Assurances of Compliance with Medicaid Regulations

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

NWCCO ensures that all members have access to services in a timely manner consistent with the appropriateness of their health need. NWCCO establishes culturally competent access-to-care standards, allowing appropriate choice for members, including diverse communities and underserved populations, access to second opinions and monitoring to ensure compliance with our standards. NWCCO provides services for primary care, women's healthcare, specialty care, behavioral health services, dental health, pharmacy, hospital, vision and ancillary services. If subcontractor is unable to provide necessary services, subcontractor has processes in place to cover and coordinate services out of network.

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

NWCCO and its provider partners ensure that the capacity of providers is sufficient in numbers to meet the healthcare needs of NWCCO's membership. NWCCO has access standards in place and will provide documentation of network adequacy through the Delivery Services Network Report on an annual basis or any time there is a significant change in the network.

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

NWCCO has policies and procedures that ensure it coordinates the care its members receive. NWCCO utilizes a Multidisciplinary Team and Health Risk assessment process to identity and coordinate member health concerns in a timely manner. Once concerns are identified NWCCO assures that care is coordinated among the member's care team and primary care physician. Additionally, NWCCO has procedures to ensure transition in cases of members moving to or from a new coordinated care organization.

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

NWCCO and its delegated entities follow consistent guidelines for processing requests for referrals and service authorizations to or from participating providers, including alternative care settings and house doctors of residential facilities. All requested services are subject to the rules and limitations of the appropriate Oregon Health Plan (OHP) administrative rules and provider guides. Standard authorization decisions are made as expeditiously as the enrollee requires and will not exceed 14 days. For expedited preauthorization or referral requests in which the provider indicates that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain

maximum function, decisions are made as expeditiously as the member's health condition requires and no later than 72 hours after the receipt of the request for service. Preauthorization for prescription drugs will be made within 24 hours of receipt of a request. If preauthorization for a prescription cannot be completed within 24 hours, NWCCO provides for dispensing of at least a 72-hour supply of the medication if the medical need for the medication is immediate.

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

NWCCO requires the completion of the initial credentialing process by a new practitioner or facility and recredentialing at least every three years for continued participation in the NWCCO's provider network. Practitioners and facilities must complete the credentialing process prior to providing services to members and will not be discriminated against for serving high risk populations or specialize in conditions that require costly treatment.

NWCCO credentials and recredentials independent physical medicine and behavioral health practitioners, licensed behavioral health providers who are affiliated with Community Mental Health Programs (CMHP) and/or Patient-Centered Primary Care Homes (PCPCH) and organizational providers (facilities) according to the National Committee for Quality Assurance (NCQA), Centers for Medicare and Medicaid Services (CMS) and Oregon Health Authority standards and rules. NWCCO will not employ or contract with providers that are excluded from participation in Federal health care programs.

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

NWCCO will safeguard confidential information about individuals. We will inform individuals about our privacy practices and will respect individual privacy rights. NWCCOs staff shall maintain the confidentiality of information whether oral, written or electronically recorded in any form or medium, without limitation. Discussion, transmission or disclosure of Protected Health Information (PHI) without authorization shall occur only for the purpose of payment, treatment and healthcare operations or as required or permitted by federal or state law. For all other disclosures, proper authorization will be obtained. NWCCO staff will limit the disclosure of PHI to the minimum necessary to accomplish a given business purpose. Access to systems will be aligned with the work functions necessary to perform required duties. Only those individuals performing those work functions will be granted system access.

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

NWCCO will provide an internal procedure for members or their representatives to voice or submit and obtain timely resolution of their complaints and appeals. Member Grievances will be resolved within 5 five business days of receipt or will be notified in the same timeframe if a delay is required to resolve the Grievance. Standard Appeals are resolved within 16 days of receipt. Expedited Appeals will be resolved as expeditiously as the enrollee's health condition requires, not to exceed 72 hours of receipt. NWCCO is the final adjudicator of all

appeals and will not discourage, encourage withdrawal, retaliate, or take punitive actions against any member or provider that uses any aspect of the grievance system, including the expedited appeal process.

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

NWCCO may delegate functions to third parties related to its Medicaid Plans. Medicaid program requirements apply to subcontractors who contract with NWCCO to provide certain administrative or health care services for enrollees on behalf of NWCCO. NWCCO shall require all subcontractors to comply with all applicable State and Federal requirements. NWCCO will monitor and audit subcontractor to ensure they are compliance with applicable laws, regulations and obligations with respect to its delegated responsibilities. Areas of non-compliance will result in corrective action and review. Continued non-compliance will result in further corrective action up to and including termination of the contract with Contractor.

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

NWCCO's staff use clinical support tools based on evidence-based guidelines and written policies to apply criteria based on individual needs and complete an assessment of the local delivery system to support clinical interventions and access to current healthcare resources for assistance in providing services to members. NWCCO clinical practice guidelines are reviewed and approved by the NWCCO's Quality Improvement Committee to ensure guidelines are being applied consistently. Clinical practice guidelines are posted on NWCCO's website for provider and member education and access. Clinical guideline information is also published in the provider administrative manuals.

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

NWCCO has policies and procedures in place and maintains a health information system that provides information related to utilization, claims, grievances and appeals, and member eligibility. NWCCO utilizes systems that accurately collect, report and process member, claims and provider data in a timely and accurate fashion. Additionally, NWCCO collects data in standardized, compliant formats and submits encounter data regularly, as required by the State contract, which provides an accurate and complete representation of services provided to members.

Northwest Coordinated Care Organization (NWCCO) NAIC Biographical Affidavits

Attachment 3 - Application Information and Certification Sheet

Legal Name of Proposer: Northwest Coordinated Care Organization, LLC

Address: 601 SW Second Avenue
Portland, OR 97204

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

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

Oregon Business Registry Number: 1526283-93

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

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

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

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

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

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

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

(Authorized to Bind Applicant)

State of Oregon)

) ss:

County of Multnomah)

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

_____

Notary Public for the State of Oregon

My Commission Expires 2-8-22

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

Attachment 4 - Disclosure Exemption Certificate

Robin Richardson ("Representative"), representing **Northwest Coordinated Care Organization** ("Applicant"), hereby affirms under penalty of False Claims liability that:

1. I am an officer of the Applicant. I have knowledge of the Request for Application referenced herein. I have full authority from the Applicant to submit this Certificate and accept the responsibilities stated herein.

2. I am aware that the Applicant has submitted an Application, dated on or about **April 22, 2019** (the "Application"), to the State of Oregon in response to Request for Application #OHA-4690-18 for CCO 2.0 (the RFA). I am familiar with the contents of the Application.

3. I have read and am familiar with the provisions of Oregon's Public Records Law, Oregon Revised Statutes ("ORS") 192.311 through 192.478, and the Uniform Trade Secrets Act as adopted by the State of Oregon, which is set forth in ORS 646.461 through ORS 646.475. I understand that the Application is a public record held by a public body and is subject to disclosure under the Oregon Public Records Law unless specifically exempt from disclosure under that law.

4. I have checked Box A or B as applicable:

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

1. A formula, plan, pattern, process, tool, mechanism, compound, procedure, production data, or compilation of information that:

i. is not patented,

ii. is known only to certain individuals within the Applicant's organization and that is used in a business the Applicant conducts,

iii. has actual or potential commercial value, and

iv. gives its user an opportunity to obtain a business advantage over competitors who do not know or use it.

Or

2. Information, including a drawing, cost data, customer list, formula, pattern, compilation, program, device, method, technique or process that:

i. Derives independent economic value, actual or potential, from not being generally known to the public or to other persons who can obtain economic value from its disclosure or use; and

ii. Is the subject of efforts by the Applicant that are reasonable under the circumstances to maintain its secrecy.

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

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

Representative's Signature

Exhibit A to Attachment 4

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

Section Redacted	ORS or other Authority	Reason for Redaction
Attachment 12 – NAIC Biographical Certificate NAIC Form 11	ORS 192.355(2)	**1.** Forms contain personal information that would constitute an invasion of privacy.
Attachment 7 – 12. f. 3. portion of response	ORS 192.345(2) Trade Secret	**2.** The number of pharmacies in our pharmacy network constitutes information that derives independent economic value, actual or potential, from not being generally known to the public or to other persons who can obtain economic value from its disclose or use.
Attachment 7 – 12. f. 4. portion of response	ORS 192.345(2) Trade Secret	**3.** The number of claims our PBM system processed in 2018 and the performance information constitutes information that derives independent economic value, actual or potential, from not being generally known to the public or to other persons who can obtain economic value from its disclose or use.
Attachment 7 – 12. f. 6. portion of response	ORS 192.345(2) Trade Secret	**4.** Certain terms within our PBM agreement constitute information that derives independent economic value, actual or potential, from not being generally known to the public or to other persons who can obtain economic value from its disclose or use.
Attachment 7 – 12. F. 6. – NW Prescription Drug Consortium Pricing	ORS 192.345(2) Trade Secret	**5.** Pricing constitutes cost data that derives independent economic value, actual or potential, from not being generally known to the public or to other persons who can obtain economic value from its disclose or use.
Attachment 7 – DSN Provider Report	ORS 192.355(2)	**6.** The report contains personal information that would constitute an invasion of privacy.

Attachment 5 - Responsibility Check Form

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

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

YES ☒ **NO** ☐.

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

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

Response: **Newly formed entity to serve Medicaid recipients in Clatsop, Columbia and Tillamook Counties through CCO contract with OHA.**

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

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

YES ☐ **NO** ☒

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

Response:

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

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

YES ☐ **NO** ☒

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

Response:

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

YES ☐ NO ☒.

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

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

YES ☒ NO ☐

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

Response:

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

YES ☐ NO ☒.

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

Response:

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

YES ☒ NO ☐.

If "NO," please explain.

Response:

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

YES ☒ NO ☐ N/A ☐ .

Submit a copy of the certificate with this form.

Response: We have included certificates for both Moda Health Plan and GOBHI in our response.

AUTHORIZED SIGNATURE

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

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

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

(Authorized to Bind Applicant)

Certificate of Completion

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

Karen Wheeler

Has successfully completed the following:

DAS - CHRO - Overview of Pay Equity

On *3/25/2019*

Certificate of Completion

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

Chante Hillen

Has successfully completed the following:

DAS - CHRO - Overview of Pay Equity

On *2/13/2019*

Attachment 6 — General Questions

A. Background Information about the Applicant

1. Questions

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

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

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

Northwest Coordinated Care Organization, LLC (NWCCO) intends to enter into Administrative Services Agreements with two of its prospective members, ODS Community Health, Inc. and Greater Oregon Behavioral Health, Inc. Additionally, NWCCO intends to engage with ODS Community Dental, the ultimate controlling parent organization of ODS Community Health, Inc., as its Dental Care Organization.

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

No

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

Primary address: 601 SW Second Avenue, Portland OR 97204

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

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

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

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

e. Prior history:

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

No

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

OHA as a CCO prior to January 1, 2019?

No

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

Yes

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

Not Applicable

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

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

NWCCO's owners, ODS Community Health, Inc. (ODSCH) and Greater Oregon Behavioral Health, Inc. (GOBHI) are equity partners and administrators of the Eastern Oregon CCO (EOCCO) that has a contract with OHA for the Cover All Kids population under contract #156268.

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

GOBHI currently holds several agreements with the OHA:

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

g. Does the Applicant (or an Affiliate of Applicant) have experience as a Medicare Advantage contractor? Does the Applicant (or an Affiliate of

Applicant) have a current contract with Medicare as a Medicare Advantage contractor? What is the Service Area for the Medicare Advantage plan?

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

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

Yes, NWCCO's affiliates ODSCH and GOBHI are equity partners and administrators of the EOCCO and have experience receiving Coordination of Benefits Agreement (COBA) crossover claims for Fully Dual Eligible Members with Traditional Medicare. NWCCO will obtain a COBA and will coordinate with COBA to receive direct crossover claims for Fully Dual Eligible Members with Traditional Medicare.

i. Does the Applicant (or an Affiliate of Applicant) hold a current certificate of authority for transacting health insurance or the business of a health care service contractor, from the Department of Consumer and Business Services, Division of Financial Regulation?

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

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

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

k. Describe Applicant's demonstrated experience and capacity for engaging Community members and health care Providers in improving the health of the Community and addressing regional, cultural, socioeconomic and racial disparities in health care that exist among Applicant's enrollees and in Applicant's Community.

Northwest CCO's affiliates ODSCH and GOBHI are equity partners and administrators of the EOCCO and through this work have demonstrated experience and capacity for engaging community members and health care providers to improve the health of their communities. Below are a number examples for how NWCCO plans to work with providers and community members to improve health and address disparities that exist.

NWCCO is organized as a health plan/provider joint equity model that allows for true buy in and engagement in the success of NWCCO beyond just a provider contract. Four of the largest care delivery systems within our geography intend to have an equity position and will have a vested interest in the success of NWCCO: Adventist Health Tillamook, Columbia Memorial Hospital, Yakima Valley Farm Workers Clinic (YVFWC) and GOBHI.NWCCO will have a Clinical Advisory Panel (CAP) that services as a clinical matters advisory group for NWCCO. The CAP will help evaluate new clinical strategies directed at achieving the Triple Aim on behalf of all

NWCCO communities.

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

From the community engagement standpoint NWCCO will have three Local Community Advisory Council's (LCAC), one in each of the three counties. The chair of each LCAC along with a County Commissioner or County Judge will serve on a Regional Community Advisory Council (RCAC). The chair of the RCAC will serve on the NWCCO board.

NWCCO will provide annual funding to each of our three LCAC's so that they can address challenges identified in each of their community health improvement plans.

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

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

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

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

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

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

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

Please refer to the Contact List included in our RFA response.

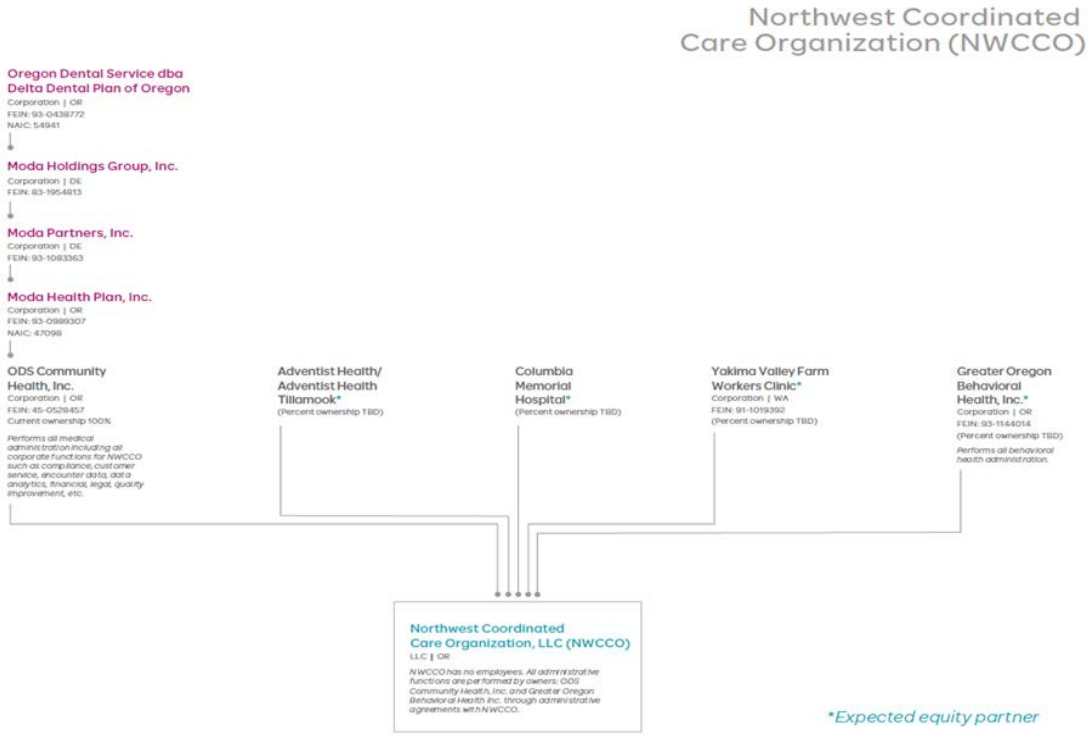
B. Corporate Organization and Structure

1. Questions

a. Provide a certified copy of the Applicant's articles of incorporation, or other similar legal entity charter document, as filed with the Oregon Secretary of State or other corporate chartering office.

Please refer to the Northwest Coordinated Care Organization Articles of Organization included in our RFA response.

