPs	Invite district representatives to review priorities and submit feedback through written survey and community forum by 3/31/20 invite to be part of review and evaluation annually each year no later than June 30
Jefferson School District				The organization was explicitly involved in developing one or more CHAs or CHPs	Invite district representatives to review priorities and submit feedback through written survey and

					community forum by 3/31/20 invite to be part of review and evaluation annually each year no later than June 30
North Marion School District				unknown	Invite district representatives to review priorities and submit feedback through written survey and community forum by 3/31/20 invite to be part of review and evaluation annually each year no later than June 30
Cascade School District				unknown	Invite district representatives to review priorities and submit feedback through written survey and community forum by 3/31/20 invite to be part of review and evaluation annually each year no later than June 30
Chemeketa Community College				The organization was explicitly involved in	Invite college representatives to review priorities and

				developing one or more CHAs or CHPs	submit feedback through written survey and community forum by 3/31/20 invite to be part of review and evaluation annually each year no later than June 30
Willamette University				The organization was explicitly involved in developing one or more CHAs or CHPs	Invite university representatives to review priorities and submit feedback through written survey and community forum by 3/31/20 invite to be part of review and evaluation annually each year no later than June 30
Western Oregon University				The organization was explicitly involved in developing one or more CHAs or CHPs	Invite university representatives to review priorities and submit feedback through written survey and community forum by 3/31/20 invite to be part of review and evaluation annually each year no later than June 30

Culturally specific organizations and organizations that work with underserved or at-risk populations (list in this column below).					
NW Human Services				The organization was explicitly involved in developing one or more CHAs or CHPs	Solicit names from entities for CCO board and CAC by 10/31/19; Review current county priorities and progress made, evaluate and solicit recommend-dations for next steps specific to their work by 5/1/20; invite to be part of review and evaluation annually each year no later than June 30
NW Family Services				The organization was not explicitly involved in developing one or more CHAs or CHPs	Solicit names from entities for CCO board and CAC by 10/31/19; Review current county priorities and progress made, evaluate and solicit recommend-dations for next steps specific to their work by 5/1/20; invite to be part of review and evaluation annually

					each year no later than June 30
Mano a Mano				The organization was not explicitly involved in developing one or more CHAs or CHPs	Solicit names from entities for CCO board and CAC by 10/31/19; Review current county priorities and progress made, evaluate and solicit recommend-dations for next steps specific to their work by 5/1/20; invite to be part of review and evaluation annually each year no later than June 30
Regional Health Equity Coalition				The organization was not explicitly involved in developing one or more CHAs or CHPs	Solicit names from entities for CCO board and CAC by 10/31/19; Review current county priorities and progress made, evaluate and solicit recommendations for next steps specific to their work by 5/1/20; invite to be part of review and evaluation annually each year no later than June 30
Other organizations (list in this column below).					

WVP Health Authority				The organization was explicitly involved in developing one or more CHAs or CHPs	As a member organization will be intimately involved in development and refinement of plan
Salem Clinic				The organization was not explicitly involved in developing one or more CHAs or CHPs	As a member organization will be intimately involved in development and refinement of plan
Faith Based Organizations including Salem Leadership Foundation and St. Edward's Church				The organization was explicitly involved in developing one or more CHAs or CHPs	Review current county priorities and progress made, solicit feedback through survey and community forum by 3/31/20
Local fitness centers, including Anytime Fitness and World Gym				The organization was explicitly involved in developing one or more CHAs or CHPs	Review current county priorities and progress made, solicit feedback through survey and community forum by 3/31/20
Salem Hospital					As a member organization will be intimately involved in development and refinement of plan
West Valley Hospital					As a member organization will be intimately involved in development and refinement of plan

Legacy Silverton Medical Center					Solicit names from entities for CCO board and CAC by 10/31/19; Review current county priorities and progress made, evaluate and solicit recommendations for next steps specific to their work by 5/1/20; invite to be part of review and evaluation annually each year no later than June 30
Santiam Hospital					Solicit names from entities for CCO board and CAC by 10/31/19; Review current county priorities and progress made, evaluate and solicit recommendations for next steps specific to their work by 5/1/20; invite to be part of review and evaluation annually each year no later than June 30
*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.					

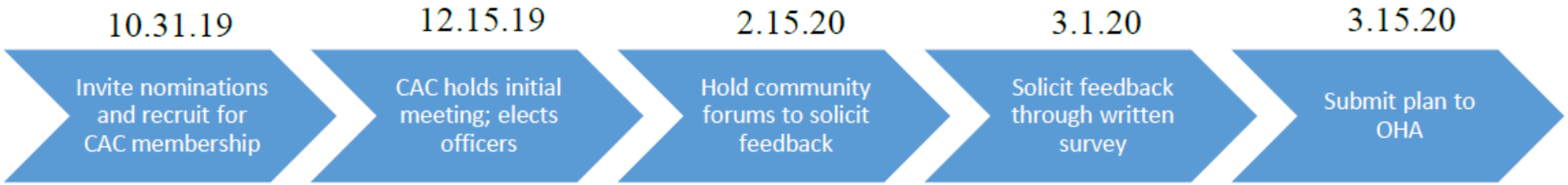
Table 5: Assessment of existing social determinants of health priorities and process to select Year 1 social determinants of health priorities

MARION POLK COORDINATED CARE, INC - RFA COMMUNITY ENGAGEMENT PLAN TABLES

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.
Housing	Marion and Polk County Collaborative CHA and CHP	Health Outcome Goal
Behavioral Health Support	Marion and Polk County Collaborative CHA and CHP	Health Outcome Goal
Substance Abuse	Marion and Polk County Collaborative CHA and CHP	Health Outcome Goal
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.		
The applicant members have already worked closely with both Marion and Polk counties and numerous other community partners, including the current CCO, to develop the updated Community Health Assessment and Community Health Improvement priorities for 2019. These priorities are listed above and will be the three areas MPCC will strive to address. Within these three areas – especially housing - there are multiple sub-issues to address. The CAC will hold community forums to solicit community feedback regarding breaking down these priority areas. Written surveys will also be distributed to selected partners who have been actively involved in past CHA and CHP development. Once information is collected and consolidated, the CAC will come to a decision regarding specific issues to address within the three priority areas, and will submit these to the CCO board for approval. Upon approval, it will be the work of the Community Advisory Committee identify local organizations and entities that are already subject matter experts in these areas. These organizations will be invited to participate in coordination with the CCO to develop new or enhance existing networks of care and tests of change to address the identified need(s). Any organization not explicitly invited will have the opportunity to propose a project they believe addresses the identified need(s) to the CAC. The thought process behind this departure from the standard practice of grants comes from a desire to truly coordinate care – across all dimensions, not just medical, dental and mental health. Thoughtful wrap around		

services that integrate the well-being of the individual while avoiding duplication, including community input and removing barriers to achieving that well-being is the intent.

The timeline is as follows:



*Applicants must include description of housing priority if already identified in CHPs. (e.g. housing overall, housing for targeted populations).

**The four key domains of social determinants of health are economic stability, education, neighborhood and built environment, and social and community health. Refer to the Social Determinants of Health and Health Equity Glossary reference document.