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



c. Describe any licenses the corporation possesses.

NWCCO does not possess any licenses.

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

NWCCO plans to enter into Administrative Services Agreements with ODS Community Health, Inc. and Greater Oregon Behavioral Health, Inc. (GOBHI).

C. Corporate Affiliations, Transactions, Arrangements

1. Questions

a. Provide an organization chart or listing presenting the identities of and

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

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

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

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

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

GOBHI will provide all behavioral health administration.

As NWCCO is a new entity no amounts have been paid to ODSCH or GOBHI to date.

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

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

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

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

D. Subcontracts

1. Informational Questions

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

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

b. What are the major subcontracts Applicant expects to have? Please provide an example of subcontracted work and describe how Applicant currently monitors Subcontractor performance or expects to do so under the Contract.

(example of subcontracted work does not count toward page limit)

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

E. Third Party Liability

1. Informational Questions

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

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

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

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

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

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

to identify if any Medicare coverage exists.

F. Oversight and Governance

1. Informational Questions

Please describe:

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

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

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

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

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

The NWCCO Board will appoint a Regional Community Advisory Council (RCAC) with representation from each of the three Local Community Advisory Councils (LCAC). The RCAC will oversees and coordinate LCAC activities including the Community Health Assessments, Community Health Improvement Plans, and preventive care activities.

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

LCACs are composed of community members and intended to represent the diversity of the communities they serve, including race/ethnicity, age, gender identify, sexual orientation, disability, and geographic location. Each County Commission will review all applications and nominate members of the LCAC, including members from county government.

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

Articles of Organization - Limited Liability Company

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

FILED
FEB 14 2019
OREGON
SECRETARY OF STATE

REGISTRY NUMBER: 152628393

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

For office use only

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

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

NORTHWEST COORDINATED CARE ORGANIZATION, LLC

2. **DURATION:** (Please check one.)

(●) Duration shall be perpetual.

( ) Latest date upon which the Limited Liability Company is to dissolve is _____

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

601 SW SECOND AVENUE

PORTLAND, OREGON 97204

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

THOMAS BIKALES

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

601 SW SECOND AVENUE

PORTLAND, OREGON 97204

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

601 SW SECOND AVENUE

PORTLAND, OREGON 97204

7. **HOW WILL THIS LIMITED LIABILITY COMPANY BE MANAGED?**

( ) This LLC will be member-managed by one or more members.

(●) This LLC will be manager-managed by one or more managers.

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

9. **OPTIONAL PROVISIONS:** (Attach a separate sheet if necessary.)

( ) **BENEFIT COMPANY:** The Limited Liability Company is a benefit company subject to sections 1 to 11 of chapter 269, Oregon Laws 2013. (additional requirements apply)

(●) **INDEMNIFICATION:** The company elects to indemnify its members, managers, employees, agents for liability and related expenses under ORS 63.160 - 63.170.

( ) SEE ATTACHED

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

THOMAS BIKALES

601 SW SECOND AVENUE

PORTLAND, OREGON 97204

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

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

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

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

SEAN JESSUP

601 SW SECOND AVENUE

PORTLAND, OREGON 97204

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

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

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

CONTACT NAME: (To resolve questions with this filing)

RYAN D. MAUGHN

PHONE NUMBER: (Include area code)

503 241-2300

NORTHWEST COORDINATED CARE ORGA

152628393-19789677 NEWORG

Subcontractor Example

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

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

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

Evicore - High tech imaging utilization management.

MedImpact - Pharmacy point of sale prescription processing.

Magellan - Dialysis management.

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

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

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

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

Biographical Resumes

Chief Executive Officer

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

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

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

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

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

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

Chief Financial Officer

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

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

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

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

Chief Medical Officer

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

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

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

Chief Information Officer

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

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

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

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

Chief Administrative or Operations Officer

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

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

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

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

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

Northwest Coordinated Care Organization

RFA OHA-4690-19 Contact Chart

	Application	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com
	Executive Summary	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com
	References	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com
1	**Attachment 1** *Letter of Intent to Apply Form*	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com
2	**Attachment 2** *Application Checklist*	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com
3	**Attachment 3** *Application Information and Certification Sheet*	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com
4	**Attachment 4** *Disclosure Exemption Certificate*	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com
5	**Attachment 5** *Responsibility Check Form*	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com

6	**Attachment 6** *General Questions*	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com
7	**Attachment 7** *Provider Participation and Operations Questionnaire*	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com
8	**Attachment 8** *Value-Based Payment Questionnaire*	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com
9	**Attachment 9** *Health Information Technology*	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com
10	**Attachment 10** *Social Determinants of Health and Health Equity*	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com
11	**Attachment 11** *Behavioral Health Questionnaire*	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com
12	**Attachment 12** *Cost and Financial Questionnaire*	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com
13	**Attachment 13** *Attestations*	**BethAnne Darby**, Director 503.952.5207 bethanne.darby@modahealth.com

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

Northwest Coordinated Care Organization (NWCCO)

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

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

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

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

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

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

Adventist Health/ Adventist Health Tillamook*
(Percent ownership TBD)

Columbia Memorial Hospital*
(Percent ownership TBD)

Yakima Valley Farm Workers Clinic*
Corporation | WA
FEIN: 91-1019392
(Percent ownership TBD)

Greater Oregon Behavioral Health, Inc.*
Corporation | OR
FEIN: 93-1144014
(Percent ownership TBD)

Performs all behavioral health administration.

Northwest Coordinated Care Organization, LLC (NWCCO)
LLC | OR

NWCCO has no employees. All administrative functions are performed by owners: ODS Community Health, Inc. and Greater Oregon Behavioral Health Inc. through administrative agreements with NWCCO.

**Expected equity partner*

Subcontractors and Delegated Entities Report

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

Reporting Year

Subcontractor/Affiliate Name	**Tax ID #** **(SSN/FEIN)**	**Correspondence Add** *Street Address / P.O. Box*
ODS Community Health	45-0528457	601 SW 2nd Ave.
Greater Oregon Behavioral Health Inc.	93-1144014	401 E. 3rd Street, Suite 101
ODS Community Dental	93-0438772	601 SW 2nd Ave.
EviCore Healthcare	14-1831391	400 Buckwalter Place Blvd
MedImpact Healthcare System Inc.	33-0567651	10181 Scripps Gateway Ct.

Magellan Rx Management	02-0676924	6870 Shadowridge Drive, Ste. 111

CCO Name: NWCCO

Reporting
2020 **Quarter** 1

ress				**Subcontractor/Affiliate Physical Address**			
City	*State*	*Zip*	*Country*	*Street Address*	*City*	*State*	*Zip*
Portland	OR	97204	USA	601 SW 2nd Ave.	Portland	OR	97204
The Dalles	OR	97058	USA	401 E. 3rd Street, Suite 101	The Dalles	OR	97058
Portland	OR	97204	USA	601 SW 2nd Ave.	Portland	OR	97204
Bluffton	SC	29910	USA	400 Buckwalter Place Blvd	Bluffton	SC	29910
San Diego	CA	92131	USA	10181 Scripps Gateway Ct.	San Diego	CA	92131

Orlando	FL	32812	USA	8621 Robert Fulton Drive	Columbia	MD	21046

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

USA	Magellan Pharmacy Services, Inc.	FL	USA	Dialysis	Magellan Health

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

NA	100	PMPM		June

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

1	2013	NA	NA	NA	December, 2018	NA

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

Kidney dialysis management.

Attachment 8 — Value-Based Payment Questionnaire

VBP Questions

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

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

   Please refer to NWCCO's completed VBP data template.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

   For VBPs which use capitation as a payment mechanism, it is important to monitor the underlying utilization to make sure that all members continue to receive the appropriate level of services. For this reason, we will collect encounter data from all of our capitated providers, which will provide insight into how people are utilizing services and how

providers are performing on quality measures. All of our data will be stored centrally, including claims data, enrollment data, REAL+D data and demographic data; and all data will be indexed with common keys. This will allow the NWCCO analytics team to run reports showing how different sub-populations have performed from an overall utilization and quality measures perspective.

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

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

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

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

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

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

   We expect to begin by establishing VBPs in category 2C, and then working to move each provider type to higher LAN levels over time, as noted in question 5 below. The size of

the performance incentive will ultimately need to be determined by the NWCCO Board, but assuming that NWCCO is eligible to earn about $6.0 million in annual quality bonus payments, and assuming distribution of 30% each to primary care practices and to hospitals, each of these provider group types could earn up to $1.8 million. These funds would be distributed to primary care practices and hospitals based on their performance meeting quality metrics. The NWCCO Board will determine the estimated incentive each year.

NWCCO will implement the Health Plan Quality Metrics Committee's 2019 Aligned Measure Menu set with particular emphasis on the Children's Health Care measures in 2020. Additionally for 2020, NWCCO will implement two hospital quality metrics for at least 1 of the hospitals located within the service area. Both of these steps will bring these provider services to LAN 2C to begin the contract period with at least 20% in category 2C+.

Children's Health Care Metrics:

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

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

Hospital Metrics:

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

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

Maternity Metrics:

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

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

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

Oral Health Metrics:

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

- Members Receiving Preventive Dental Services
- Oral Evaluation for Adults with Diabetes

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

Behavioral Health Metrics:

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

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

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

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

   All of NWCCO partners have demonstrated experience implement VBP models. Moda in particular, has demonstrated experience implementing Value Based Payment models in both Medicaid through EOCCO and in its commercial lines of business through OEBB and PEBB. As we begin operating in the NWCCO service area we will initially take a gradual approach to implementing VBPs and work with our partners to design and implement the VBP models that work best for the community.

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

2010	Moda joined the OHLC's PCPCH Demonstration Project for Medical Homes
2011	Established a Coordinated Care Network for OEBB
2012	EOCCO was established with the following concepts: - EOCCO implemented a shared savings model limited to primary care and hospital participation only - EOCCO's equity partner, GOBHI assumed full risk for behavioral health services - EOCCO made quality bonus payments to PCP's based solely on membership attribution.
2015/2016	EOCCO invited Specialists to participate in the shared savings model and PCP's had the option of a full risk capitation option.

2017/2018	Moda became a payer participating in CPC+ with EOCCO and OEBB, PEBB Moda and EOCCO significantly increased its financial investment in primary care and PCPCH's through higher capitation payments and higher PCPCH payments up to the levels in place today. PCP quality bonus payments were based 100% on performance.
2018/2019	EOCCO transitioned more eligible PCP practices from a Fee-For-Service contract to a full risk capitation model for primary care services. EOCCO required participation in EOCCO's shared savings model in order for PCP's to be eligible for PCP quality bonus payments.

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

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

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

Year	Estimated Percent of Payments in LAN category 2C+	Estimated Percent of Payments in LAN category 3B+	Service type focus area	LAN category focus areas
2020	23.0%	0%	Children's Health Care, Hospital Care	2C
2021	43.0%	38.0%	Maternity Care	2C, 3B
2022	51.0%	44.0%	Oral Health Care	2C, 4A
2023	67.0%	44.0%	Behavioral Health Care	2C and higher
2024	75.4%	44.0%	Recruitment of additional providers into VBPs, enhancements to existing VBP	2C and higher

			arrangements as needed to achieve at least 70% VBP	

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

Attachment 7 — Provider Participation and Operations Questionnaire

1. Governance and Organizational Relationships

a. Governance (recommended page limit 1 page)

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

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

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

(2) The proposed Community Advisory Council (CAC) in each of the proposed Service Areas and how the CAC was selected consistent with ORS 414.625.

NWCCO will support three LCACs and one RCAC, each representing a broad set of stakeholders including local government, public health, OHP members, and health and human service focused non-profit organizations dedicated to meeting the social, educational, and cultural needs for people of all ages and backgrounds in the region. LCACs are composed of community members and intended to represent the diversity of the communities they serve, including race/ethnicity, age, gender identify, sexual orientation, disability, and geographic location. Each County Commissioner will review all applications and nominate members of the LCAC, including members from county government. The names will be submitted annually to the NWCCO Board of Directors for final approval of CAC membership.

(3) The relationship of the Governance Structure with the CAC, including how the Applicant will ensure transparency and accountability for the governing body's consideration of recommendations from the CAC.

The NWCCO Board will appoint a Regional Community Advisory Council (RCAC) with representation from each of the three Local Community Advisory Councils (LCAC). The RCAC will oversees and coordinate LCAC activities including the Community Health Assessments, Community Health Improvement Plans, and preventive care activities.

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

LCACs will be composed of community members and intended to represent the diversity of the communities they serve, including race/ethnicity, age, gender identify, sexual orientation,

disability, and geographic location. Each County Commissioner will review all applications and nominate members of the LCAC, including members from county government.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

N/A

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

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

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

EOCCO has MOUs with the DHS offices within our service area. EOCCO also has Collaborative and Multidisciplinary Teams (MDT) that are designed to meet the needs of EOCCO Members with extreme complex care coordination needs. EOCCO care management leadership meets with the APD leaders in each of the EOCCO counties. This collaboration between EOCCO and APD is outlined in the Memorandum of Understandings. Members can be referred to MDT by EOCCO

employees, APD employees, or any member of the medical community such as physicians, nurses, DC planners and community health workers.

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

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

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

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

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

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

NWCCO through GOBHI has executed MOUs under CCO 1.0 with both the Local Mental Health Authorities and the local Community Mental Health Programs in each county served. MOUs are in place with the following CMHPs: Tillamook Family Counseling Center, Clatsop Behavioral Healthcare and Columbia Community Mental Health.

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

In order to facilitate the local Behavioral Health Plan, and outline shared goals commensurate with CCO 2.0, MOUs will be reviewed and amended after initiation of the new contract to be effective by January 1, 2020 per the contract template provided in the RFA. Applicant will enter a MOU with Local Mental Health Authority that will be enforced and honored. Improved health outcomes and increased access to services through coordination of safety net services and Medicaid services.

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

- **DHS Child Welfare and Self Sufficiency field offices in the Service Area**
- **Oregon Youth Authority (OYA) and Juvenile Departments in the Service Area**

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

NWCCO through GOBHI, works closely with community partners utilizing a number of different relationships, both formal and informal. Contracts are utilized when the relationships involve funding mechanisms. MOUs are used to outline responsibilities where different organizations are contributing different resources to projects or programs. Committees, meetings, and other events are also utilized to build relationships and streamline processes. GOBHI, on behalf of NWCCO, created the Oregon Center on Behavioral Health and Justice Integration with funding from OHA to assist jurisdictions across the state. The goal was to implement and improve systemic and programmatic efforts in the treatment of individuals with serious behavioral health needs who come into contact with the justice system, while ensuring accountability and safety. The Center provides information, training, and technical assistance to behavioral health and justice partners working closely with Local Public Safety Coordinating Councils (LPSCC).

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

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

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

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

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

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

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

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

- **Encourage Members to be active partners in their health care, understanding to the greatest extent feasible how the approach to activation accounts for the social determinants of health;**
- **Engage Members in culturally and linguistically appropriate ways;**
- **Educate Members on how to navigate the coordinated care approach and ensure access to advocates including Peer wellness and other Traditional Health Worker resources;**
- **Encourage Members to use effective wellness and prevention resources and to make healthy lifestyle choices in a manner that is culturally and linguistically appropriate;**
- **Provide plain language narrative that informs patients about what they should expect from the CCO with regard to their rights and responsibilities; and**
- **Meaningfully engage the CAC to monitor and measure patient engagement and activation.**

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

- Direct communication to Members, parents and caregivers tailored to the Member's situation and disease state. This includes information regarding self-management for specific conditions such as alcohol use and liver disease, mood and depression, chronic pain, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD) and others. NWCCO will attend health fairs to engage members and provide educational resources.
- New Member packets will contain a Health Risk Assessment (HRA) used for determining what the Member feels are their biggest concerns with respect to managing their health. The HRAs will then be used to determine if a Member is eligible for Health Coaching services. The HRAs will be available in both English and Spanish.
- NWCCO plans to implement specialized programs engage members during certain episodes of care. One possible example of this is the RGA Rosebud program for babies undelivered and delivered, focused on high-risk pregnancies and infants. The case management services provided for perinatal and neonatal members include resources for additional clinical opinions – perinatologists, neonatologists and specialized nurse consultants are available for consult through RGA Reinsurance Company, Moda's reinsurance partner. NWCCO would identify the high-risk pregnancy members and refers them to RGA for perinatal case management. Rosebud RN's begin outreach and engagement right away and assess needs and perform

ongoing outreach, keeping NWCCO informed along the way. For babies born at 34 weeks and under, NWCCO would refer them to the Rosebud program's neonatal team while the baby is in the hospital and after discharge.

- Members would be engaged in quality improvement activities using various tools such as gift card incentives for compliance with preventive screening measures, or direct telephonic health coaching to those who self-identify as tobacco users, or those who have been denied authorization for a procedure due to their tobacco use.
- Member communication will be extended to all Members, not just those accessing services, but in addition, we will provide comprehensive Member detail to primary care physicians, including Member contact information, which facilitates provider outreach to engage Members in wellness and preventive visits to close gaps in care.
- NWCCO and its provider partners will develop collaborative teams with the communities in the three county service area. These teams will incorporate Traditional Health Workers, community partners and providers.
- Quality Improvement Specialists will interact directly with the CAC, providing data regarding progress toward incentive measures. These conversations will provide the opportunity for ideating member engagement solutions focused on enhancing member engagement and incentive results.
- NWCCO plans to offer funds through a CBIR program and through the reimbursement of Traditional Health Workers.

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

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

a. Patient-Centered Primary Care Homes

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

(1) Describe Applicant's PCPCH delivery system.

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

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

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

(3) Describe how the Applicant will encourage the use of Federally Qualified Health Centers (FQHC), Rural health clinics, migrant health clinics, school-based health clinics and other safety net providers that qualify as Patient-Centered Primary Care Homes.

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

b. Other models of patient-centered primary health care

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

N/A

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

N/A

4. Network Adequacy (recommended page limit 3 pages)

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

a. Evaluation Questions

(1) How does Applicant intend to assess the adequacy of its Provider

Network? Please include specific data points used to inform the assessment and the methodology for how adequacy will be evaluated.

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

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

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

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

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

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

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

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

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

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

- Geographic location of participating Providers and Medicaid enrollees including distance, travel time, means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities.
- Data on complaints and grievances.
- Data on accessibility of appointments and appropriate range of preventative and specialty services for the population enrolled or expected to be enrolled.
- Reports from Member Services, Care Management or other areas indicating that the needs of an identified Member(s) are unable to be met.
- Data on the anticipated Medicaid enrollment and anticipated enrollment of Fully Dual Eligible individuals.
- Membership profile, as developed and periodically updated under the auspices of the Quality Improvement Committee. This profile, which may be divided into account or product-line specific sections, includes the below information on NWCCO's membership:
    - Identified cultural, racial, ethnic, linguistic, demographic, and risk characteristics.
    - Recognized clinical risks including physical or developmental disabilities, serious mental illness, multiple chronic conditions and severe injuries.
    - Expressed special and cultural needs and preferences.
- Expected utilization of services, the characteristics and healthcare needs of enrollees.
- Numbers and types (training, experience, specialization) of providers required to furnish the contracted Medicaid services.
- Number of network providers who are not accepting new Medicaid Members.
- The Provider Network sufficiency in numbers and areas of practice and geographically distributed in a manner that the covered services are reasonably accessible to enrollees as stated in ORS 414.736.
- Ability of care to be integrated and coordinated (i.e. availability of PCPCHs, CCBHCs).

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

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

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

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

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

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

(4) How does Applicant intend to monitor Member wait times to appointment? Please include specific data points used to monitor and how that data will be collected.

NWCCO will use a variety of mechanisms to monitor access and access to NWCCO services, including member complaints, surveys (Oregon Health Authority annual Consumer Assessment of Healthcare Providers and Systems survey, internal member or provider survey) and/or practitioner office site surveys triggered by member complaints on access.

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

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

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

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

(5) How will Applicant ensure sufficient availability of general practice oral health Providers and oral health specialists such as endodontists? Please provide details on how the full time equivalent availability of Providers to serve Applicant's prospective Members will be measured and periodically validated.

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

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

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

1. Emergency dental care is provided within 24 hours
2. Urgent dental care is seen within 1 to 2 weeks or as indicated in the initial screening
3. Routine dental care is seen within an average of 8 weeks and within 12 weeks or the community standard, whichever is less, unless there is a documented special clinical reason which would make access longer than 12 weeks appropriate.

(6) Describe how Applicant will plan for fluctuations in Provider capacity, such as a Provider terminating a contract with the Applicant, to ensure that Members will not experience delays or barriers to accessing care.

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

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

b. Requested Documents

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

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

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

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

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

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

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

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

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

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

c. Appropriate review of prior authorized services (consistent and appropriate application of Prior Authorization criteria and notification of Adverse Benefit Determinations down to the Subcontractor level).

Authorization requests will be managed in a time sensitive, systematic process where submitted clinical documents are reviewed by Utilization Management Coordinators who base authorization decisions utilizing consistent MCG criteria, OARs, and current NWCCO policies

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

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

a. Care Coordination:

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

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

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

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

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

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

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

(3) Describe how the Applicant will develop a tool for Provider use to assist in the culturally and linguistically appropriate education of Members about Care Coordination, and the responsibilities of both Providers and Members in assuring effective communication.

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

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

(4) Describe how the Applicant will work with Providers to implement uniform methods of identifying Members with multiple diagnoses and who are served with multiple healthcare and service systems.

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

NWCCO will have dedicated staff who promote the use of EDIE/PreManage by provider training, technical assistance and best practice examples to our providers. All CMHP's are currently using EDIE/PreManage, as well as hospitals and a large number of primary care clinics, making it easy to identify members attempting to access services in multiple healthcare settings. Through the use of EDIE/PreManage providers can obtain real-time information about

ED utilization activity. Users with access to EDIE/PreManage can view the information on demand for patients in their care, including those with multiple diagnosis. Users can find up to date information on current providers and care recommendations from Hospitals, PCP providers, EOCCO care managers and CMHPs. EDIE/PreManage provides a place where users can contribute critical information about high risk patients to assist ED providers in patient care and treatment. This includes members with multiple diagnosis and those receiving care from multiple health care provides.

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

(5) Describe how Applicant will implement an intensive Care Coordination and planning model in collaboration with Member's PCPCH and other service providers such as Community Developmental Disability Programs and brokerages for Members with developmental disabilities that effectively coordinates services and supports for the complex needs of these Members.

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

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

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

(6) Describe how the Applicant will meet state goals and expectations for coordination of care for Members with severe and persistent mental illness receiving home and Community-based services covered under the State's 1915(i) SPA and Members receiving DHS Medicaid-funded LTC services, given the exclusion of DHS Medicaid- funded LTC services from Global Budgets.

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

team will meet regularly with representatives from APD staff to further coordinate care and the delivery of services.

(7) Describe the evidence-based or innovative strategies the Applicant will use within their delivery system network to ensure coordinated care, including the use of Traditional Health Workers, especially for Members with intensive Care Coordination needs, and those experiencing health disparities.

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

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

NWCCO will support clinics utilizing CHWs to provide evidence-based interventions within their enrolled populations through referrals by primary care providers, including but not limited to individuals experiencing chronic conditions, those who could benefit from preventative care and screening, and individuals requiring support to access social services programs. This growing workforce has also been supported through a contract with Oregon State University's Professional and Continuing Education (PACE) program, which provides distance education and support to state certification to prospective rural and frontier Community Health Workers, reducing unnecessary travel for new professionals entering the health care field.

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

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

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

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

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

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

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

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

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

NWCCO will screen and send an assessments of those individuals who have been identified as needing intensive care coordination (ICC). The ICC initial assessment will be initiated within

30 days of the date a member is identified for ICC and completed within 60 days of that date. NWCCO will assign a care coordinator to engage each member newly identified for ICC. The care coordinator will initiate telephonic contact with the member within ten business days of case assignment. The care coordinator will make two telephonic attempts on different days and times of day; and one attempt by mail.

(b) Describe how the Applicant will provide access to primary care to conduct culturally and linguistically appropriate health screenings for Members to assess individual care needs or to determine if a higher level of care is needed.

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

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

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

(a) Describe the Applicant's plan to address appropriate Transitional Care for Members facing admission or discharge from Hospital, Hospice or other palliative care, home health care, adult foster care, skilled nursing care, residential or outpatient treatment for mental health or substance use disorder, the Oregon State Hospital or other care

settings. This includes transitional services and supports for children, adolescents and adults with serious Behavioral Health conditions facing admissions or discharge from residential treatment settings and the state Hospitals.

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

(b) Describe the Applicant's plan to coordinate and communicate with Type B AAA or APD to promote and monitor improved transitions of care for Members receiving DHS Medicaid-funded LTC services and supports, so that these Members receive comprehensive Transitional Care.

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

(c) Describe the Applicant's plan to develop an effective mechanism to track Member transitions from one care setting to another, including engagement of the Member and Family Members in care management and treatment planning.

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

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

(a) Describe the Applicant's standards and procedures that ensure the development of individualized care plans, including any priorities that

will be followed in establishing such plans for those with intensive Care Coordination needs, including Members with severe and persistent mental illness receiving home and Community-based services covered under the State's 1915(i) SPA.

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

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

Individual care plans will be established for all NWCCO members that are in Complex Case Management. The care plans will note that the self-management plan has been discussed with the patient and the date that has been done. It will also delineate whether a goal(s) is determined by the member, care giver, family or ICM. Those goals are then prioritized and managed with input from the member at least monthly, to set interventions tailored to the individual needs of the member, care giver and the member's family and support system. Prioritization will also include the desired level of involvement of all parties.

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

(b) Describe the Applicant's universal screening process that assesses individuals for critical risk factors that trigger intensive Care Coordination for high needs Members; including those receiving DHS Medicaid-funded LTC services.

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

(c) Describe how the Applicant will factor in relevant Referral, risk assessment and screening information from local Type B AAA and APD offices and DHS Medicaid-funded LTC Providers; and how they

will communicate and coordinate with Type B AAA and APD offices

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

(d) Describe how the Applicant will reassess high-needs Members at least semi- annually or when significant changes in status occur to determine whether their care plans are effectively meeting their needs in a person-centered, person- directed manner.

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

(e) Describe how individualized care plans will be jointly shared and coordinated with relevant staff from Type B AAA and APD with and DHS Medicaid-funded LTC Providers and Medicare Advantage plans serving Fully Dual Eligible Members.

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

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

(11) Describe the Applicant's plan for coordinating care for Member oral health needs, prevention and wellness as well as facilitating appropriate Referrals to oral health services.

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

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

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

b. Care Integration (recommended page limit 1½ pages)

(1) Oral Health

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

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

b. Describe Applicant's plan for ensuring that preventive oral health services are easily accessible by Members to reduce the need for urgent or emergency oral health services.

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

(2) Hospital and Specialty Services

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

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

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

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

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

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

(c) Performance expectations for communication and medical records sharing for Hospital and specialty treatments, at the time of Hospital admission or discharge, for after-hospital follow up appointments.

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

(d) A plan for achieving successful transitions of care for Members, with the PCPCH or Primary Care Provider and the Member in central treatment planning roles.

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

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

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

(1) Describe how the Applicant will:

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

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

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

NWCCO will meet biweekly with each county's APD office to discuss transitions of care and complex cases. This is accomplished with our MDT program, and each APD office will have the

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

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

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

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

(b) Team approaches: Care Coordination positions jointly funded by the DHS Medicaid-funded LTC and health systems, or team approaches such as a multi- disciplinary care team including DHS Medicaid-funded LTC representation.

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

(c) Services in Congregate Settings: DHS Medicaid-funded LTC and health services provided in congregate settings, which can be limited to one type of service, such as "in home" Personal Care Services provided in an apartment complex, or can be a comprehensive model, such as the Program of All-Inclusive Care for the Elderly (PACE)

NWCCO will meet biweekly with each county's APD office to discuss transitions of care and complex cases. This will be accomplished with our MDT program, and each APD office will have the direct contact information for all NWCCO supervisors and coordinators to ensure rapid communication and triaging of needs. A daily email distribution list will notify APD of their

Members who have transferred to LTC services, and facility contact information will be provided to the DT coordinators at transfer. In addition, leadership from physical and behavioral case management and APD offices will meet quarterly to discuss the successes of the MDT program, as well as to identify areas of improvement to best communicate the member's needs.

(d) Clinician/Home-Based Programs: increased use of Nurse Practitioners, Physician Assistants, or Registered Nurses who perform Assessments, plan treatments, and provide interventions to the person in their home, Community-based or Nursing Facility setting.

NWCCO will partner with local public health departments to implement a universal screening and nurse home visiting program for providing in home services for infant and maternal health. NWCCO will also utilize tele-behavioral health to provide services to Members in their homes or alternative care settings. NWCCO will also meet biweekly with each county's APD office to discuss transitions of care and complex cases.

d. Utilization management

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

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

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

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

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

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

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

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

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

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

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

7. Accountability (recommended page limit 1½ pages)

Accountability for each aspect of the Triple Aim—better health, better care and lower costs—is a central tenet of Health System Transformation. CCOs will be held

accountable for their performance on outcomes, quality, health equity and efficiency measures identified by OHA through a public process in collaboration with culturally diverse stakeholders.

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

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

CCO 2.0 Accountability Standards include:

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

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

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

b. Will the Applicant participate in any external quality measurement and reporting programs (e.g. HEDIS reporting related to NCQA accreditation, federal reporting for Medicare Advantage lines of business)?

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

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

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

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

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

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

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

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

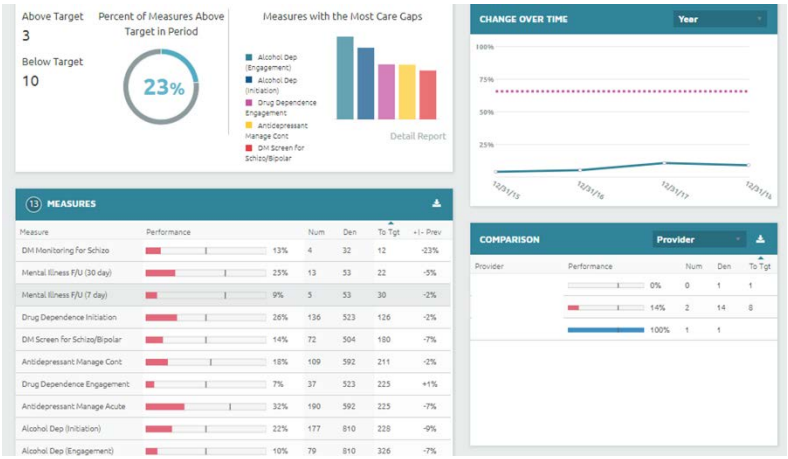
The objectives of the NWCCO QIC Committee will include:

- Establish and maintain organizational systems to ensure access to high quality, medically necessary, culturally competent and safe delivery of physical health, behavioral health and dental health services in the most appropriate setting.

- Transform the delivery of service to a model that is integrated and outcome-base
- Continuously improve the quality and safety of the care and service delivered to thereby:
  - Improve the health status of NWCCO population and their communities
  - Ensure member satisfaction with experience of care
- Ensure the delivery of cost-effective care and services
- Continuously evaluate the quality and safety of service delivery provided to members to identify improvement opportunities
- Promote communication and collaboration between NWCCO and our partners
- Support NWCCO practitioners and providers to improve the quality and safety of care and service delivered in their respective settings

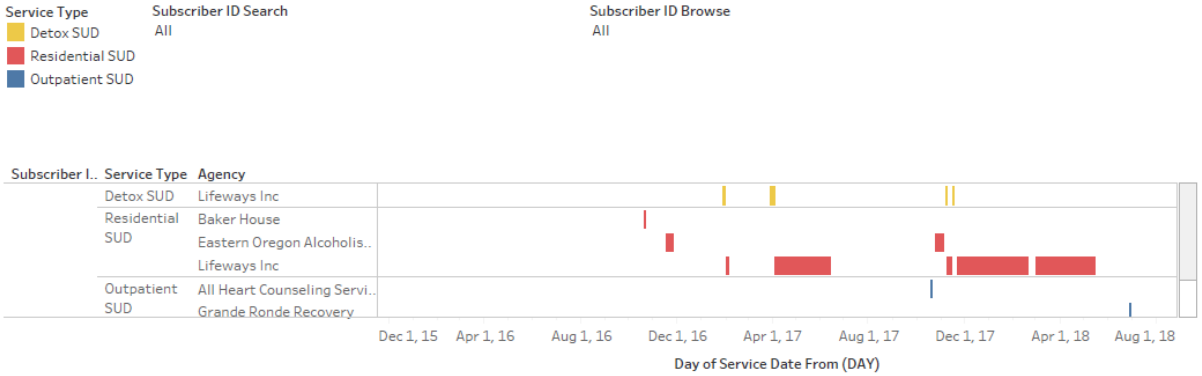
d. Describe the mechanisms that the Applicant has for sharing performance information with Providers and contractors for Quality Improvement.