Marion Polk Coordinated Care℠

MPCC Attachment 10 – Social Determinants of Health and Health Equity

A. Community Engagement

A.1.a Marion Polk Coordinated Care (MPCC) has made a concerted effort to engage the community in the development of this application. MPCC principle members provide care to OHP members at virtually every point on the healthcare continuum. This comprehensive experience uniquely enables the board and advisory committee to advocate on behalf of Marion and Polk counties' diverse membership. Both formal and informal conversations with stakeholders throughout the service area were held during the development of this application. The contents of this application include numerous examples of MPCC principle members engaging community stakeholders in efforts to improve health outcomes and the experience of care. True coordination of care for the most vulnerable populations is impossible without the close partnership of our social service agencies, public health partners, providers and the members who access the services and as such, MPCC will continue to make partnership a priority.

A.1.b Please see the included Community Engagement Plan: RFA4690-MPCC-Att10-Community Engagement Plan and RFA4690-MPCC-Att10-Community Engagement Narrative.

B. Social Determinants of Health and Health Equity (SDOH-HE) Spending, Priorities, and Partnership

B.1. a No agreements or MOUs with entities that meet the definition of SDOH-HE partners are currently in place. Collectively, the MPCC principle members have extensive experience partnering with stakeholders and entities meeting the definition of SDOH-HE partners as well as stakeholders including Salem Housing Authority, Salem Free Clinic, Project Access, Family Building Blocks, Mano A Mano, Oregon Family Support Network, Marion and Polk County Public Health, Early Learning Hub, Marion-Polk Food Share and more.

B.1.b As a newly formed entity, MPCC does not currently have performance milestones of metrics in place. These will be developed in conjunction with our newly formed Community Advisory Committee as well as input from members, providers and the community as a whole.

B.1c There is no policy currently in place. MPCC will select specific community health needs, including social determinants of health, that have been identified and prioritized by the Community Health Assessment (CHA) and Community Health Improvements Plan (CHP) assembled by the local public health network of partnership. The CAC will review the CHA, CHP, CCO data and other relevant information and make recommendations to the board for:

- areas of health related and SDOH-HE focus in the coming year
- feedback they have received from the community regarding the best way for the CCO to address these focus areas
- local organizations with whom the CCO should partner to achieve the best outcome for the patient
- a proposed budget

In order to inform their recommendations, the CAC will lead community forums seeking input and involvement from members, providers and the community at large regarding areas of focus and best practices to address needs. These forums will occur no less than once a year. Priority areas will be reviewed and reevaluated annually as well.

Once spending priorities have been identified, the CAC will track not only spending on SDOH-HE related programming, but also established metrics related to care. Prior to launching initiatives, partners participating in the work will establish both process and outcome metrics and timelines to meet these metrics. The goals and tactics will be submitted to the CAC for regular review. The CAC will evaluate at least semi-annually the impact of the work, need for adjustments, future funding, and/or replication in other areas, if applicable. The CAC will prepare and submit a report to the full board no less than annually that outlines past SDOH-HE spending and future recommendations.

B.1.d Community Advisory Committee meetings will be open to the public, with time for public comment at the beginning of each meeting. Agendas and meeting minutes will be posted on the MPCC website. The CAC and Board will adhere to an established conflict of interest policy and all members of the board and the CAC will sign a statement that affirms they have read and understand said policy. Members of both the CAC and the Board will also be given an opportunity at the beginning of each meeting to declare a conflict of interest with any agenda item and abstain from that portion of the meeting.

Organizations and entities invited to participate in initiatives will be selected based on published criteria, including, but not limited to, past experience working with vulnerable populations, collaboration with others to successfully meet community needs, based locally and with preference shown to non-profit organizations. Needs specific to geographic locations (remote and with fewer resources) will also be given special consideration. Interested parties not explicitly invited to participate will have the opportunity to propose a project or program they believe addresses the identified need(s) to the CAC. Funded initiatives and the work currently underway to support them will be available for review on MPCC's website, as will the above mentioned process and outcome metrics. As initiatives are introduced, transparency surrounding the work will be critically important to demonstrate accountability. In addition, metrics are tracked online through a visually simple to understand scorecard, outcome of funded work (meaning whether or not goals were met), amounts spent and member lives impacted will be reported at CAC meetings at least semi-annually. These results will also be shared at ongoing community forums led by the CAC.

B.1.e MPCC will use a broad range of metrics to assess the impact of investments made to address the statewide housing priority. The CCO will examine the impact each investment has on member satisfaction, healthcare utilization, health outcomes and pertinent community partnerships. Additionally, each housing-related investment will be required to target one of the following priorities:

- Health Equity and Racial Justice
- Homelessness
- Permanent and Supportive Housing

- Homeownership
- Rural Communities

B.2.a Below is the criteria MPCC will apply when selecting SDOH-HE partners.

- Preference will be given to organizations with 501(c)3 status and those organizations based in MPCC's service area county or primarily serving those in the MPCC service area.
- The degree to which the organization's values are consistent with and enhance improving the patient experience and outcome, increasing access to care and lowering costs.
- Past experience and track record of success working with vulnerable populations and collaboration with others to successfully meet community needs.
- The capacity of the organization to implement and sustain the proposed initiative.
- The organization's fiscal responsibility and management qualifications.
- Probability of CCO fund as leverage to access additional funding from other sources.
- The degree to which the organization's work complements other programs or services offered in the community, but does not duplicate.
- The potential impact and number of people who will benefit from their partnership.
- The likelihood that the health of the community will be improved as a result of the partnership.
- Partners located in or serving remote areas with fewer resources will also be given special consideration.

B.2.b Once the CAC has identified and recommended SDOH-HE spending priorities to the CCO board, these will be listed on the MPCC website along with established metrics. Organizations and entities identified by the Community Advisory Committee will be invited to participate in initiatives to best address identified priority areas. Interested parties not explicitly invited to participate will have the opportunity to propose a project or program they believe addresses the identified need(s) to the CAC. An application process to do so will be available on MPCC's website, as will the work currently underway and criteria by which the partners were selected. The CAC will hold community forums – initially to solicit community feedback regarding priority areas – and after year one, to communicate work currently underway, report results, evaluate progress of current work and reevaluate overall community needs, asking for additional community input. The forums will be open to the public and will be advertised on MPCC's website, through social media and by invitation to key stakeholders. Additionally, Community Advisory Committee meetings will be open to the public with agendas and meeting minutes will be posted online.

The thought process behind this departure from the standard practice of grants comes from a desire to truly coordinate care – across all dimensions, not just medical, dental and mental health. Thoughtful wrap around services that integrate the well-being of the individual while avoiding duplication of services and removing barriers to achieving that well-being is the intent.

B.2.c MPCC is working with our TPA to develop a referral and tracking process for members with identified SDOH needs and for members enrolled in specific SDOH programs. MPCC

will be able to track expenses and member enrollment with this functionality. The identified members will be reviewed based on the specific programs metrics to measure outcomes.

B.2.d MPCC has submitted a Community Engagement Plan which will be utilized for selecting Community SDOH-HE spending priorities in line with existing CHP priorities and the statewide priority on Housing-Related Services and Supports.