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



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

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



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

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

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

- Information system claims edits such as appropriateness of services and level(s) of care, reasonable charges, and potential excessive over-utilization;
- Post-processing review of claims and other claim analytics;
- Practitioner credentialing and re-credentialing policies and procedures, including on-site reviews
- Prior authorization policies and procedures (member eligibility verification, medical necessity, appropriateness of service requested, covered service verification, appropriate referral);
- Utilization management practices, such as prior authorization, concurrent review, discharge planning, retrospective review;
- Quality improvement practices;
- Dental/medical/pharmacy claims review such as appropriateness of services and level(s) of care, reasonable charges, and potential excessive over-utilization.
- As circumstances warrant, referrals from committees such as Quality Improvement Operations, Dental Quality Improvement, Credentialing, and Pharmacy & Therapeutics Committees;
- Practitioner and member handbooks language regarding the reporting of potential fraud, waste and abuse;
- Member and practitioner mailings to educate about potential areas of fraud, waste, and abuse and how to recognize schemes;

- Staff (including senior management and subcontractors) training regarding potential fraud, waste and abuse detection, reporting, and correction efforts. Such training occurs at least annually and is also part of new hire orientation for new employees.
- Monitoring of practitioner and member appeals and grievances;
- Encounter data validation. Confirmation with a statistically valid portion of the population that services as billed by the provider were actually received by the member. As part of this process, Contractor sends member verification letters to OHP members and performs follow-up if a timely response is not received.
- Monthly federal exclusion screening of all staff, providers and subcontractors. Excluded individuals will not be employed by the Contractor or its subcontractors.

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

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

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

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

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

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

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

Quality is the foundation of all PHME activities. PHME staff will utilize the PDSA (Plan-Do-Study-Act) cycle to standardize the way we test change and monitor progress. Program performance will be evaluated by analyzing medical and pharmacy claims, member and clinic-reported clinical outcomes, Patient Activation Measure change and member survey data. The

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

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

b. Please describe your experience and plan to emphasize and implement wellness and health improvement activities and practices within your organization for Members and staff, including partners and contracts in place to strengthen this aspect of health care.

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

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

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

c. Outline your experience, staffing, policies, procedures, and capacity to collect the necessary electronic and other data that will be required for meeting regular performance benchmarks to evaluate the value of Health Services delivered by your CCO. Describe how CCO accountability metrics serve to ensure quality care is provided and serve as an incentive to improve care and the delivery of services.

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

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

d. Describe your policies and procedures to ensure a continuity of care system for the coordination of care and the arrangement, tracking and documentation of all Referrals and Prior Authorization.

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

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

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

No. NWCCO is not under any sanctions by CMS.

b. Is Applicant currently Affiliated with a Medicare Advantage plan? If no, how will Applicant ensure they are contracted or Affiliated with a Medicare Advantage plan prior to the Effective Date of the Contract?

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

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

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

See Service Area Table below.

Service Area Table

County (List each desired County separately)	Maximum Number of Members-Capacity Level
Clatsop	10,000
Columbia	12,000
Tillamook	8,000

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

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

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

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

(3) **The exception request is not designed to minimize financial risk and does not create adverse selection, e.g. by red-lining high-risk areas.**

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

Service Area Table

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

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

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

a. Standard #1 - Provision of Coordinated Care Services

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

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

Based upon the Applicant's Community health assessment and plan for delivery of integrated and coordinated health, mental health, and substance use disorder treatment services and supports and oral health services, describe Applicant's comprehensive and integrated care management network and delivery system network serving Medicaid and dually eligible Members for the following categories of services or types of service Providers that has agreed to provide those services or items to Members, whether employed by the Applicant or under subcontract with the Applicant:

- **Acute Inpatient Hospital Psychiatric Care**
- **Addiction treatment**
- **Ambulance and emergency Medical Transportation**
- **Assertive Community Treatment**
- **Community Health Workers**
- **Community prevention services**
- **Dialysis services**
- **Family Planning Services**
- **Federally Qualified Health Centers**
- **Health Care Interpreters (qualified/certified)**
- **Health education, health promotion, health literacy**
- **Home health**
- **Hospice**
- **Hospital**
- **Imaging**
- **Intensive Case Management**
- **Mental health Providers**
- **Navigators**
- **Non-Emergent Medical Transportation**
- **Oral health Providers**
- **Palliative care**
- **Patient-Centered Primary Care Homes**
- **Peer specialists**
- **Pharmacies and durable medical Providers**
- **Rural health centers**
- **School-based health centers**
- **Specialty Physicians**

- **Substance use disorder treatment Providers**
- **Supported Employment**
- **Tertiary Hospital services**
- **Traditional Health Workers**
- **Tribal and Urban Indian Health Services**
- **Urgent care center**
- **Women's health services**
- **Others not listed but included in the Applicant's integrated and coordinated service delivery network.**

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

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

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

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

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

Service Category Description QHCI, THW, FQHC, RHC, Hospice, PC, SNF: Qualified to deal with all age categories and populations including those who may be blind or disabled, have

high health care need, multiple chronic conditions, and mental illness or substance use disorder. Some examples of the specialties and sub-specialties include family practice, internal medicine, hospice and palliative care, skilled nursing, home health and preventive medicine.

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

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

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

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

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

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

NWCCO will have contractual agreements in place with each of the available public health departments within the three county service area to provide point of contact services including but not limited to immunizations, disease treatments and family planning services. Additionally, NWCCO will contract with public health departments to provide well child care visits, school based clinic services and other services as they are available. GOBHI currently has contractual agreements with each of the community mental health programs that provide services within NWCCO's three county service area and we intent to extend the contractual agreements to NWCCO.

Publicly Funded Health Care and Service Programs Table

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

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

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

While we look forward to continued collaboration and partnership, NWCCO partners have engaged the community in the development of this application. That work is reflected in the Community engagement plan, included in Attachment 10. In addition to the Clatsop, Columbia, and Tillamook county community meetings, noted below. NWCCO partners will continue to engage the community in the geographic service areas s to increase participation, partnership, and collaboration with providers, community organizations and residents of the region throughout 2019. Proposed interventions and CHIP priorities will be presented and proposed changes/updates will be integrated into plans launching on 1/1/2020.

Date	Location/Method	Summary of Participants
March 15, 2019	Astoria / In Person	All potential equity partners meeting/visioning: Moda, GOBHI, Adventist Health, Columbia Memorial Hospital, Rinehart Clinic, Yakima Valley Farm Workers
April 2, 2019	Mail	Letter to behavioral health providers
April 5, 2019	E-mail message	Columbia County Local Community Advisory Council
April 12, 2019	NWESD Offices / In person	Met with school superintendent and Northwest Educational Service District staff

(2) Describe the agreements with counties in the Service Area that achieve the objectives in ORS 414.153(4). If any of those agreements are under negotiation, the Applicant must submit the executed agreement prior to OHA issuing the CCO Contract.

NWCCO, through GOBHI, is currently contracted with each county health department and community mental health program through the county health departments.

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

N/A

d. Standard #4 – Services for the American Indian/Alaska Native Population (AI/AN) (recommended limit ½ page)

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

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

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

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

There are no Tribal sovereign nations within the three counties that comprise NWCCO. Yet Native Americans are the third largest ethnic group within the catchment area. There are XXX identified members, with potentially more due to ethnicity being self-reported. Currently NWCCO through GOBHI informs and makes available to all Native Americans, services, and providers of those services, consistent with their preferences. NWCCO through GOBHI is working to assure Members have access to services provided by Native American providers, for both outpatient and inpatient behavioral health services. Since many of these services are located outside of the NWCCO region, efforts will be made to utilize tele-behavioral health if Members would prefer not to make the drive into Portland. NWCCO continually monitors out-of-network utilization to identify opportunities to further contract with Native American providers being utilized by our Members.

Additionally, for individuals of federally or locally recognized tribes that have members living in the area, NWCCO will be conducting outreach in 2019 with the intent to include tribe members in the CAC and other governance structures.

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

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

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

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

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

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

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

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

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

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

- Use of OPDP as the backbone of our pharmacy network and reimbursement strategy to better manage prescription drug costs.
- Transparent pricing – services will be delivered for a low single administration fee per approved claim.
- 100 percent pass-through of pharmacy charges and payments – aggressive pharmacy network financial guarantees will apply for brand and generic drugs. Any network over-performance will be passed directly to NWCCO; there will be no spread retained by NWCCO's PBM.
- 100 percent pass-through of manufacturer rebates, which will help lower the total drug cost.
- No concealed markups by our PBM and no hidden administration charges or costs.
- An exclusive specialty pharmacy, Ardon Health, a Portland-based specialty pharmacy that works closely with providers throughout our service area and understands the unique

healthcare needs of NWCCO members with complex conditions that require specialty medications.
- Local and experienced clinical pharmacists who oversee benefits and work directly with prescribers to ensure the right medications are utilized at the right time.
- A dedicated pharmacy customer service team.
- Personalized educational materials and tools for members available through our web-portal.
- A local customer support team that will work daily with NWCCO leadership to ensure the pharmacy program is targeted to perform against key objectives.

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

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

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

Evidence-based Practice Center), and national drug compendia. Our P&T Committee meets quarterly to update and revise the NWCCO formulary.

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

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

(3) Describe Applicant's ability to ensure an adequate pharmacy network to provide sufficient access to all enrollees and how Applicant will communicate formulary choices and changes to the network and other medical professionals and how to make non- formulary, i.e. Prior Authorization, requests.

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

[redacted]

Given the critical role that specialty medications play in health care today, our pharmacy network will include Ardon Health (Ardon), a dedicated Portland-based specialty pharmacy with strong regional expertise that offers a more personalized connection with patients and prescribers in the Northwest. Ardon is amongst a small number of pharmacies accredited for specialty pharmacy by both URAC and ACHC. In addition, Ardon holds ACHC Distinction in Oncology.

A unique offering of Ardon is the ability to provide a single point of concierge services for onboarding members requiring access to Limited Distribution Drugs (LDD). This allows members and prescribers to use a single source for all their specialty pharmacy needs, including LDD medications.

Ensuring prescribers and members understand their formulary choices and the PA and step therapy requirements for prescribed medications is critical to administering NWCCO's pharmacy benefit. Positive formulary changes can occur quarterly after a product has been approved by the P&T Committee for inclusion in NWCCO's formulary. Negative changes can occur two times per year, in January and July. NWCCO will use individualized member communication strategies that effectively communicate formulary changes that adversely impact drug selection and utilization. Member communication occurs no less than 30 days prior to a change, but we aim for 60 days advance notice, with additional mailings to support members that start the medication after the notification date. We will work closely with our provider community and community representatives to ensure written materials that communicate pharmacy plan changes are clear and concise.

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

(4) Describe Applicant's capacity to process pharmacy claims using a real-time Claims Adjudication and Provider reimbursement system and capture all relevant clinical and historical data elements for claims paid in their entirety by the CCO and when the coordination of benefits is needed to bill Third Party Liability (TPL) when the CCO is the secondary coverage.

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

Coordination of Benefits (COB) is supported when a member has healthcare coverage under more than one plan. If a member is covered by more than one pharmacy plan, NWCCO coordinates benefits with other insurers to help the member receive the full benefit of those

plans. By coordinating benefits, NWCCO may be able to reduce the overall cost incurred for covered services.

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

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

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

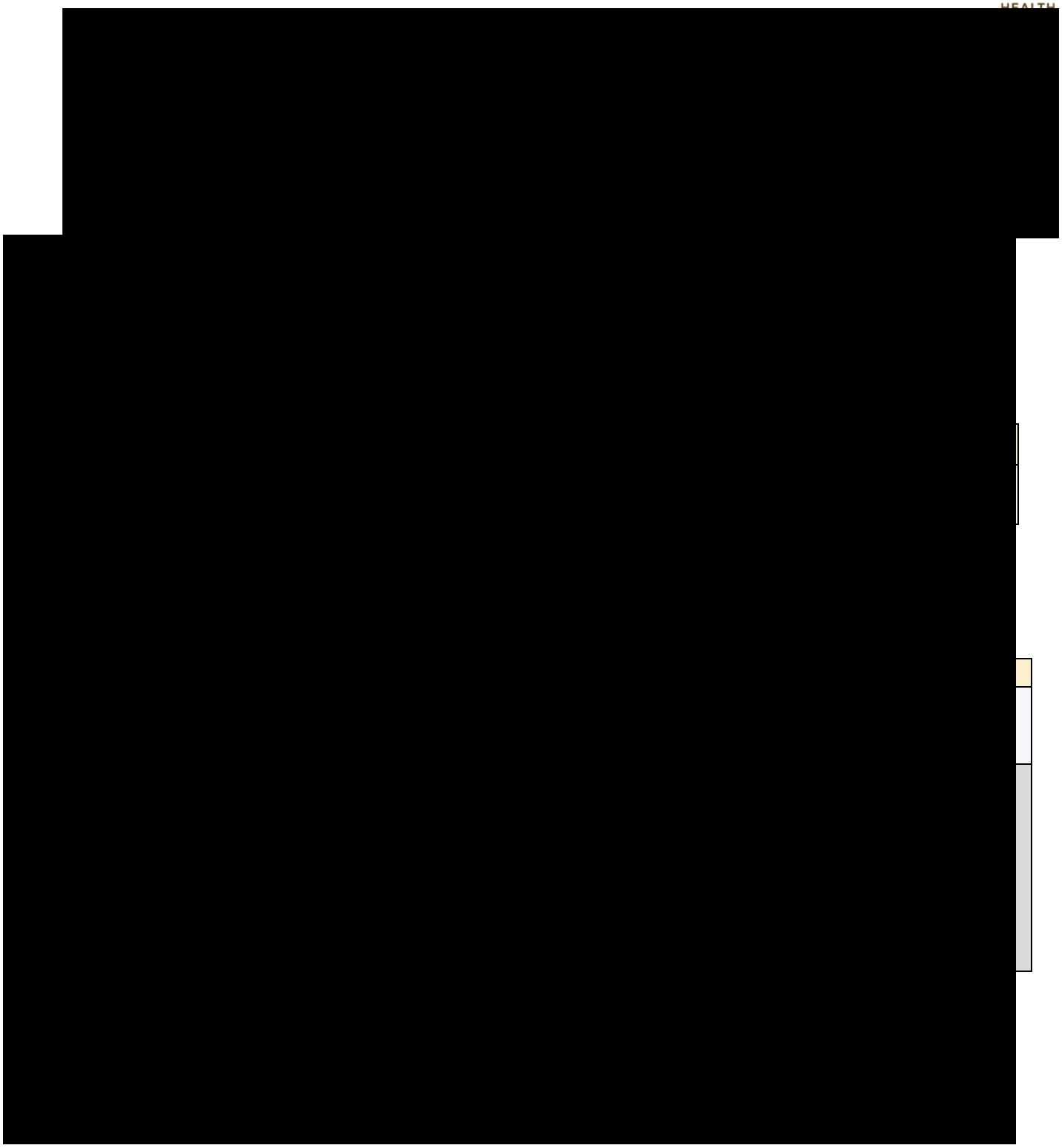
NWCCO will utilize an online PA platform that allows providers to submit authorization requests 24 hours a day, 7 days a week, 365 days a year. The platform is available at no-cost to providers and is integrated with many electronic medical record (EMR) systems. The platform also allows providers to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

(6) Describe Applicant's contractual arrangements with a PBM, including:

- **The contractual discount percentage(s) from Average Wholesale Price (AWP) or the percentage above Wholesale Acquisition Cost (WAC) the Contractor will receive from the PBM including rebate and incentive agreements or other funds received from the PBM by the CCO or any other type of any pricing arrangements between the CCO and PBM not based on a percentage discount from AWP or the percentage above WAC.**
- **The dispensing fees associated with each category or type of prescription (for example: generic, brand name, mail order, retail choice 90, specialty).**
- **The administrative fee to be paid to the PBM by CCO on a quarterly basis including a description of the associated administrative fee for each category or type and a description of the amount and type of any other administrative fees paid to PBM by Contractor.**

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

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



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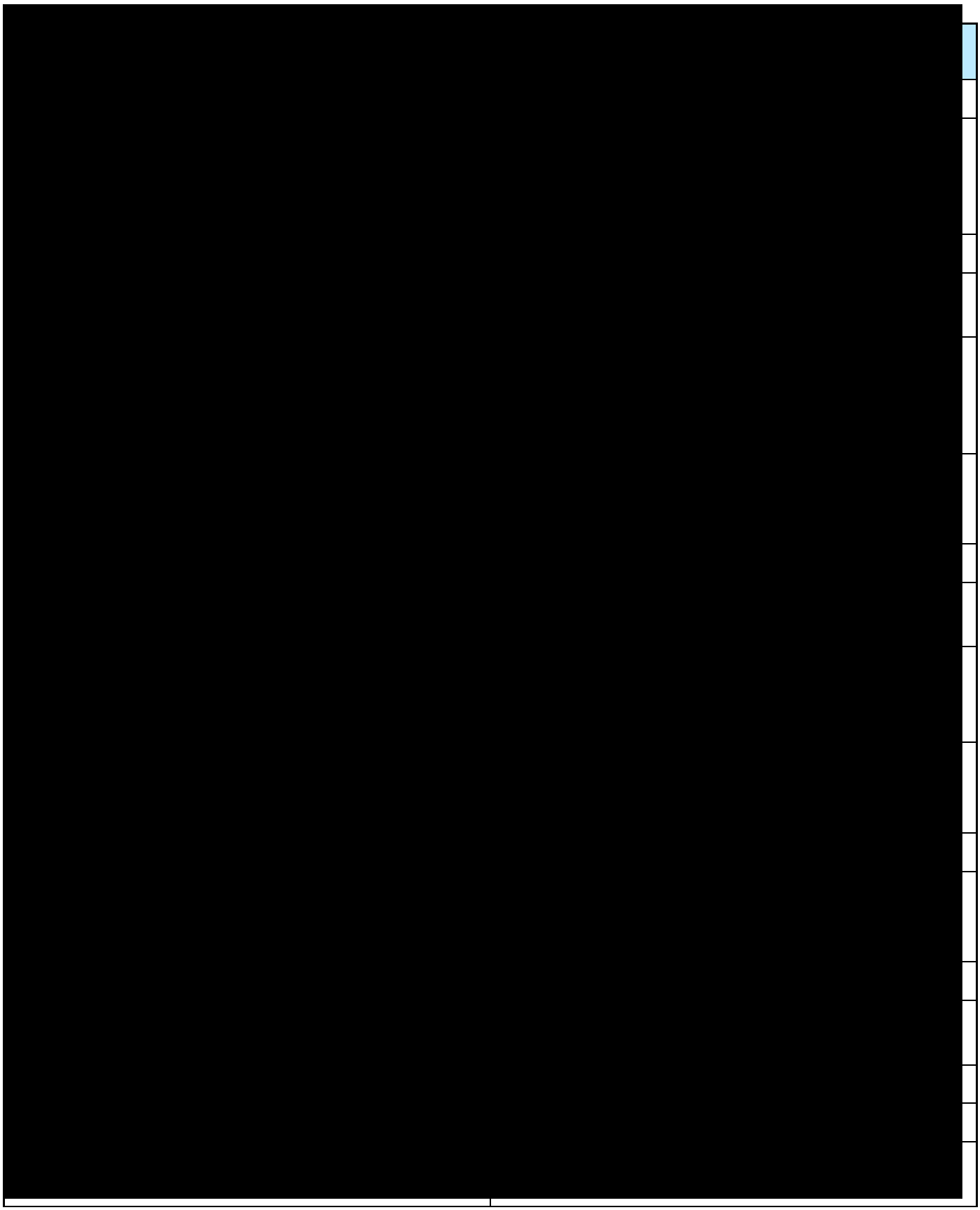

(7) Describe Applicant's ability to engage and utilize 340B enrolled Providers and pharmacies as a part of the CCO including:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) Describe how the Applicant will monitor and adjudicate claims for Provider Preventable Conditions based on Medicare guidelines for the following:

- **Adverse Events; and**
- **Hospital Acquired Conditions (HACs).**

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

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

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

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

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

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

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

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

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

(6) Please describe how you will coordinate with Medicare Providers and, as applicable, Medicare Advantage plans to reduce unnecessary ED visits or hospitalization for potentially preventable conditions and to reduce readmission rates for Fully Dual Eligible Members.

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

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

General Instructions

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

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

CCO RFA DATA COLLECTION - VALUE-BASED PAYMENTS

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

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

Optional - describe any relevant details about your predicted VBPs - using terminology from LAN categories - for 2020. (50 words or less)	This is the minimum membership estimate. Based on 18,750 members. For 202 of payments to be in LAN category 2C+ and 0% of payments to be in LAN categ focus on expanded VBP service type of Children's Health Care and Hospital Ca

a	b	c
Value-Based Payment Category	**Examples (lists not exhaustive)**	**Total dollars paid for provider contracts and/or arangements, excluding contracts that are exclusively FFS**
2A Foundational Payments for Infrastructure & Operations	care coordination fees and payments for HIT investments	
2B Pay for Reporting	bonuses for reporting data or penalties for not reporting data	
2C Pay-for-Performance	bonuses for quality	$ 26,929,849
3A Shared Savings	savings shared with contracted entity	
3B Shared Savings and Downside Risk	episode-based payments for procedures and comprehensive payments with upside and downside risk	
4A Condition-Specific Population-Based Payment	capitation payments for specialty services	

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

All VBP Sub-total	**$**	**26,929,849**
VBP 2C or higher sub-total	**$**	**26,929,849**

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20 NWCCO expects 23.0%
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d	e	f
Non-Value-Based Payment Category	**Examples (lists not exhaustive)**	**Total dollars paid for provider contracts and/or arrangements**
Fee for service payments	All contracts and/or payment arrangements that are exclusively fee for service	$ 90,156,449
3N: Risk-based payments not linked to quality	payments with upside and downside risk but no connection to quality	
4N: Capitated payments not linked to quality	capitation payments with no connection to quality	$ -

Total payments	**$**	**117,086,298**
Percent of payments that are VBP 2C or higher		**23%**

CCO RFA DATA COLLECTION - VALUE-BASED PAYMENTS

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

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

Optional - describe any relevant details about your predicted VBPs - using terminology from LAN categories - for 2020. (50 words or less)	This is the maximum membership estimate. Based on 31,250 members. For 20 23.0% of payments to be in LAN category 2C+ and 0% of payments to be in LA we will focus on expanded VBP service type of Children's Health Care and Hosp

a	b	c
Value-Based Payment Category	**Examples (lists not exhaustive)**	**Total dollars paid for provider contracts and/or arangements, excluding contracts that are exclusively FFS**
2A Foundational Payments for Infrastructure & Operations	care coordination fees and payments for HIT investments	
2B Pay for Reporting	bonuses for reporting data or penalties for not reporting data	
2C Pay-for-Performance	bonuses for quality	$ 44,883,081
3A Shared Savings	savings shared with contracted entity	
3B Shared Savings and Downside Risk	episode-based payments for procedures and comprehensive payments with upside and downside risk	
4A Condition-Specific Population-Based Payment	capitation payments for specialty services	

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

VBP Sub-total	**$ 44,883,081**

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Non-Value-Based Payment Category	**Examples (lists not exhaustive)**	**Total dollars paid for provider contracts and/or arrangements**
Fee for service payments	All contracts and/or payment arrangements that are exclusively fee for service	$ 150,260,750
3N: Risk-based payments not linked to quality	payments with upside and downside risk but no connection to quality	
4N: Capitated payments not linked to quality	capitation payments with no connection to quality	

Total payments	**$**	**195,143,831**
Percent of payments that are VBP		**23%**

CCO RFA DATA COLLECTION - VALUE-BASED PAYMENTS

CONTRACTOR/CCO NAME:

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

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

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

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

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

VBP Sub-total	**$ -**

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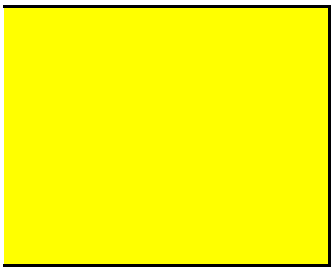

d	e	f
Non-Value-Based Payment Category	**Examples (lists not exhaustive)**	**Total dollars paid for provider contracts and/or arrangements**
Fee for service payments	All contracts and/or payment arrangements that are exclusively fee for service	
3N: Risk-based payments not linked to quality	payments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

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

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

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

Primary Care:

- PCPCH
- Capitation

Quality Incentive Measures (including children's health care)

- Shared Savings Model

Hospital & Specialty Care:

- Shared Risk/Shared Savings Models
- Quality Incentive Measures

Oral Health:

- Capitation
- Quality Incentive Measures

Behavioral Health:

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

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

ered Primary Care Home (PCPCH) program

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

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

	3*	
	4*	
	4	

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

see the Definitions tab.

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

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

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

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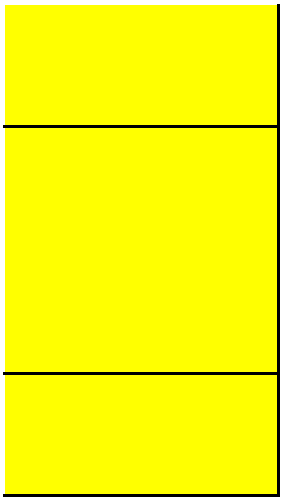
models take into
ls have considered

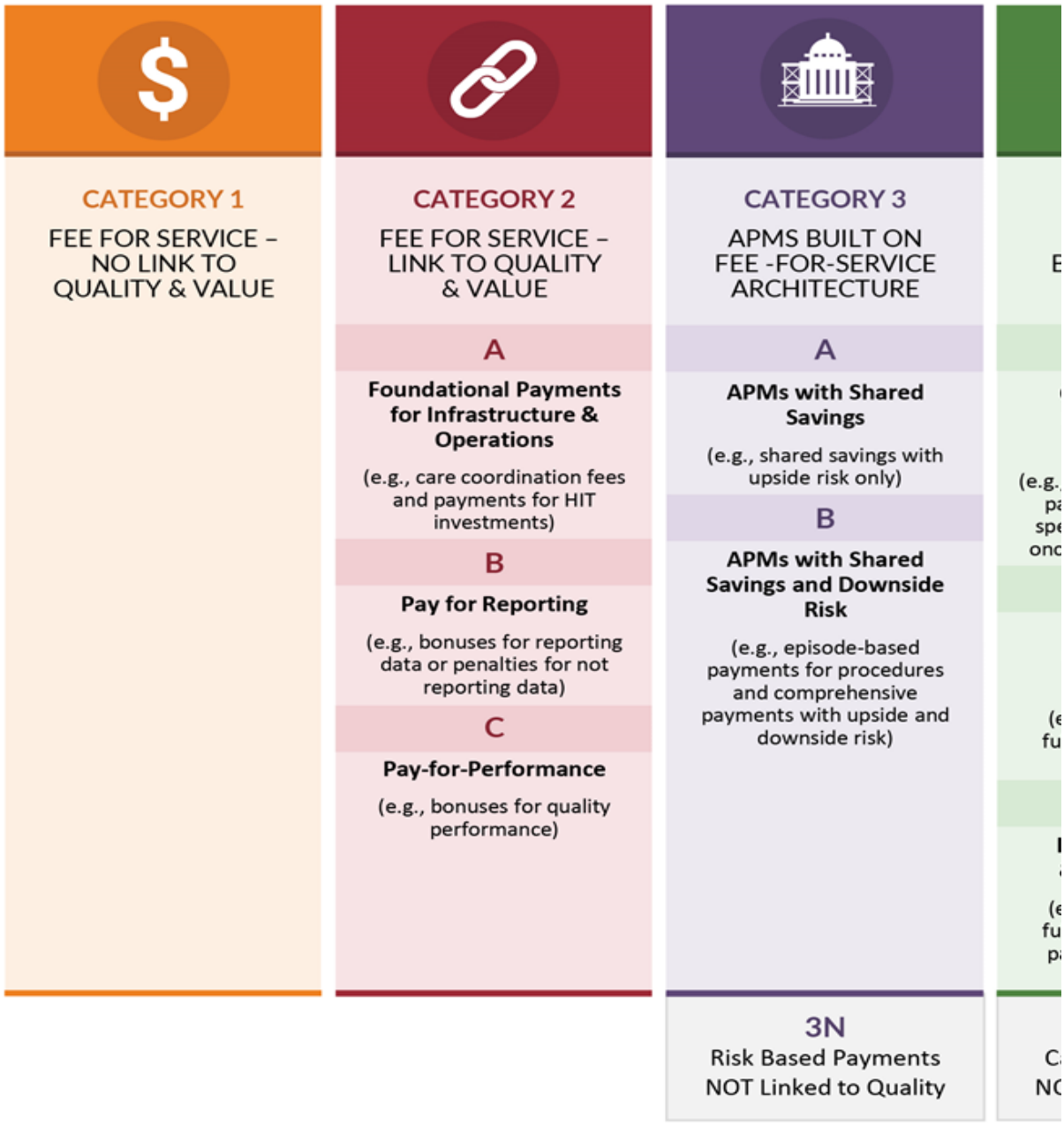
oth the PCPCH tier
eds have more

2020. B) These
llen into 2A, but we
ments will vary
hat members with



econciliations (3) or

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



CATEGORY 4

POPULATION – BASED PAYMENT

A

Condition-Specific Population-Based Payment

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

B

Comprehensive Population-Based Payment

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

C

Integrated Finance & Delivery System

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

4N

apitated Payments
OT Linked to Quality

Definitions

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

Attachment 9 — Health Information Technology

A. HIT Partnership

1. Informational Question (recommended page limit 1 page)

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

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

B. Support for EHR Adoption

1. Evaluation Questions (recommended page limit 5 pages)

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

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

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

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

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

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

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

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

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

As it relates to Behavioral Health Providers, all of the NWCCO CMHPs are currently utilizing EHRs. Columbia Community Mental Health is using Credible, and Clatsop Behavioral Health and Tillamook Family Counseling are using CareLogic. The inventory process referenced above would identify non-CMHP behavioral health providers that are not using an EHR.

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

In the NWCCO area, ODS operates two Arrow Clinics in Clatskanie and Astoria which provide the Medicaid dental services for Columbia and Clatsop counties. In Tillamook County, there is also support from Willamette Dental. With ODS (a “sister” company of Moda) and Willamette Dental, the working relationship between the NWCCO and the DCOs will be strong and provide opportunities for coordination and EHR development.

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

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

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

All health providers face a variety of barriers when working towards adopting and improving their EHRs, including: determining the appropriate EHR vendor type, staff usability, reporting capability, data sharing compatibility, and cost. During the process of preparing the EHR inventory of the providers in this region, we will gain a better understanding of the specific barriers they are experiencing, which will define the approach needed to address these barriers through education, funding resources, sharing best practices with other providers serving OHP populations, or other methods.

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

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

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

2. Informational Questions (recommended page limit 2 pages)

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

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

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

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

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

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

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

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

C. Support for Health Information Exchange (HIE)

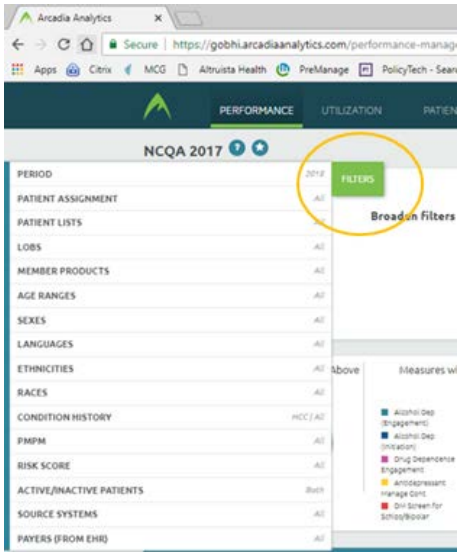
1. Evaluation Questions (recommended page limit 8 pages)

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

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

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

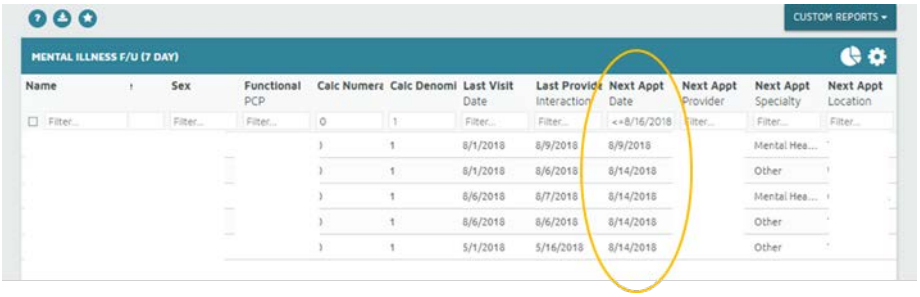
c. How will Applicant support increased access to HIE for Care Coordination among contracted oral health Providers? Please describe your strategy, including any focus on use cases or types of Providers, any HIE tool(s) or HIE methods included, and the actions you plan to take.