B.2.e MPCC will use a broad range of metrics to assess the impact of investments made to address the statewide housing priority. The CCO will examine the impact each investment has on member satisfaction, healthcare utilization, health outcomes and pertinent community partnerships. Additionally, each housing-related investment will be required to target one of the following priorities:

- Health Equity and Racial Justice
- Homelessness
- Permanent and Supportive Housing
- Homeownership
- Rural Communities

C. Health-Related Services (HRS)

C.1.a MPCC will structure the process for requests for Health Related Services for community investments to be inclusive of many parties. Funding requests may be submitted by community members, health care providers, and other community partners engaged with the CHP. Requests for funding will be evaluated by the CAC and CAP to ensure value and community need. The CAC and CAP will evaluate the using OAR 410-141-3150 Health Related Services. Upon review the funding request will be sent to the Board of Directors for approval. All approved community benefit investments will be included in MPCC Transformation and Quality Strategy mid-year and annual reports.

D. Community Advisory Council membership and role

D.1.a MPCC will draw from a number of data sources to ensure the CAC membership is reflective of the community. The CCO will review eligibility data to assess demographic representation, claims data to ensure adequate focus is placed on prevalent chronic conditions, and survey data to assess the needs and experiences of MPCC members. MPCC will also work with local public health departments to incorporate community-level data into all strategic planning activities. These data sources, coupled with insights and information from community partners, will help ensure that MPCC has an accurate understanding of its members demographic composition.

MPCC will utilize the data provided by OHA, collected by staff and provided by the provider community to define the demographic composition of Medicaid members.

E. Health Equity Assessment and Health Equity Plan

E.1.a MPCC is committed to the equitable delivery of services to underserved, socially disadvantaged, and ethnically diverse groups which include services that are culturally and linguistically appropriate. MPCC staff shall participate in annual cultural competency/diversity/health equity training. This entails mandatory attendance that is recorded via sign-in attendance log.

MPCC tracks provider completion of cultural competency trainings. Network education will be performed annually to inform on the importance of completing cultural competency and health equity training. MPCC will direct the provider network to utilize the cultural competency and health equity trainings recommended by the Office of Equity and Inclusion.

E.1.b MPCC has robust data collection and analysis capabilities that draw from a number of sources. MPCC partners have experience using the following data sources to procure REAL+D data:

- Claims data
- Eligibility data
- Patient surveys
- Patient focus groups
- Public Health data
- Data from community service organizations

Moving forward, MPCC will continue to expand its data collection capacity and will work to ensure actionable REAL+D data is used to inform the development of all CCO strategies.

E.2.a MPCC organizational practices have been developed to ensure provision of culturally and linguistically appropriate service. MPCC will collect data from the OHA eligibility files and community sources and aggregate the membership for both ethnicity and language needs. Tracking this data will allow MPCC to proactively ensure adequate workforce both for provider and certified interpreters to meet the health care needs of different cultures and those with limited English proficiency effectively.

E.2.b MPCC will continue the process started by our principle members to integrate diversity into all of the processes of the organization. Diversity becomes a lens for looking at, identifying, developing, and advancing talent. So when we think about recruitment, we ensure that all managers are trained on how to relate to the diversity of the population that they recruit from.

As our demographics is diverse, we focus on diversity in our workforce so that we can learn from our own diversity to make ourselves more effective at meeting the needs of our population. MPCC believes that the most effective organizations, are organizations that don't simply use their diversity in order to have legitimacy with clients, but use their diversity to increase the cultural competence of their workforce.

MPCC believes in recruiting a diverse workforce for all areas of the company. Some of the key strategies we will continue are as follows:

- Recruitment
- Internal Advancement
- Fostering existing diversity
- Training and education
- Identifying tends
- Population analysis

One of our goals when thinking about diversity, is to make sure we're building the cultural ability to connect across a myriad of areas, backgrounds, and focuses. It's difficult to be a true leader in today's world without a minimum level of cultural dexterity.

MPCC's aim is to ensure we're creating a culture where every individual is valued for their unique contributions and that they are able to achieve their highest potential.

E.2.c MPCC will ensure that members have access to linguistically appropriate care in several ways. The MPCC provider directory will indicate alternate languages spoken by health care providers to allow patients to select provider who can communicate in their preferred language. MPCC will contract with local interpreter agencies that employee certified interpreters and offer written translation of materials. These interpreters will be accessible to the network providers to ensure delivery of quality healthcare services in a way that patients can understand. Interpreter services may be accessed on-site, via phone or video.

MPCC will monitor for and evaluate the quality of linguistically appropriate services by review of complaint data (including survey response) as it pertains to linguistically and culturally services. Any complaint regarding language services will be an opportunity for education to improve the cultural competency in our network.

MPCC will audit provider offices with secret shopper survey and the Access and Availability survey to ensure a member request for language services is accommodated. Provider network will be educated at minimum, annually on the importance of providing linguistically appropriate care, the guidance requiring that requests be accommodated and the contracted providers to deliver interpreter services.

E.2.d MPCC will require provider network to comply with 42 CFR 438.10, 42 CFR part 92 and Section 1557 of the Affordable Care Act. This expectation will be in the contract for each provider/clinic in the network.

MPCC will monitor for compliance using the Annual Access and Availability survey. Complaint data will be monitored and tracked for opportunities to educate and ensure compliance within our provider network.

MPCC will provide network education at a minimum annual regarding the unique needs of members with disabilities and the requirements offices are expected to meet to serve these members.

F. Traditional Health Workers (THW) Utilization and Integration

F.1.a The use of clinic and county based traditional health workers (THWs) and MPCC peer mentors for members with intensive care coordination needs and those experiencing health disparities is vital to MPCC's success. One of MPCCs principle members, WVP Health Authority, has used traditional health workers since 2006, adding more peer mentored programs since then.

MPCC programs utilizing THWs are measured and evaluated by monitoring and performing data analysis to establish whether the programs objectives are met. For example:

- Emergency Department Intervention Team (EDIT) – Emergency room utilization is monitored to ensure success. This program currently employees 6 peer mentors.
- Marion-Polk Obstetrics Mentoring Services (MOMs) – Outcomes of the population served through this program are monitored for positive outcomes. This program currently employees 4 peer mentors.
- Family Support Coordinators (FSC) – FSC success in evaluating by reviewing the success of the member and the utilization of appropriate healthcare. This program currently employees 3 peer support mentors.
- Behavioral Health Coordinators – The outcomes for this team are yet to be established. Projected 2+ peer support mentors.
- Intensive Case Management (ICM) – This programs success in monitored by the success of the individual member and the utilization of appropriate healthcare. This program employees 1 Transition of Care Coordinator (TOCC) peer support mentor and is projected to add 1 more TOCC peer support, 1 behavioral health TOCC peer support and 1 SNP TOCC peer support mentor.

Multiple clinics in our network also employee THW. One of our principle members, WVP Health Authority, participates in a behaviorist group in our network with varying licensures. The Behavioral Health in the Primary Care Clinic program provides a model overview, training requirements and compensation for the funding of behavioral health positions in the primary care setting to integrate behavioral health into a multi-disciplinary primary care team.

Below are the participants by specialty type for the Behavioral Health in the Primary Care Clinic program which are in MPCC's network:

- Doctor of Philosophy/Psychologist – 5
- Doctor of Psychology – 2
- Licensed Clinical Social Worker – 12
- Marriage & Family Therapist - 1

- Other/Mentors - 2

F.1.b MPCC employees 14 THWs and is projected to add an additional 5. The THW employed by MPCC are compensated through standard payroll. MPCC also supports THWs throughout our network with alternative payment structures such as PCPCH Tier payments, case rates, bonuses for quality, grants and capitation.

F.2.a Please see the attached THW Integration and Utilization Plan: RFA4690-MPCC-Att10-Social Determinants of Health and Health Equity-THW Integration and Utilization Plan

G. Community Health Assessment and Community Health Improvement Plan

G.1 Please see Community Engagement Plan: RFA4690-MPCC-Att10-Social Determinants of Health and Health Equity-Community Engagement Plan.

Marion Polk Coordinated Care℠

Traditional Health Workers Integration and Utilization Plan

Introduction

The use of clinic and county based traditional health workers (THWs) and MPCC peer mentors for members with intensive care coordination needs and those experiencing health disparities is vital to MPCC's success. One of MPCCs founding organizations, WVP Health Authority, has used traditional health workers since 2006, adding more peer mentored programs since then. MPCC recognizes the importance of integration and utilization of culturally and linguistically diverse THWs to support members and member care teams.

MPCC will continue the use of THWs to serve as a support network for members and providers. THWs provide services that help people better manage their health by addressing the social determinants of health. Examples of these services include brief mental health interventions, smoking cessation advice, nutrition counseling, and connecting people to community-based resources like housing, transportation, and substance abuse treatment.

THWs play an important role in supporting and extending the work of the primary care providers. For example, THWs can assist primary care providers in meeting the standards for PCPCH which include care management, medication management, and self-care support, by providing patients with services that align with these standards, such as:

- Assessing and addressing barriers to health goals.
- Developing and documenting patient self-management plans and goals.
- Providing educational resources or referring to educational resources.

The specific team members who make up THWs is community driven. Our data analysis provides insight, along with community referral assist in identifying the gaps in health, social, and economic resources in a community. MPCC will continue to design and implement community programs, led by THWs to best address those gaps, with consideration of community demographics and the capacity of local partners.

Integration

MPCC will continue to integrate THWs in all care settings, which include but are not limited to the following: outpatient, in-patient and behavior health settings. MPCC is currently addressing the needs for THWs by continuing programs such as:

- Emergency Department Intervention Team (EDIT) – This program currently employees 6 peer mentors.
- Marion-Polk Obstetrics Mentoring Services (MOMs) – This program currently employees 4 peer mentors.
- Family Support Coordinators (FSC) – This program currently employees 3 peer support mentors.

- Intensive Case Management (ICM) – This program employees 1 Transition of Care Coordinator (TOCC) peer support mentor in additional to clinical staff.

Communication

MPCC will continue to employ several tactics that address communication of availability of services. These include but are not limited to the following:

- ✓ Handbook
- ✓ Mailings
- ✓ Website
- ✓ Provider Education
- ✓ Informational sheets located in various areas of our community (provider offices, bus stations, community resource centers, local agencies, DHS, etc.)

Increase THW Utilization

- MPCC plans to expand its current THW program by adding additional staff to support existing programs as well as implementing new programs, to address community needs. The ICM program is scheduled to add 1 more TOCC peer support, 1 behavioral health TOCC peer support and 1 SNP TOCC peer support mentor.
- Behavioral Health Coordinators – This will be a new program and is projected to add 2+ peer support mentors.
- MPCC will provide education to providers about THW best practices including enrollment and billing requirements, supervision, core competencies and the scope of practice to ensure that THWs are utilized to their full capacity and encourage and assist providers to recruit THWs into their practices.
- MPCC will evaluate feedback from the Community Advisory Council to further understand the needs of the community.

Multiple clinics in our network also employee THWs. MPCC will foster the growth of THW in the clinic settings with value based payments such as PCPCH Tier payments, case rates, bonuses for quality, capitation and funding for the Behavioral Health in the Primary Care program. The Behavioral Health in the Primary Care Clinic program provides a model overview, training requirements and compensation for the funding of behavioral health positions in the primary care setting to integrate behavioral health into a multi-disciplinary primary care team which can include THWs.

Through the Behavioral Health in the Primary Care program the group discusses best practices for integrating THW in the clinics. MPCC will participate in this program as well as other delivery methods and meetings to determine how best to assist clinics in communicating with members about the benefits and availability of THW services. MPCC will also establish referral programs in which members may self-refer or be referred to THW services.

Implement THW Commission Best Practices

MPCC's THWs are trained to provide member assistance within the full scope of practice for their individual experience and associated programs which include the following:

- Care Coordination/System Navigation;
- Outreach and Direct Service;
- Coaching and Social Support;
- Advocacy, Organizing, and Cultural Mediation;
- Education; and
- Assessment, Evaluation and Research.

Data/Measurement

MPCC will monitor the integration and utilization of THWs through encounter data, referral sources and clinic outreach. Members receiving services from THWs will be analyzed to identify trends in healthcare cost, appropriate use of healthcare services and the reduction of negative social determinants of health when possible. Member feedback, complaints, member satisfaction tools and surveys will also be used to complete the minimum reporting requirements. At minimum, MPCC will report on the following areas:

- Number of engagement of THWs as part of the Members Care Team by THW types.
- Number of encounters per THW with each member.
- Number of documented interactions per THW with each member.
- Number of THW's paid and how they are paid (if applicable).
- Number of THWs in clinical based.
- Number of THWs in community based.
- Number of members able to do self-referrals to THWs without a pre-authorization.

THW Liaison

MPCC will continue to employee the THW Liaison position (supervisor), currently employed by WVP Health Authority and will continue to be the central hub to THWs, consumers and the community within the CCO healthcare system for coordinating: Workforce, Payments, Utilization, Supervision, Service Delivery, & Member Accessibility to THW services.

Title:
Category:
Sub-Section:

Document Owner: Krista Lovaas	Date Created: 04/09/2019
Approver(s): Manual Rivera	Date Approved: 04/10/2019

Provision of Culturally Appropriate Services

Policy

MPCC is committed to ensuring access to quality culturally appropriate care for our health plan members. MPCC recognizes the importance of cultural competency in the healthcare delivery system and the impact that cultural differences have on health outcomes.

Procedure

Health Plan Staff Training
MPCC coordinates and requires annual cultural competency training for all health plan staff.

Provider Network
MPCC network providers are encouraged to complete Cultural Competency training in alignment with their licensing board recommendations. This will be documented in the credentialing software and identified on the Provider Directory for those who have completed a training.

Monitoring
MPCC will monitor for and evaluate the quality of culturally appropriate services by review of complaint data (including survey response) as it pertains to culturally competency in the delivery system. Any complaint regarding cultural competency will be an opportunity for education to improve the cultural competency in our network.

Provider Network Education
Provider network will be educated at minimum, annually on the importance of providing culturally competent healthcare. Provider education will include cultural competency course as provided by the Office of Equity and Inclusion or other OHA approved courses.