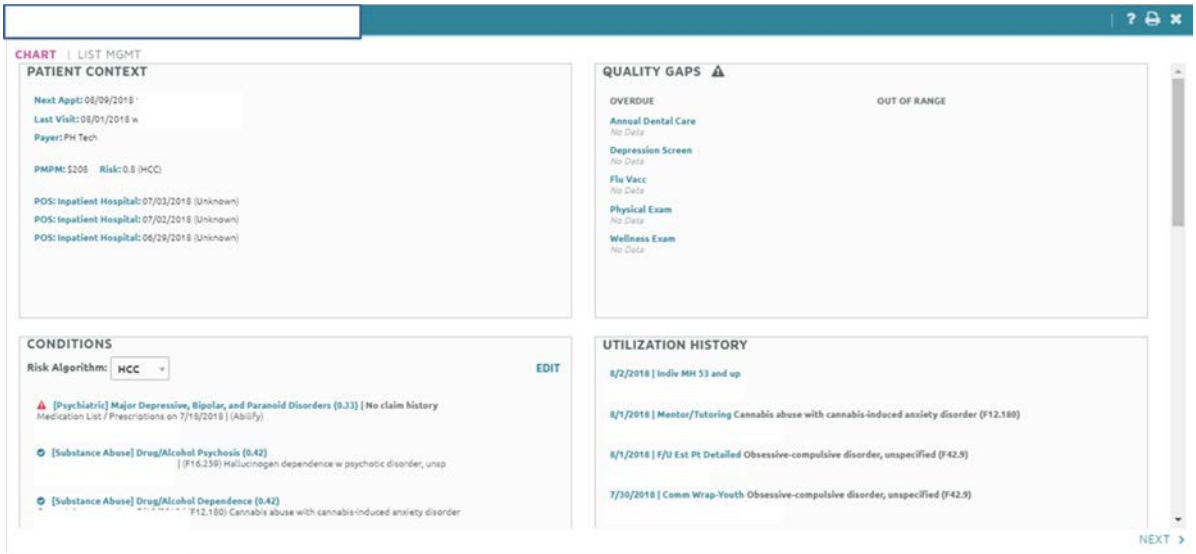
As a new CCO, NWCCO has not yet committed to a specific HIE path or solution. In Eastern Oregon, we have partnered with Arcadia Analytics to support quality metric reporting and data sharing among our connected provider EHRs. This platform allows providers to view high level visit information of their patients who have received services from other providers who are also integrated in the platform. Additionally, if a clinic chooses to change their EHR vendor and are already integrated with Arcadia Analytics, they will not lose access to pertinent patient level data from their previous EHR as the data will still be accessible within the platform. One of NWCCO's stakeholders is Greater Oregon Behavioral Health Inc. (GOBHI). This organization has purchased a separate license for Arcadia Analytics and has been using it with behavioral health providers in the NWCCO counties.

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

One example of how this HIE tool is being used in the NWCCO counties currently is for SPMI. Once an individual is discharged, the CMHP staff ensure that a 7-day visit follow-up occurs. The Arcadia Analytics platform provides notifications when a member is discharged and in need of follow-up. This information can be accessed in the HIE in a number of different ways, including the generation of a list that shows each member who needs follow up, when they were last seen, and if they have an appointment scheduled. The CCO also monitors if 7-day follow-up visits have occurred and when necessary, provides CMHP staff support in successfully making the 7-day follow-up visit is completed. (In 2018, 94.48% of NWCCO Members received a follow-up with 7 days of hospitalization for a mental illness, surpassing the goal of 66%.)



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



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

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

In Eastern Oregon, the EOCCO created opportunities for Community Based Initiative Reinvestment programs. A similar program could be created by NWCCO to assist practices requiring financial support with the implementation of EDIE/PreManage, to identify and follow a cohort of patients. This reinvestment program encourages

collaboration between hospitals, behavioral health and/or primary care to reduce barriers and increase access, coordinate care, and integrate new services or workflows. The program also promotes interventions that target patients with mental/behavioral health needs and/or multiple chronic conditions, the use of CHWs for care coordination and patient education, utilization of telehealth services for low acuity complaints presenting to the ED in partner hospitals, and primary care and behavioral health organizations. The final determination regarding the details for implementing such a reinvestment program will be made by the key NWCCO provider stakeholders.

The EDIE/PreManage tool is already accessible to all hospitals, CMHPs and a number of primary care clinics in the NWCCO region. And, as noted above, NWCCO will focus on expanding the accessibility and use of this tool. Care coordination processes using EDIE/PreManage are already being used with behavioral health providers in the region, and NWCCO will expand these processes to other providers, similar to what currently exists in Eastern Oregon.

The current processes in place facilitated by EDIE/PreManage with behavioral health providers in the region include:

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

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

- Members with Severe and Persistent Mental Illness (SPMI): To coordinate care, in 2018 NWCCO CMHP staff enter PreManage care plans on all members with an SPMI that were currently receiving services. The goal of the care plans was to provide the ED physician key information when the member visits the ED. (Note: As part of the CCO's CMHP 2018 VBP program, over 236 members now have active behavioral health care plans in PreManage. In 2019, the CMHPs are required to enter a care recommendation into PreManage for every assigned member with an SPMI.)

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

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

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

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

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

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

Action Plans: After completing an inventory of the providers in the NWCCO area using EDIE/PreManage, a detailed roadmap will be created to expand the utilization of the EDIE/PreManage tool across the network of providers. The best mechanisms to incorporate

oral health providers will also be evaluated based on the EHR inventory information obtained. Initial activities will be focused on those discussed above, and subsequent areas of focus will be determined as we evaluate effectiveness of best practices learned.

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

Please see attached HIT Roadmap.

d. How will Applicant ensure access to timely Hospital event notifications for contracted physical health Providers? Please describe your strategy, including any focus on use cases or types of Providers, which HIE tool(s), and the actions you plan to take.

e. How will Applicant ensure access to timely Hospital event notifications for contracted Behavioral Health Providers? Please describe your strategy, including any focus on use cases or types of Providers, which HIE tool(s), and the actions you plan to take.

f. How will Applicant ensure access to timely Hospital event notifications for contracted oral health Providers? Please describe your strategy, including any focus on use cases or types of Providers, which HIE tool(s), and the actions you plan to take.

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

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

g. How will Applicant access and use timely Hospital event notifications within your organization? Please describe your strategy, including any focus areas and methods for use, which HIE tool(s), and any actions you plan.

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

NWCCO will established internal PreManage cohorts that monitor NWCCO members who meet notification criteria for conditions "most likely to readmit", including sepsis,

pneumonia, COPD, and heart failure. Once identified, these members will be followed by NWCCO Nurse Case Managers.

As noted previously, all of the NWCCO CMHPs have been working with GOBHI and their use of EDIE/PreManage will continue as they begin working with this new CCO. The processes currently in place for these CMHP's will continue as follows:

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

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

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

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

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

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

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

2. Informational Questions (recommended page limit 2 pages)

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

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

OHA's assistance would also be appreciated in surveying HIE utilization statewide. Reporting on utilization by clinic would be helpful in identifying and prioritizing outreach and provider onboarding initiatives. Survey components could include information on current clinic workflow, current technology utilized, barriers to implementation including IT staffing, financial barriers other clinic priorities. As with EHR utilization, NWCCO will seek to create a comprehensive inventory of HIE utilization in the area. Based on our existing relationships with the providers and stakeholders, this should not be difficult. However, the process would potentially be more efficient and consistent if OHA could provide this support during 2019, prior to the contract start.

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

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

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

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

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

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

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

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

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

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

D. Health IT For VBP and Population Health Management

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

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

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

b. What plans do you have for collecting and aggregate data on SDOH&HE, that may be self-reported or come from providers rather than be found in claims? Can you match demographic and SDOH&HE- related data with claims data?

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

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

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

The NWCCO analytics team will produce high-level dashboards for OHP populations that highlight trends and opportunities in care delivery. For example, the team will be able to produce reports that highlight characteristics of members who have not been using primary care services, to help develop plans for impacting that population. Other areas of focus can include ED utilization, quality measures (OHA Incentive Measures) analysis, pharmacy cost and utilization, high risk members, and more.

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

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

determinants of health, childhood trauma, and child and/or parent behavioral health risks and contact with the justice system.

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

2. Evaluation Questions (recommended page limit 15 pages)

a. Describe how Applicant will use HIT to administer VBP arrangements (for example, to calculate metrics and make payments consistent with its VBP models). Include in your description how Applicant will implement HIT to administer its initial VBP arrangements and how Applicant will ensure that it has the necessary HIT as it scales its VBP arrangements rapidly over the course of 5 years and spreads VBP arrangements to different care settings. Include in your description, plans for enhancing or changing HIT if enhancements or changes are needed to administer VBP arrangements over the 5-year contract, including activities, milestones, and timelines.

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

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

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

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

- Advanced member attribution methodologies, which are deployed as needed in place or alongside direct member selection of PCPs (the preferred method of PCP assignment), taking into account members' historical utilization patterns, PCPCH

tier status, PCP network status (in or out of network), geographic area, provider specialty, and/or other factors.

- Established processes for designing, producing, maintaining, and distributing VPB progress reports to providers.
- Established processes for making payments to providers under VBPs, including fee-for-service claims payments, capitation payments, quality bonus payments, and shared savings payments.
- Established processes for collecting penalties from providers for cases in which providers do not perform to cost or quality expectations under VPBs.
- Two years' experience with managing VBPs under the CPC+ program, with infrastructure in place to administer the capitation and quality payments inherent in that program.
- Strong analytics team with deep knowledge and experience in health care data generally and VBPs specifically, supported by state-of-the-art analytics tools and technology such as SAS, Tableau, Tableau Server, Business Objects, Crystal Reports, etc.
- Robust data warehouse built on SQL Server technology, updated weekly, which includes all medical, pharmacy, vision, dental, behavioral health, enrollment, and demographic data needed to support VBP administration.

Two of the NWCCO stakeholders, Moda and GOBHI, have worked together on developing a HIE, Arcadia Solutions for the OHP population in Eastern Oregon. The experience they have gained, coupled with the experience and current status of EHR and HIE participation by other NWCCO stakeholders and participating providers will guide the strategic HIE path for this new CCO. The goals for creating such an HIE strategy for NWCCO during the next 5 years will include:

- Bidirectional exchange of health and wellness information collected from a variety of data sources and disciplines; connectivity and participation not reliant on standardized data file exchange thereby allowing for the exchange of more diverse datasets, mitigating the administrative burden of participation, as well as making it easier to connect to a wider variety of unaffiliated EHRs.
- Robust analytics platform focused on tracking performance metrics, cost drivers, utilization trends, and operational functions. HEDIS, NQF, CCO incentive, and internally produced measures drive VBP activities, and cost and utilization data drives solutions for facilitating care interventions and transformation.
- Population risk driven by diagnosis, social determinants, utilization and other data, incorporating behavioral health and oral health.

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

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

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

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

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

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

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

As noted previously, the behavioral health CMHPs in Columbia, Clatsop and Tillamook counties have been working with the current CCO, through GOBHI, using an Arcadia Analytics HIE platform to collect data for VBP metrics. For 2019 the CMHPs were able to choose 2 "elective measures" to work on from the following: depression screen with follow-up care, depression remission, patients with schizophrenia/bipolar disorder on anti-psychotic medications who have been screened for diabetes, unhealthy alcohol screenings, patients with a follow-up visit within 7-days of an ED visit for mental health, and children with physical activity counseling. These measures are currently tracked utilizing the HIE. In 2018, these CMHPs implemented a system wide patient reported outcome assessment called the PROMIS Global Health Assessment. During 2018, CMHPs received VBP dollars for building this assessment into their EHRs and showing proof that they could generate a report. In 2019, to earn VBP dollars the CMHPs must complete the assessment on at least 30% of their members. In 2020, the goal is that all members have completed an assessment, allowing NWCCO to begin looking at changes over time on individual, clinic and CCO levels. This is an example of how NWCCO will utilize HIE to structure VBP and opportunities for improving outcomes.

b. Describe how Applicant will support contracted Providers with VBP arrangements with actionable data, attribution, and information on performance. Include in your description, plans for start of Year 1 as well as plans over the 5 year contract, including activities, milestones, and timelines. Include an explanation of how, by the start of Year 1, the Applicant will provide contracted Providers with VBP arrangements with each of the following:

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

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

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

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

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

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

Date	Topic	Activity / Milestone
2012	Data exchange	First EHR data sharing agreements implemented and data transmissions begin
2013	PCPCH capitation begins	First program to increase primary care capabilities by funding PCPCH infrastructure, via capitation payments for members with serious and/or multiple chronic conditions

2013	Attribution	Development and implementation of attribution models to support VBPs, including risk-adjusted total cost of care calculations by provider entity
2014	PCPCH capitation	PCPCH infrastructure payments expanded statewide for all members in VBP plans
2014	Provider reporting	Development and population of a new provider contact database, to allow secure electronic transmission of VBP reporting to provider personnel involved with VBP management (beyond the traditional contracting personnel)
2014	Provider Reporting	First incentive measures progress reports distributed to CCO providers, showing current and active list of all VBP members with care gaps, plus YTD performance statistics on overall measure set
2014-2015	Provider reporting	Rollout of standard monthly provider reporting package, to provide timely and actionable information for providers to manage their patients under VBPs, such as: > Complete list of members assigned / attributed > Risk stratification of all assigned members > Summary of diagnoses and chronic conditions > Complete claims and prescription history for high-risk members > Care gap information such as missing PCP visits, screenings, or diagnostic tests, with targeted care gap details for members with chronic disease (e.g. HBA1c) > Interim performance reports showing bonuses (or penalties) incurred under VBPs
2015	Provider Reporting	Provider reports portal goes live. Providers have online access to monthly and quarterly reports on cost, quality, utilization, and member attribution in a secure environment; secure e-mail connections, prompts, and reminders continue via secure e-mail
2015	Provider Reporting	Near-daily IP / ED notification reporting goes live, to immediately warn PCPs of ED admissions or inpatient authorizations for their assigned populations
2016	Provider reporting	First risk-adjusted total cost of care reports generated and sent to providers, with provider results calculated and compared to a variety of risk-adjusted benchmarks, with cost, utilization, and quality performance broken down by type of service
2016	Payment Models	First large scale distributions of provider bonus payments under CCO shared risk models – all of which performed favorably and resulted in shared savings distributions

2016	Data exchange	EOCCO work begins with Arcadia Analytics to create direct connections to provider EHRs, with data to flow to a common platform with a web portal for providers to access and manage quality data
2017	EDIE / PreManage	PreManage feed to enhance population management efforts in care coordination and ED utilization
2017	Payment Models	Rollout of first comprehensive primary care capitation model (Category 4A) to selected EOCCO providers, eliminating fee-for-service payments for most primary care services
2018	Payment Models	VBP quality measures tied to capitation payments for risk bearing behavioral health providers
2018	Payment Models	Comprehensive population-based payments (Category 4A) adopted for a majority of CCO primary care practices
2018	Payment Models	OHP members covered by the first agreement in HCP-LAN Category 4B
2019	Data exchange	Complete EHR quality metric and care gap data, plus claims data, available for 55% of EOCCO patients in the Arcadia Analytics web-based reporting platform
2019	Provider reporting	Development and production of referral pattern reporting, to provide PCPs with insights into the cost and quality of specialists and facilities in their referral network
2019	Provider reporting	Development and production of enhanced pharmacy opportunity reports, which compare PCPs and specialists to benchmarks on their utilization of brand name and specialty medications, and highlight any adherence issues
2019	Provider reporting	Next generation of Provider Reports Portal goes live (Spring 2019), with vastly improved navigation and organization features, with added ability for providers to access any and all custom and ad hoc analysis produced by the VBP team, all in one place
2020	Payment Models	Adjustment of EOCCO hospital payment model to move from Category 3N to 3B, adding new quality measures from the state-approved list

NWCCO Analytics and Information Technology staff will work with the providers to assure information is being captured accurately and transmitted correctly. This includes validating information, working as a liaison when there are issues and providing technical assistance. Also, as previously discussed, provider teams are individually supported by NWCCO staff who assist with understanding VBP reporting. Some reports are delivered in PDF form, where readability and presentation of information is critical to provider understanding and acceptance. However, reports containing tabular data – for example

member rosters with risk stratifications and care gaps – are sent in Excel form, with pre-set filter buttons to make it easy for non-technical staff to sort and filter the lists for action and/or analysis. In addition, every report contains a mini-glossary of terms, and is supported by complete documentation of every term, abbreviation, column name, etc. made available alongside the reports on the Provider Reporting portal.