Title:
Category:
Sub-Section:

Document Owner: Krista Lovaas	Date Created: 04/09/2019
Approver(s): Manual Rivera	Date Approved: 04/10/2019

Provision of Linguistically Appropriate Services

Policy

MPCC is committed to ensuring access quality culturally and linguistically appropriate care for our health plan members. MPCC provides access to certified interpreters for members with Limited English Proficiency, or those who are deaf or hard of hearing when communicating verbally or in writing with health plan staff or network providers.
This policy ensures that certified, interpreter services are available for members who are hearing impaired or have Limited English Proficiency and may consequently experience difficulty communicating with the plan or providers due to a language or cultural barrier.
MPCC contracts with the following type of interpretation/translation services for its members:

- Onsite/dispatched language/ASL interpreters;
- Telephone interpretation;
- Video interpretation; and
- Written translation

Procedure

<u>Interpreter Services for a Health Care Service</u>
MPCC provides its members with certified interpreter services which are culturally appropriate for members who are hearing impaired or have Limited English Proficiency

1) Interpreter services are available to members at no charge.
2) Treating providers arrange for the interpreter upon members, or legal representatives' request.
3) The provider will verify the following with the requestor:
   a) Member name and ID;
   b) Appointment date and time and location;
   c) Language service needed.
4) The provider will contact a contracted interpreter vendor and schedule an interpreter for the member with the above information.
5) Provider will coordinate with the interpreter vendor regarding any changes in scheduling.
6) Interpreter vendor will submit invoice to MPCC for payment, required elements for billing must be present on the invoice to allow payment.

Interpreter Services for Customer Service

1) MPCC Customer Service has qualified Spanish interpreters on staff to assist in communication between members and the plan.
2) If a language other than Spanish is needed, or the Spanish speaking staff is unavailable the Customer Services representative will coordinate with a contracted interpreter vendor to join the phone call.
   a) Interpreter vendor will collect member information prior to joining the call.
3) Interpreter vendor will submit invoice to MPCC for payment, required elements for billing must be present on the invoice to allow payment.

Written Translation Services

1) MPCC will translate all written materials or include taglines in the prevalent non-English languages in the state.
2) MPCC members may request materials in their preferred language. Materials will be translated and delivered to member within 14 days of request.
3) Requests for translation of documents will be tracked by MPCC staff.

Audit & Monitoring

MPCC will monitor for and evaluate the quality of linguistically appropriate services by review of complaint data (including survey response) as it pertains to linguistically and culturally services. Any complaint regarding language services will be an opportunity for education on the requirement for providing health care services in the members preferred language.

MPCC will perform random audits of provider offices with secret shopper survey's to ensure access to interpreter services for members with Limited English Proficiency.
MPCC will perform the annual Access and Availability survey on 10% of network provider offices to ensure a member request for language services is accommodated.

Provider Network Education

Provider network will be educated at minimum, annually on the importance of providing linguistically appropriate care, the guidance requiring that requests be accommodated and the contracted providers to deliver interpreter services.
MPCC will provide network education at a minimum annual regarding the unique needs of members with disabilities and the requirements offices are expected to meet to serve these members as outlined in Section 1557 of the Affordable Care Act.

Attachment 13 — Attestations

Applicant Name: Marion Polk Coordinated Care, Inc.

Authorizing Signature: _____

Printed Name: Dean Andretta

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: Based on recent analysis, the cost to the health plan is greater using the OPDP, rather than a direct contract with the Pharmacy Benefit Manager (MedImpact) due to increased administration costs.

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: MPCC is looking forward to the opportunity to partner with OHA in the interest of aligning the formulary and PDL where there is cost savings to both the CCO and the state.

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: MPCC will align our formulary with the PDL as required by the OHA. We will also align our formulary as recommended by the P&T committee where there is a cost savings to both the CCO and the state.

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: MPCC will post both the formulary and the Prior Authorization criteria in a format designated by the OHA and will post concurrently or before any changes to the formulary and the PA criteria.

7. Financial Reporting Tools and Requirements

a. Is Applicant willing to partake of all financial, legal and technological requirements of the National Association of Insurance Commissioners (NAIC) in whatever capacity necessary to file its financial information with OHA under NAIC standards?

☒ Yes ☐ No

If "no" please provide explanation: _____

b. Will Applicant report its required financial information to OHA on the NAIC's Health Quarterly and Annual Statement blank ("Orange Blank") through the NAIC website as described in this RFA, under NAIC standards and instructions?

☒ Yes ☐ No

If "no" please provide explanation: _____

c. Will Applicant report its financial information to OHA using Statutory Accounting Principles (SAP), subject to possible exemption from SAP for 2020 as described in this RFA?

☒ Yes ☐ No

If "no" please provide explanation: _____

d. Will Applicant file the financial reports described in this RFA, including Contract Exhibit L and supplemental schedules with the instructions referenced in this RFA?

☒ Yes ☐ No

If "no" please provide explanation: _____

e. Is Applicant willing to resubmit its pro forma financial statements for three years starting in 2020, modified to reflect the Enrollment expected assuming other CCOs that may operate in Applicant's Service Area?

☒ Yes ☐ No

If "no" please provide explanation: _____

f. Does Applicant commit to preparing and filing a Risk Based Capital (RBC) report each year based on NAIC requirements and instructions?

☒ Yes ☐ No

If "no" please provide explanation: _____

g. Is Applicant willing to submit quarterly financial reports including a quarterly estimation of RBC levels to ensure financial protections are in place during the year?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

h. Is Applicant willing to have its RBC threshold evaluated quarterly using a proxy calculation?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

i. If Applicant's estimated RBC falls below the minimum required percentage based on the quarterly estimation, is Applicant willing to submit a year-to-date financial filing and full RBC evaluation?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

8. Accountability to Oregon's Sustainable Growth Targets

a. Does Applicant commit to achieving a sustainable growth in expenditures each calendar year (normalized by membership) that matches or is below the Oregon 1115 Medicaid demonstration project waiver growth target of 3.4%?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Does Applicant similarly commit to making a good faith effort towards achievement of future modifications to the growth target in the waiver?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Does Applicant agree that OHA may publicly report on CCO performance relative to the sustainable growth rate targets (normalized for differences in membership)?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Does Applicant agree that OHA may institute a Corrective Action Plan, that may include financial penalties, if a CCO does not achieve the expenditure growth targets based on the current 1115 Medicaid waiver?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

9. Potential Establishment of Program-wide Reinsurance Program in Future Years

a. Will Applicant participate in any program-wide reinsurance program that is established in years after 2020 consistent with statutory and regulatory provisions that are enacted?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Will Applicant use private reinsurance contracts on only an annual basis so as to ensure ability to participate in state-run program if one is launched at the start of a calendar year?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Does Applicant agree that implementation of program-wide reinsurance program will reduce capitation rates in years implemented as a result of claims being paid through reinsurance instead of with capitation funds?

☒ Yes ☐ No

If "no" please provide explanation: This will depend on the reinsurance options available, the coverages (specialty drugs, capitated claims, etc.). MPCC is supportive of the concept and believes it has the potential to reduce reinsurance costs and is anxious to participate in the development and dialogue.

_____

10. CCO Solvency Standards and OHA Tools to Regulate and Mitigate Insolvency Risk

a. Is Applicant willing to have its financial solvency risk measured by Risk Based Capital (RBC) starting in 2021?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to achieve a calculated RBC threshold of 200% by end of Q3 of 2021 and thereafter to maintain a minimum RBC threshold of 200%?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to report to OHA promptly if it determines that its calculated RBC value is or is expected to be below 200%?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to report to OHA promptly if it determines that its actual financial performance departs materially from the pro forma financial statements submitted with this Application?

☒ Yes ☐ No

If "no" please provide explanation: _____

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

☒ Yes ☐ No

If "no" please provide explanation: _____

11. Encounter Data Validation Study

a. Is Applicant willing to perform regular chart reviews and audits of its encounter claims to ensure the Encounter Data accurately reflects the services provided?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

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

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

H. Member Transition Plan (Attachment 16)

1. Is Applicant willing to faithfully execute its Member Transition Plan as described in Attachment 16?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

Attachment 14 — Assurances

Applicant Name: Marion Polk Coordinated Care, Inc.

Authorizing Signature: _____

Printed Name: Dean Andretta

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]

   [X] 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]

   [X] 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]

   [X] Yes [ ] No

   If "no" please provide explanation: _____

4. Will Applicant have an ongoing quality performance improvement program for the services it furnishes to its Members? Will the program include an internal Quality Improvement program based on written policies, standards and procedures that are designed to achieve through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas and that are expected to have a favorable effect on health outcomes and Member satisfaction? The improvement program will track outcomes by race, ethnicity and language. The Applicant will communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance. [See OAR 410-141-0200]

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

5. Will Applicant make Coordinated Care Services accessible to enrolled Members? Will Applicant not discriminate between Members and non-Members as it relates to benefits to which they are both entitled including reassessment or additional screening as needed to identify exceptional needs in accordance with OAR 410-141-3160 through 410-141-3170? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance.? [See 42 CFR 438.206 to 438.210; and OAR 410-141-3220]

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

6. Will Applicant have written procedures approved in writing by OHA for accepting, processing, and responding to all complaints and Appeals from Members or their Representatives that are consistent with Exhibit I of the Appendix B "Sample Contract"? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.228, 438.400 – 438.424]

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

7. Will Applicant develop and distribute OHA-approved informational materials to Potential Members that meet the language and alternative format requirements of Potential Members? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.10; OAR 410-141-3280]

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

8. Will Applicant have an on-going process of Member education and information sharing that includes appropriate orientation to the Applicant provided in the Member handbook or via health education, about the availability of intensive Care CoordinationCare Coordination for Members who are aged, blind and/or disabled, or are part of a prioritized population, and appropriate use of emergency facilities and urgent care? Will Applicant will communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.10; and OAR 410-141-3300]

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

9. Will Applicant have written policies and procedures to ensure Members are treated with the same dignity and respect as other patients who receive services from the Applicant that are consistent with Appendix B, Core Contract? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.100, ORS 414.635 and OAR 410-141-3320]

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

10. Will Applicant provide Intensive Care Coordination (otherwise known as Exceptional Needs Care Coordination or ENCC) to Members who are Aged, Blind or Disabled; Members with high health needs or multiple chronic conditions; Members receiving Medicaid-funded long-term care or long-term services and supports or receiving Home and Community-Based Services (HCBS) under the state's 1915(i), 1915(j), or 1915(k) State Plan Amendments or the 1915(c) HCBS waivers, or Behavioral Health priority populations in accordance with OAR 410-141-3170? Will Applicant ensure that Prioritized Populations, who sometimes have difficulty with engagement, are fully informed of the benefits of Care Coordination? Will Applicant ensure that their organization will be Trauma Informed by January 1, 2020? Will Applicant utilize evidence-based outcome measures? Will Applicant ensure that Members who meet criteria for ENCC receive contact and service delivery as required in OAR 410-141-3170? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.208]

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

11. Will Applicant maintain an efficient and accurate billing and payment process based on written policies, standards, and procedures that are in accordance with accepted professional standards, OHP Administrative Rules and OHA Provider Guides? Will Applicant and its Providers or Subcontractors will not hold Members responsible for debt incurred by the Applicant or by Providers if the entity becomes insolvent? Will Applicant have monitoring systems in operation and review the operations of these systems on a regular basis. The Applicant will communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 447.46]

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

12. Will Applicant participate as a trading partner of the OHA in order to timely and accurately conduct electronic transactions in accordance with the HIPAA electronic transactions and security standards? Has Applicant executed necessary trading partner agreements and conducted business-to-business testing that are in accordance with accepted professional standards, OHP Administrative Rules and OHA Provider Guides? Will Applicant have monitoring systems in operation and review the operations of these systems on a regular basis? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 45 CFR Part 162; OAR 943-120-0100 to 943-120-0200]

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

13. Will Applicant maintain an efficient and accurate system for capturing Encounter Data, timely reporting the Encounter Data to OHA, and regularly validating the accuracy, truthfulness and completeness of that Encounter Data based on written policies, standards, and procedures that are in accordance with accepted professional standards, CCO and OHP Administrative Rules and OHA Provider Guides? Will Applicant have monitoring systems in operation and review the operations of these systems on a regular basis? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.242; and the Contract]

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

14. Will Applicant maintain an efficient and accurate process that can be used to validate Member Enrollment and Disenrollment based on written policies, standards, and procedures that are in accordance with accepted professional standards, OHP Administrative Rules and OHA Provider Guides? Will Applicant have monitoring systems in operation and review the operations of these systems on a regular basis? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.242 and 438.604; and Contract]

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

15. Assurances of Compliance with Medicaid Regulations

Item 15 of this Attachment 14 has ten assurances of Compliance with Medicaid Regulations. These Assurances address specific Medicaid regulatory requirements that must be met in order for the Applicant to be eligible to contract as a CCO. For purposes of this section and the federal Medicaid regulations in 42 CFR Part 438, a CCO falls within the definition of a "managed care organization" in 42 CFR 438.2. This section asks the Applicant to provide a brief narrative of how the Applicant meets each applicable Assurance. The Applicant must provide supporting materials available to the OHA upon request.

Please describe in a brief narrative how Applicant meets the standards and complies with the Medicaid requirements cited in the Medicaid Assurances in Item 15:

a. Medicaid Assurance #1 – 42 CFR § 438.206 Availability of services.

b. Medicaid Assurance #2 – 42 CFR § 438.207 Assurances of adequate capacity and services.

c. Medicaid Assurance #3 – 42 CFR § 438.208 Coordination and continuity of care.

d. Medicaid Assurance #4 – 42 CFR § 438.210 Coverage and authorization of services.

e. Medicaid Assurance #5 – 42 CFR § 438.214 Provider selection.

f. Medicaid Assurance #6 – 42 CFR § 438.224 Confidentiality.

g. Medicaid Assurance #7 – 42 CFR § 438.228 Grievance and Appeal systems.

h. Medicaid Assurance #8 – 42 CFR § 438.230 Subcontractual relationships and delegation.

i. Medicaid Assurance #9 – 42 CFR § 438.236 Practice guidelines.

j. Medicaid Assurance #10 – 42 CFR § 438.242 Health information systems.

Attachment 15 — Representations

Applicant Name: Marion Polk Coordinated Care, Inc.

Authorizing Signature: _____

Printed Name: Dean Andretta

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: No, MPCC will hire and manage the employees of the CCO.

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: MPCC will have a contract with a Third Party Administrator for a portion of the systems and information technology such as claims processing, encounter submission and work flow for referrals and prior authorizations.