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

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

d. Describe how you will help educate and train Providers on how to use the HIT tools and data that they will receive from the CCOs.

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

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

The following table describes some of the activities currently in place in Eastern Oregon that will be replicated in NWCCO and adjusted as the HIE strategy is defined.

Date	Topic	Activity / Milestone
Q1 Annually	New Incentive Measures	Staff updates provider clinics regarding the current year incentive measures via email and NWCCO website.
Q2 Annually	Clinic Visits	Staff travels to clinics to review provider progress reports, new measures, metric related workflows, review of previous year preliminary results, clinic incentive measure trends, and discuss available resources.

Q4 Annually	Clinic Visits	Staff travels to clinics to review current year incentive measure progress, and determine any additional initiatives to implement to meet the current year metrics.
Weekly	HIE Vendor Touchpoint	Staff meets weekly with HIE vendor (Arcadia Analytics for EOCCO) to review current status of the onboarding process and allow for continual communication to ensure any barriers are addressed
Quarterly	HIE Vendor Focus Group	Staff facilitates meeting with HIE vendor (Arcadia Analytics for EOCCO) and on-boarded clinics to address common questions/concerns and identify resolutions.
Bi-weekly	EDIE/PreManage Touchpoint	Staff meets with PreManage vendor (CMT) staff on a bi-weekly basis to review current status of the onboarding process and allow for continual communication to ensure barriers are addressed as they arise.
Continually	QI clinic support	Clinic staff will have continual access to QIS's through a shared email NWCCOMetrics@modahealth.com as well as phone contact. This allows clinics a streamlined way to reach out and request assistance as needed regarding the provider progress reports and any other related data questions.
Annually	Staff and Clinician Summit	NWCCO's Clinical Advisory Panel will coordinate an annual conference for providers and staff. Relevant updates to HIE strategy and technology plans will be presented.

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

e. Describe the Applicant's plans for use of HIT for population health management, including supporting Providers with VBP arrangements. Include in the response any plans for start of Year 1 as well as plans over the 5-year contract, including activities, milestones, and timelines. Describe how Applicant will do the following:

(1) Use HIT to risk stratify and identify and report upon Member characteristics, including but not limited to past diagnoses and services, that can inform the targeting of interventions to improve outcomes? Please include the tools and data sources that will be used (e.g., claims), and how often Applicant will re-stratify the population.

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

f. What are your plans to provide risk stratification and Member characteristics to your contracted Providers with VBP arrangements for the population(s) included in those arrangement(s)?

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

g. Please describe any other ways that the Applicant will gather information on, and measure population health status and outcomes (e.g., claims, clinical metrics, etc.).

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

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

(1) Data sources: What data sources do you draw on – for example, if you incorporate clinical quality metrics, what data do you collect and how? How often do you update the data? How are new data sources added? How do you address data quality?

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

Authorization data is used to provide the earliest possible alert for inpatient admissions, to make sure that providers have the maximum opportunity to coordinate care. This data

is generated continuously, and extracted from core Moda systems several times per week so that it can be summarized and reported out to PCPs immediately.

EHR data can be collected in several ways. Providers can submit data to Moda to be incorporated into the ADW. Or, once the HIE plan for NWCCO is created, there will be options to have EHR data pulled from the provider systems into a central repository. The setup process for each provider data feed involves a significant amount of testing and validation, as different providers may store data differently even if they are using the same EHR. EHR data combined with claims data will then be used to support the annual submission process for clinical quality measures.

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

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

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

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

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

(3) Tools:

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

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

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

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

Report Name	Purpose / Description	Frequency	Status
ER / Inpatient Notification	Timely notification to PCPs for ED admissions and inpatient authorizations	2-3X / week	Current
Member Roster	List of assigned members for each provider. Basic risk and utilization info.	Monthly	Current
High Risk Member Report	Detail on high risk members, such as diagnosis and treatment history	Monthly	Merged with Member Roster
Chronic Condition Report	Detail on all members with a chronic condition (e.g. Diabetes, COPD, etc.)	Monthly	Merged with Member Roster
Inpatient & ER Report	List of all Inpatient and Emergency Room visits	Monthly	Merged with Member Roster
High Risk Member Claims Detail	List of all claims for high-risk members	Monthly	Current

Pharmacy	List of all claims for prescriptions filled, including medication possession ratios	Monthly	Current
Member Detail Report	Contains basic member demographic and contact information, including name, address, and phone number.	Monthly	Merged with Member Roster
Settlement Report	Calculates the amount of the risk sharing bonus earned by each provider	Quarterly	Current
Utilization Summary Report	Displays utilization statistics such as PMPM cost and claims/000 by service category, PCP utilization, drug costs, etc., with benchmarks	Quarterly	Current
Quality Summary Report	Shows YTD progress compared to targets for quality measures	Monthly	Current
Quality Progress Report	Highlights specific members with gaps in care and/or opportunities to influence quality metric performance, plus overall summary of performance	Monthly	Current
Pharmacy opportunity report	Identifies members with pharmacy management opportunities; highlights excessive use of drugs with less expensive and equally effective alternatives	Quarterly	In development
Facility referral analysis	Stratifies facilities and ancillary providers by quality and cost of care, to inform referral decisions	TBD	In development

(4) Workforce: Do you have staff (in-house, contractors or a combination) who can write and run reports and who can help other staff understand the data? What is your staffing model, including contracted staffing?

All reports and analysis are produced, maintained, and distributed by an in-house Analytics team, staffed by Moda. Reports produced by vendor systems will be audited and validated via joint efforts of vendor and in-house staff. The Analytics team produces all analysis and reporting for VBPs, but also produces customer reporting, internal management reporting, regulatory reporting, and other tasks. With access to Moda's large analytics capabilities, NWCCO is supported by a team which has the scale to conduct

training and development activities, invest in new tools, techniques, and processes, and generally maintain a high level of analytics excellence. Members of the Analytics team have significant experience in the analytics generally and health care data specifically, and many have advanced credentials including Ph.D, MPH, and MBA.

(5) Dissemination: After reports are run, how do you disseminate analysis to Providers or Care Coordinators in your network? How do you disseminate analysis within your organization?

Initially, the primary method of report distribution will be via the Provider Reporting portal. Providers can log in and see the complete history of their clinical and financial reports that pertain to VBPs (the reports listed above). NWCCO will maintain a contact database of provider personnel involved in quality and medical management activities, including e-mail addresses, and this information is used for outreach and transmission purposes where needed. Often, announcements of new or updated reports are sent via e-mail, to prompt visits to the provider portal. Some reports are also sent via secure (encrypted) e-mail, though we are transitioning away from this method of delivery.

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

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

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

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

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

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

NWCCO will be supported by excellent Analytics and Actuarial team members who can effectively articulate the progress made, including defining targets and success. NWCCO will be data-driven and relationship-driven, similar to the way the governance model for EOCCO has been functioning. VBP performance, quality performance, management performance, results of targeted interventions and other initiatives will all be tracked through data, and adjustments for HIT support will be made through data-driven decisions. Solutions for how the adjustments should be handled, or how larger strategy changes should be made, will be relationship-driven and developed in collaborative forums.

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

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

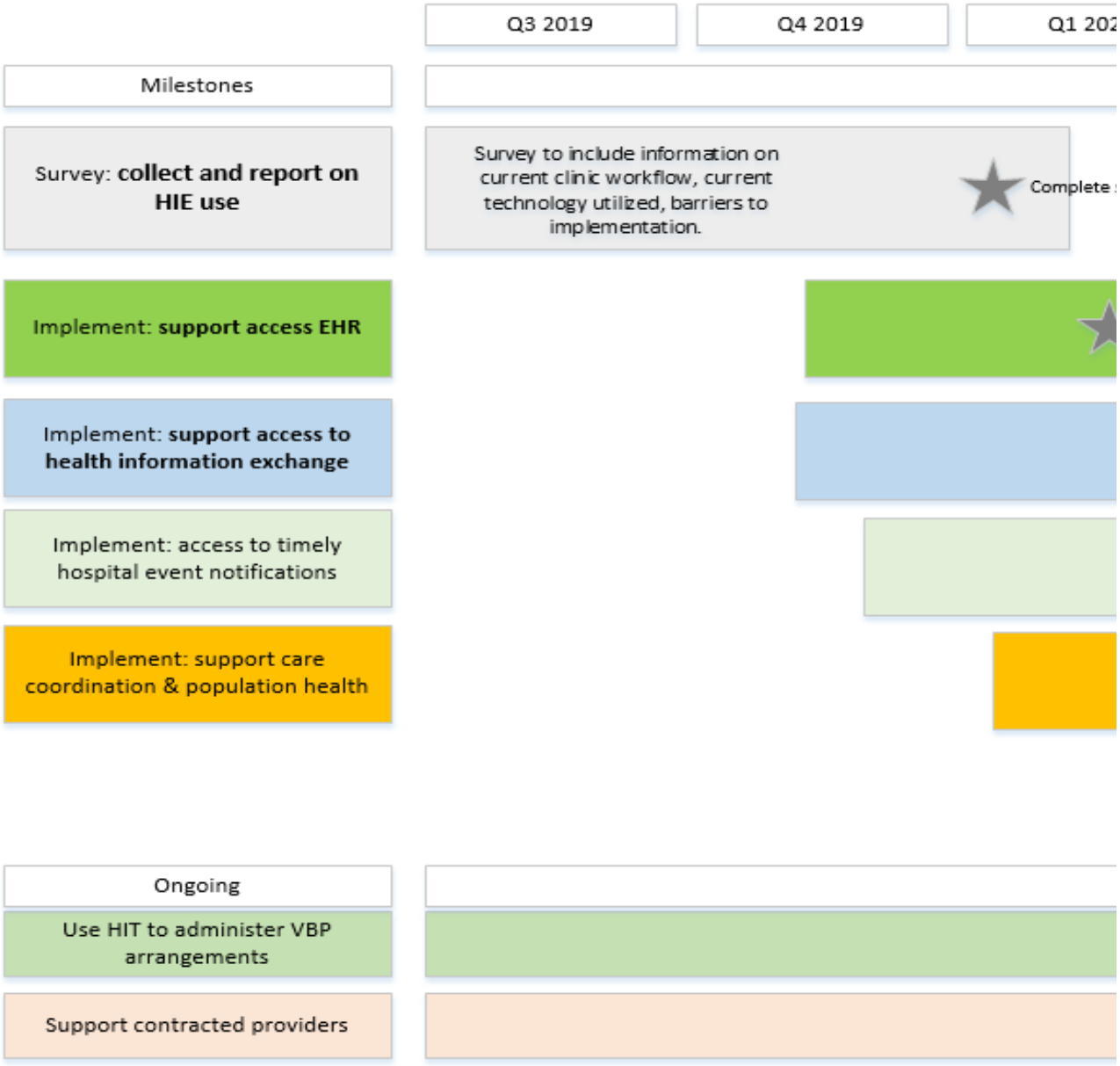
On a tactical level, usage tracking has been enabled on the Provider Reporting portal, so that the team can gain insights into which providers are viewing and downloading which reports. Although the next-generation update to the portal will to some extent create some obsolescence in this tracking data,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

(7) Addressing challenges: What challenges do you anticipate related to HIT to support VBP arrangements with contracted Providers, including provider-side challenges? How do you plan to mitigate these challenges? Do you have any planned projects or IT upgrades or transitions that would affect your ability to have the appropriate HIT for VBP?

NWCCO already possesses the technology, infrastructure, people, and processes to fully support a wide range of VBPs. Provider-side challenges are resolved on an ongoing basis through the NWCCO governance structure and through targeted provider engagement activities discussed previously. There is always room for

improvement, and planned upgrades are in the works for our technology and reporting platforms, as well as our level of staffing (e.g. adding positions). These planned changes will have a positive impact on our future capabilities, with no interruption of current capabilities.

NWCCO HIT Roadmap Data Collection



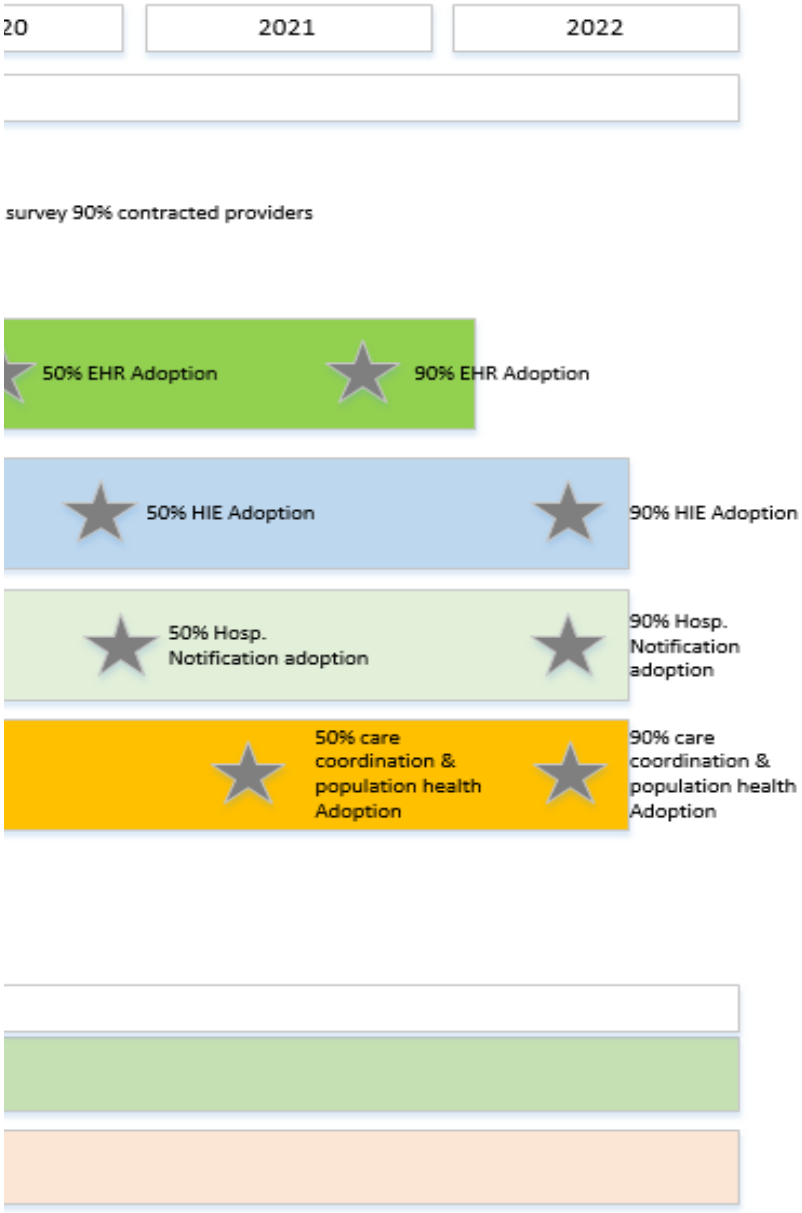


Exhibit L
Appendix B – Sample Contract

NWCCO HIT Roadmap Data Collection

EHR Adoption	
Physical Health	
Behavioral Health	
Oral Health	
All	

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

EHR Adoption	
Physical Health	
Behavioral Health	
Oral Health	
All	

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

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

Q3 2019

Utilzing Hospital Event Notifications	
Physical Health	
Behavioral Health	
Oral Health	
All	

Access to HIE	
Physical Health	
Behavioral Health	
Oral Health	
All	

Q3 2020

Utilzing Hospital Event Notifications	
Physical Health	
Behavioral Health	
Oral Health	
All	

Access to HIE	
Physical Health	
Behavioral Health	
Oral Health	
All	

Q3 2021

Utilzing Hospital Event Notifications	
Physical Health	
Behavioral Health	
Oral Health	
All	

Access to HIE	
Physical Health	
Behavioral Health	
Oral Health	
All	

Q3 2022

Utilzing Hospital Event Notifications	
Physical Health	
Behavioral Health	
Oral Health	
All	

Access to HIE	
Physical Health	
Behavioral Health	
Oral Health	
All	

Q3 2023

Utilzing Hospital Event Notifications	
Physical Health	
Behavioral Health	
Oral Health	
All	