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: MPCC will have a contract with a Third Party Administrator (TPA) for claims processing.

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: The TPA for claims will also perform portions of the 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: MPCC will contract with WVP Health Authority for credentialing services.

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: MPCC will employee the utilization operations staff.

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: No, MPCC will perform 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: MPCC will utilize the call center associated with the TPA.

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: No, MPCC staff with perform all of the 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: MPCC will contract with WVP Health Authority for provider contracting.

11. Will Applicant will have contracts with related entities, contractors and Subcontractors to perform, implement or operate any aspect of the CCO operations for the CCO Contract, other than as disclosed in response to representation 1-10 above?

☐ Yes ☒ No

Explanation:

12. Other then VBP arrangements with Providers, will Applicant sub-capitate any portion of its Capitation Payments to a risk-accepting entity (RAE) or to another health plan of any kind?

☐ Yes ☒ No

Explanation:

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: MPCC's founding partners, WVP Health Authority, Salem Health and Salem Clinic, all have experience as a risk-accepting entity of a 2019 CCO. In addition, WVP Health Authority has a management services agreement with a 2019 CCO.

Marion Polk Coordinated Care℠

MPCC Attachment 16 - Member Transition Plan

2. Plan Contents

2.a Marion Polk Coordinated Care (MPCC) will work with other CCOs to develop partnerships facilitating care coordination and seamless transitions, which include social and support services, crisis management services and community prevention, self-management programs and other service benefits available to members. Also, MPCC provides several programs that will facilitate care coordination by informing providers/organizations of services available to assist in care coordination, wellness support, empowerment and self-care opportunities; Intensive Case Management (ICM), Family Support Coordinators (FSC), Emergency Department Intervention Team (EDIT), Transition of Care Coordinators (TOCC), and Marion-Polk Obstetrics Mentoring Services (MOMs).

MPCCs communication plan includes the documentation and storage of mailings, phone calls, any meeting minutes, emails and notes from care coordination efforts with member, member representatives, DHS Medicaid-funded LTC providers, mental health crisis services, and home and community-based services. Information may be shared with any identified provider/organization that is involved in care coordination for identified MPCC members.

Types of information that may be shared may include, but is not limited to:

- Care Plans
- Medication fill history
- Case Management activity
- Health Risk Screening (HRS)
- Referral and Prior Authorization history
- Involvement in community resource programs

Communication methods with pertinent organizations involved in member health services and coordination via:

- Formal and informal meetings at varied entities
- Performance Health Improvement and/or Case Management software
- Electronic Health Record
- Secure fax, or
- United States Postal Service mailings, or
- Secure email, or
- Video conference, or
- Phone, or
- Other secure telecommunications as identified

2.b.1 MPCC will provide the following data elements to the receiving CCO in mutually agreed upon HIPAA compliant format, Excel, CVS, PDF etc: Current PCP of record, behavioral health providers of record, currently active pre-authorizations, pre-authorizations for any services rendered in the prior 24 months, or length of coverage, whichever is greater, pharmacy fill details for the prior 24 months, and current reported ICD 10 diagnosis from pre-authorization and claims data.

MPCCs communication plan includes the documentation and storage of mailings, phone calls, any meeting minutes, emails and notes from care coordination efforts with member, member representatives, DHS Medicaid-funded LTC providers, mental health crisis services, and home and community-based services. Information may be shared with any identified provider/organization that is involved in care coordination for identified MPCC members.

Enli, Performance Health Improvement/Case Management software, and Community Integration Manager (CIM) allows MPCC to assign a provider or organization, that is involved in members health and wellbeing, direct access to contribute to MPCC member care coordination management in real time. Providers/organizations that are assigned and actively involved in MPCC member individual care plan (ICP), can update, provide recommendations or view member health status, other providers that may be involved in the members care, community resources and programs that the member may be enrolled.

2.b.2 MPCC will be as transparent as possible, once alerted of member's movement to another CCO. MPCC will securely communicate the transferring member PCP, BH Provider, and any specialty providers to the receiving CCO within 21 calendar days.

MPCC will extract the currently assigned PCP and behavioral health providers from the core processing system. MPCC will utilize pre-authorizations and claims data to identify specialty providers for transferring members. This information will be provided to the receiving CCO in a mutually agreed upon HIPAA compliant format, Excel, CVS, PDF etc.

2.b.3 All MPCC members will have full support of continuity of care activities, irrespective of their health care status when transferring to a new CCO. Members with special health care needs will be referred to ICM and other supportive programs within MPCC and the community to ensure seamless transitions, including but not limited to Prior Authorizations, prescription medications and any case management services that had been provided. MPCC ICM may coordinate with the receiving CCO ICM to ensure continuity of care. MPCC will ensure timely and accurate transmission of requested data from the receiving CCO in a mutually agreed upon HIPAA compliant format, Excel, CVS, PDF etc. Also see 2.b.1 for process related to members in at risk populations.

2.c MPCC ICM will provide direct outreach, via phone calls and/or member mailings, to high-needs and other specific member groups and their provider care teams transferring out of the CCO to educate on the transition process and steps taken to ensure a smooth transition of care to the receiving CCO. This will include, assisting Members and Providers in the transition process, monitoring the transition of care to identify and address issues during the transition process, and collaborating with community partners and the Receiving CCO. See 2.b.1 for communication paths and shared data elements.

2.d.1 MPCC will accept data from CCO's for all incoming members in a mutually agreed upon HIPAA compliant format, Excel, CVS, PDF etc., to include data elements in 2.b.1. Data will be uploaded and stored in Enli, Performance Health Improvement/Case Management software, and Community Integration Manager (CIM) as appropriate. Validation will be performed on the data received to ensure that it is accurately represented into the appropriate system. Reports will be run to ensure that members with immediate or high needs are immediately followed up by the appropriate team.

2.d.2 MPCC will be able to accept and mirror the members PCP, BH Provider, and any specialty providers from the members previous CCO. In the instance that the member's primary care or other provider of service is not a contracted provider, MPCC will authorize services for the member to the non-contracted provider on a temporary basis, in accordance with current OAR requirements or until such time that an appropriate contracted provider can be identified and the member can be safely transitioned. If circumstances exist that would make it clinically inappropriate for the member to transfer care, MPCC will offer alternative contractual agreements to the provider for the member.

2.d.3 All MPCC members will have full support of continuity of care activities, irrespective of their health care status and whether they are transferring in to MPCC or transferring to another CCO. Members with special health care needs will be referred to ICM and other supportive programs within MPCC and community to ensure seamless transitions, including but not limited, to Prior Authorizations, prescription medications and any case management services that had been provided to ensure access to all medically necessary services for members at risk of serious detriment to their physical and mental health, hospitalization or institutionalization.

MPCC will enter and approve authorizations for services approved by the transferring CCO. Authorizations will be approved in accordance with current OAR requirements or until such time that an appropriate contracted provider can be identified for a clinically appropriate transition, or treatment can be safely completed. ICM will coordinate with members and providers to ensure a safe appropriate transfer for the members care. Authorizations may be

extended beyond the transition time if clinically appropriate to ensure continuity of care.

2.d.4 Marion Polk Coordinated Care (MPCC) will work with other CCOs to facilitate care coordination and seamless transitions, which include social and support services, crisis management services and community prevention, self-management programs and other service benefits available to members. Also, MPCC provides several programs that will facilitate care coordination by informing providers/organizations of services available to assist in care coordination, wellness support, empowerment and self-care opportunities; Intensive Case Management (ICM), Family Support Coordinators (FSC), Emergency Department Intervention Team (EDIT), Transition of Care Coordinators (TOCC), and MOMs.

MPCC ICM will provide direct outreach, via phone calls and/or member mailings, to high-needs and other specific member groups and their provider care teams transferring into the CCO to educate on the transition process and steps taken to ensure a smooth transition of care to MPCC. This will include, assisting Members and Providers in the transition process, monitoring the transition of care to identify and address issues during the transition process, and collaborating with community partners and transferring CCO. See 2.d.1 for communication paths and shared data elements.

hub inc.
MARION & POLK EARLY LEARNING HUB

earlylearninghub.org

April 8, 2019

Oregon Health Authority
635 Capitol Street, Room 350
Salem, OR 97301

To Whom It May Concern:

This letter of reference is in support of Marion Polk Coordinated Care, Inc. and its submission to be awarded an OHA Coordinated Care Organization contract via RFA-OHP-4690-19.

Marion Polk Early Learning Hub, Inc's mission is to convene, collaborate and catalyze action in our region to better align services and resources for children and families to ensure children are more ready for kindergarten. This mission aligns closely with that of MPCC and its principal organizations.

Over the last five years, the principles of Marion Polk Coordinated Care have demonstrated a willingness to partner and support Marion Polk Early Learning Hub, Inc. and work to establish connections between early learning and healthcare for the children and families we mutually serve.

We look forward to continuing our partnership with MPCC and coordinating our efforts to improve the health and well-being of the children in our community. We will continue to focus on the current health-related initiatives, including improving referral pathways between clinics and early learning providers; and the support to increase immunization, Well-Child checks, and literacy. We hope to continue work to support families and child care providers in meeting a child's significant behavioral health care needs.

Marion Polk Coordinated Care is best suited to provide the leadership and commitment to the community to transform healthcare delivery and meet the challenges of CCO 2.0. The intersection between health and early learning/kindergarten readiness is a critical and with these and other systemic partnerships, we can together make significant changes in the lives of children and families.

Please do not hesitate to contact me should you need any further information or have any questions.

Sincerely,

Lisa Harnisch
Executive Director

(503) 485-3219 | info@earlylearninghub.org | 2995 Ryan Drive SE, Suite 100 Salem, OR 97301

Salem Clinic
Belong. For life.

April 8, 2019

Oregon Health Authority
635 Capitol Street, Room 350
Salem, OR 97301

To Whom It May Concern:

This letter of reference is in support of Marion Polk Coordinated Care, Inc. and its submission to be awarded an OHA Coordinated Care Organization contract via RFA-OHP-4690-19.

The principles of Marion Polk Coordinated Care have demonstrated their ability to administer the Oregon Health Plan via the Managed Care Organization, Marion Polk Community Health from 2001 thru 2012 and via the Coordinated Care Organization, Willamette Valley Community Health.

As the largest multi-specialty clinic in the Marion Polk County service area, Salem Clinic and its providers place its full support and confidence with Marion Polk Coordinated Care to advance the systems of care and lead the transformation of care in support of the patients in our community.

Marion Polk Coordinated Care is best suited to provide the leadership and commitment to the community to transform healthcare delivery and meet the challenges of CCO 2.0.

Please do not hesitate to contact me should you need any further information or have any questions.

Sincerely,

D. Ryan Farwell, CPA, MBA
Administrator, Salem Clinic, PC

Salem Health Hospitals & Clinics

Salem Health
P.O. Box 14001
Salem, Oregon 97309-5014
503-561-5200 • salemhealth.org

April 10, 2019

Oregon Health Authority
635 Capitol Street, Room 350
Salem, OR 97301

To Whom It May Concern:

This letter of reference is in support of Marion Polk Coordinated Care and its submission to be awarded an OHA Coordinated Care Organization contract via RFA-OHP-4690-19.

The principles of Marion Polk Coordinated Care have demonstrated their ability to administer the Oregon Health Plan via the Managed Care Organization, Marion Polk Community Health from 2001 thru 2012 and via the Coordinated Care Organization, Willamette Valley Community Health.

As the largest provider of healthcare in the Marion Polk County service area, Salem Health Hospital & Clinics puts its full support and confidence with Marion Polk Coordinated Care to advance the systems of care and lead the transformation of care in support of the patients in our community.

Marion Polk Coordinated Care is best suited to provide the leadership and commitment to the community to transform healthcare delivery and meet the challenges of CCO 2.0.

Please do not hesitate to contact me should you need any further information or have any questions.

Sincerely,

Cheryl Wolfe
President and Chief Executive Officer, Salem Health Hospital & Clinics

SALEM PEDIATRIC CLINIC

2478 13TH STREET S.E. ☐ SALEM, OREGON 97302

PHONE 503 /362-2481 FAX 503 /371-7803

WARREN L. GRIFFIN, III, M.D., F.A.A.P.
MELANIE A. RONAI, M.D., F.A.A.P.
VINCENT J. KOLETAR, M.D., F.A.A.P.
N. JOANNE HYNDMAN, M.D., F.A.A.P.
JENNIFER E. WIRSIG, M.D., F.A.A.P.
SUZANNE M. BAILEY, M.D., F.A.A.P.
ANDREA Z. STOUT, M.D., F.A.A.P.
ELIZABETH L. KING, M.D., F.A.A.P.
ANNA LAM, D.O., F.A.A.O.
THU B. VU, M.D., F.A.A.P.
KARI E. CARSTENSEN, M.D., F.A.A.P.
RACHAEL M. HIEBERT, M.D., F.A.A.P.
MATTHEW C. HATLER, M.D., F.A.A.P.
HALIE GOFFRIER, P.A.-C
CHELSEA ROBERTS, P.A.-C
ADMINISTRATOR:
LIZ CASEBEER

April 8, 2019

Oregon Health Authority
635 Capitol Street, Room 350
Salem, OR 97301

To Whom It May Concern:

This letter of reference is in support of Marion Polk Coordinated Care, Inc. and its submission to be awarded an OHA Coordinated Care Organization contract via RFA-OHP-4690-19.

The principles of Marion Polk Coordinated Care have certainly demonstrated their ability to administer the Oregon Health Plan via the Managed Care Organization, Marion Polk Community Health from 2001 thru 2012 and via the Coordinated Care Organization, Willamette Valley Community Health. Through these endeavors they have developed a depth of knowledge regarding our local community needs that cannot be underestimated.

As a pediatric clinic in the Marion Polk County service area, Salem Pediatric Clinic serves over 7,800 kids on the Oregon Health Plan. On behalf of our providers and organization, we have full support and confidence in Marion Polk Coordinated Care's ability to advance the systems of care and lead the transformation of care in support of the patients in our community. We look forward to the partnership with MPCC.

Marion Polk Coordinated Care is best suited to provide the leadership and commitment to the community to transform healthcare delivery and meet the challenges of CCO 2.0.

Please do not hesitate to contact me should you need any further information or have any questions.

Sincerely,

Vince Koletar, MD
Salem Pediatric Clinic, Partner