Access to HIE	
Physical Health	
Behavioral Health	
Oral Health	
All	

Q3 2024

Utilzing Hospital Event Notifications	
Physical Health	
Behavioral Health	
Oral Health	
All	

Access to HIE	
Physical Health	
Behavioral Health	
Oral Health	
All	

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

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

NWCCO HIT Status: Physical Health

		Organization Name
1	Physical Health	Adventist Health Tillamook
2	Physical Health	Astoria Womens Health LLC
3	Physical Health	Awaken Natural Medicine
4	Physical Health	Clatskanie Family Medical Clinic Inc
5	Physical Health	Coastal Health Center PC
6	Physical Health	Columbia Memorial Hospital
7	Physical Health	CRM Physicians LLC
8	Physical Health	Lower Columbia Clinic
9	Physical Health	OHSU Hospitals and Clinics
10	Physical Health	Pacific Family Medicine, LLP
11	Physical Health	Providence Health and Services
12	Physical Health	Manzanita Primary & Specialty Care
13	Physical Health	Saint Helens Internal Medicine
14	Physical Health	The Middle Way Health Care, LLC
15	Physical Health	The Rinehart Clinic
16	Physical Health	Yakima Family Farm Workers
17	Physical Health	Wimahl Family Clinic
18	Public Health	Clatsop County Public Health
19	Public Health	Columbia Health Service
20	Public Health	Tillamook County Community Health Centers
21	Public Health	Tillamook County Community Health Centers
22	Specialty Care	Bridgeport Eye Physicians LLC
23	Specialty Care	Coastal Eye Care LLC
24	Specialty Care	Family Vision Clinic
25	Specialty Care	Lighthouse Vision Care PC
26	Specialty Care	National Vision Inc
27	Specialty Care	Natural Path Health Services
28	Specialty Care	Nourish Natural Family Medicine
29	Specialty Care	Oregon Eye Specialists
30	Specialty Care	Watershed Community Wellness LLC
31	Specialty Care	Weichert Wellness LLC
32	Specialty Care	The Oregon Clinic
33	Specialty Care	Vital Health Center

Practice Name	Phone Number	EHR Product Name	EHR Version Number
Tillamook Regional Medical Center	5038425546		
Astoria Womens Health LLC	5033257800		
Awaken Natural Medicine	5038426532		
Clatskanie Family Medical Clinic Inc	8666222455		
Coastal Health Center PC	5038423661		
Columbia Memorial Hospital	5033384085		
CRM Physicians LLC	5034301777		
Lower Columbia Clinic	5033259131		
OHSU Family Medicine Clinic, Scappoose	5034184222		
Pacific Family Medicine, LLP	5033255300		
Providence Seaside Hospital	5037177000		
Manzanita Primary & Specialty Care	5033686244		
Saint Helens Internal Medicine	5033666244		
The Middle Way Health Care, LLC	5038424809		
The Rinehart Clinic	8003685182		
Coastal Family Health Center	5033258315		
Wimahl Family Clinic	5033382993		
Clatsop County Public Health	5033258500		
Columbia Health Service	5033974651		
North County Health Center – Rockaway Beach	5033552700		
South County Health Center - Cloverdale	5033924200		
Bridgeport Eye Physicians LLC	5037385361		
Coastal Eye Care LLC	5033254401		
Family Vision Clinic	5033972020		
Lighthouse Vision Care PC	5038426363		
National Vision Inc	5097342511		
Natural Path Health Services	5034293928		
Nourish Natural Family Medicine	5033684312		
Oregon Eye Specialists	5037177690		
Watershed Community Wellness LLC	5039740914		
Weichert Wellness LLC	5033684393		
The Oregon Clinic	5032810561		
Vital Health Center	5034810283		

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

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

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

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

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

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

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

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

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

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

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

NWCCO HIT Status: Behavioral Health

		Organization Name
1	Behavioral Health	Clatsop Behavioral Health
2		Choices Counseling
3		Columbia Community Mental Health
4		OHSU
5		Rinehart Clinic
6		Tillamook Family Counseling Center
7	BH in Primary Care	Adventist Health
8		Adventist Health
9		OHSU
10		Providence St. Joseph Health
11		Rinehart Clinic
12		Yakima Family Farm Workers (FQHC)
13		Legacy Medical Group - St. Helen's

Practice Name	Phone Number	EHR Product Name
Clatsop Behavioral Health	5033255722	
Choices Counseling	5033254499	
Columbia Community Mental Health	5033975211	
OHSU Clinic - Scappoose	5034184222	
Rinehart Clinic	18003685182	
Tillamook Family Counseling Center	5038428201	
Adventist Health Medical Office - Manzanita	5033686244	
Adventist Health Medical Office – Tillamook	5038425546	
OHSU Clinic - Scappoose	5034184222	
Providence Seaside Clinic	5037177060	
Rinehart Clinic	18003685182	
Coastal Family Health Center	5033258315	
Legacy Medical Group - St. Helen's	5033970471	

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

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

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

Q3 2021				
EHR Product Name	**EHR Version Number**	**2015 Certified EHR**	**Access to Hospital Event Notifications**	**Status of Hospital Event Notifications**

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

Q3 2022				
2015 Certified EHR	Access to Hospital Event Notifications	Status of Hospital Event Notifications	Access to HIE	Status of HIE

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

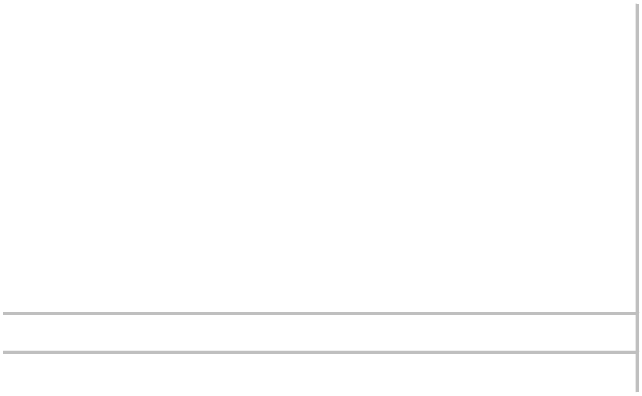
2023				
Status of Hospital Event Notifications	Access to HIE	Status of HIE	Using HIE for Care Coordination	EHR Product Name

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

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

NWCCO HIT Status: Oral Health

		Organization Name
1	Oral Health	Sandcreek Dental LLC
2		Tillamook County Family Health Center
3		Smile Dentures PLLC
4		Bayshore Dental Images LLC
5		St Helens Pediatric Dentistry
6		Arrow Dental LLC
7		Vernonia Dental LLC
8		The Smile Store LLC
9		Seth V Senestraro DDS PC



Practice Name	Phone Number	EHR Product Name
Sandcreek Dental LLC	5038427788	
Tillamook County Family Health Center	5038423936	
Smile Dentures PLLC	5038367711	
Bayshore Dental Images LLC	5039650014	
St Helens Pediatric Dentistry	5033964750	
Arrow Dental LLC	5037288970	
Vernonia Dental LLC	5034290880	
The Smile Store LLC	8339091050	
Seth V Senestraro DDS PC	5038426544	

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

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

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

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

Q3 2021			
EHR Version Number	2015 Certified EHR	Access to Hospital Event Notifications	Status of Hospital Event Notifications

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

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

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

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

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

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

Access to HIE	Status of HIE	Using HIE for Care Coordination

NWCCO's HIT Narrative

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

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

Responses

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

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

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

Final Report Template

Instructions

Deadline: Please refer to your contract

Contacts:

For questions contact Sankirtana Danner, danners@ohsu
E-mail completed report to Sankirtana Danner danners@ohsu.edu

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Report Information

Grantee name:

Project Title:

Award Type:

Report submitted by:

Phone number for questions:

Email address:

Report Questions

A. Overall project goals (1-2 paragraphs)

B. Results:

1. **Please provide a one to two-page narrative summary of the results of your project (include: objectives, activities, description of how your activities aligned with your metric goals, and a description of your overall results).**

2. **Provide data on your targeted incentive measure(s) and/or other goals using the table below:**

Targeted Metric	Activity Planned	Current Results	
		#of EOCCO Members	*#of Non-EOCCO Members*

EXAMPLE: *AWC visits*	*AWC fair*	*250/450*	*200*

3. **Were there any significant changes to your project team, goals, or activities, including any changes to targeted incentive measures and clinical services outlined in your original proposal? (please explain)**

4. **What challenges or barriers did you experience and how did you address them?**

5. **What were the most important outcomes of your project?**

6. **What have been the most successful and the least successful aspects of your project?**

7. **What one or two stories do you have that capture the impact of this project?** (Such as people/communities the project has helped; lives that have changed; work that led to policy change, such as legislation or regulation; and quality improvement or research breakthroughs)

8. **How has your project affected your organization and your community?**

9. **Was there any media coverage or publications related to this project? If yes, what type (e.g. print, TV, radio, newsletter, website, other)?**

10. **What is the plan for sustaining this project?**

11. **Were there any significant changes to your project budget that have not already been reported? (please explain)**

12. Please complete the budget table below showing how funds for your project were expended compared to your original grant budget.

Personnel								
Name	**Role**	**FTE**	**Salary Originally Requested**	**Benefits Originally Requested**	**Total Originally Requested**	**Actual Spent**	**In-Kind Cash Contribution**	**In-Kind non-cash Contribution**
Equipment and Supplies								
Name of Item	**Description**							
Travel								
Location	**Description**							
Other expenses								
Name of Item	**Description**							
GRAND TOTAL								

2019 LCAC Community Benefit Initiative Reinvestments
Grant Application Review Sheet

Cover Sheet Information

Name of LCAC:

Project Title:

Other Application Details

Agreement to Participate Letters (list organizations):

Write a paragraph describing the proposed project, including goals of the project and incentive measures addressed:

Grant Scoring Table

		Response Scale				
		Strongly Disagree 1	Disagree 2	Neutral 3	Agree 4	Strongly Agree 5
I.	**SIGNIFICANCE**					
I.1	The focus of this project is on an important health problem faced by this community					
I.2	This project focuses on least one EOCCO incentive measure that the county is struggling to meet					
TOTAL SCORE SECTION I						
II.	**APPROACH**					
II.1	The project plan has clearly stated **goals**					
II.2	The proposed **incentive measure(s)** (and CHP goals if present) are appropriately matched to the project's overall goals and proposed activities					
II.3	The proposed **activities** are clear, reasonable, and match the proposed goals.					
II.4	**The proposal describes a feasible and detailed timeline**					
II.5	The proposed **data collection plan** includes a clear baseline, reasonable targets, a clear plan for how data will be collected **(including tracking EOCCO members)**, and matches the proposed activities and CHP goals if present					
II.6	The **budget** is clear, reasonable and appropriate to the work proposed.					
II.7	The **budget** allots at least 30% of funds towards activities to address incentive measures					
II.8	There is an appropriate plan in place to address potential **risks** with the project					
TOTAL SCORE SECTION II						

III.	**COMMUNITY AND STAFF**					
III.1	The proposal describes appropriate and adequate **staffing and support**, with the required skills and experience, to achieve the work and the proposed timeline.					
III.2	The **LCAC and community** have demonstrated a commitment to the topic/population/issue addressed by this project.					
III.3	The project includes the **documented stakeholders** (e.g. organizations and community partners) likely to contribute to its success, **including Letters of Committment**					
TOTAL SCORE SECTION III						
IV.	**IMPACT AND SUSTAINABILITY**					
IV.1	The project is likely to have a high impact on the health, health care, and costs of care for CCO members and their communities, based on the resources being expended. **(potential ROI)**					
IV.2	The project is likely to be **sustained** and/or replicated in other environments.					
TOTAL SCORE SECTION IV						
TOTAL APPLICATION SCORE						

Overall Grant Feedback

Overall Strengths of the Proposal:
Overall Weaknesses of the Proposal:
Suggestions for Improvements/Technical Assistance Areas:

Reviewer Notes

RFA COMMUNITY ENGAGEMENT PLAN TABLES

Applicants must provide a detailed plan for community engagement according to the required components in the RFA Community Engagement Plan Reference Document, including identified gaps and plans to address gaps. **Applicant's Community Engagement Plan must be no more than 4 pages (according to the RFA spacing and font restrictions), excluding tables. Tables should be completed in the format provided below and submitted with Applicant's Community Engagement Plan (narrative).**

Table 1: Stakeholders to be included in the engagement process			
All applicants must complete this full table. Applicants may add rows as needed.			
Part 1a. List stakeholder types to be included in the engagement process. Applicants must include, at a minimum, plans to engage the following stakeholder types: OHP consumers, community-based organizations that address disparities and the social determinants of health ("SDOH-HE"), providers, including culturally specific providers as available (includes physical, oral, behavioral, providers of long term services and supports, traditional health workers and health care interpreters), Regional Health Equity Coalitions (if present in the service area), early learning hubs, local public health authorities, local mental health authorities, other local government, and tribes. Add additional rows as needed.	**Part 1b.** List specific agencies, organizations and individuals, based on the stakeholder types identified in Part 1.a, with which the applicant will engage. Add additional rows under the stakeholder type as needed.	**Part 1b.** Describe why each listed agency, organization and individual was included.	**Part 1b.** Describe how Applicant plans to develop, maintain or strengthen relationships with each stakeholder and maintain a presence within the community.
OHP consumers (list in first column below)			
To be determined as we form LCACs and RCAC	OHP Members	Gain insight from member perspective	We will seek Member involvement on the LCACs and RCAC
Community-based organizations that address disparities and SDOH-HE (list in first column below)			
Local Housing Authority	Northwest Oregon Housing Authority (NOHA); Todd Johnston	Develop, plan and coordinate housing development	We have an active partnership relationship with Mr. Johnston. *(Letter of support requested)*
Community Action Agency	Clatsop Community Action Agency	Address housing (rental assistance, case management, transitional housing) and food insecurity; child services and home visiting	Build upon existing early childhood services partnership
Community Action Agency	Columbia Community Action Team (C.A.T.)	Address housing and food insecurity; child services and home	Build upon existing partnership

		visiting - – serves all three counties	
Community Action Agency	Community Action Resource Enterprises (CARE), Inc. (Tillamook Community Action)	Address housing and food insecurity; child services and home visiting; domestic violence	Build upon existing partnership
Basic Needs	Turning Point Community Center (Columbia)	Food and other basic needs in emergency crisis situations	Build partnership
Basic Needs	Hope of Rainier	Emergency service to meet basic needs (food/necessities)	Build partnership
Foster children	FosterClub	Connect, inform and build empowerment for young people in foster care system	Build partnership
Hispanic/Latino advancement	Jorge Gutierrez, Lower Columbia Hispanic Council; partner on NW Early Learning Hub; stakeholder in early learning and services for Hispanic/Latino families	Promotes health, education, and social and economic advancement of area Latinos	Build upon existing partnership
Social support – youth and LGBTQ	Lower Columbia Q Center	Social support for young people in sobriety and LGBTQ population	Build / strengthen partnership
Recovery Housing	Helping Hands	Coordinate and address housing needs for people in SUD recovery	Regular meetings; build upon existing partnership
Domestic Violence	Clatsop County Women's Resource Center	Coordinate and address needs for victims of domestic violence	Regular meetings
Domestic Violence	The Harbor	Advocacy, prevention and support for domestic violence, sexual assault and stalking	Build upon existing partnership
Domestic Violence	SAFE	Survivor support and prevention re: domestic and sexual assault, stalking, intimate partner violence	Build upon existing partnership
Domestic Violence	Tillamook County Women's Resource Center	Shelter, helpline, support groups, education re: domestic violence and sexual assault	Build upon existing partnership
Department of Human Services	DHS-District One; Amy Youngflesh	Coordinate and prioritize services for people with self-sufficiency, child welfare involvement and vocational rehabilitation needs	Build upon existing partnership *(Letter of support requested)*
Disability Services	Northwest Senior and Disabled Services (Clatsop and Tillamook)	Coordinate services; participate in MDT	Establish partnership

Food Bank	Clatsop Community Action Regional Food Bank	Address food insecurity	Establish partnership
Senior and Disability Services	Northwest Senior and Disability Services	Senior nutrition, caregiver training, project independence, info and referral	Establish partnership
Employment	Oregon Employment Dept. (WorkSource)	Vocational rehabilitation, job preparation and education, job search and resume assistance	Establish partnership
Transportation	Sunset Empire Transportation	Bus service in Clatsop County	Establish partnership
Transportation	Northwest Ride Center	Transportation or gas reimbursement for eligible health plans	Strengthen existing partnership
Providers, physical health, including culturally specific providers as available (list in first column below)			
Hospital and primary care service provider	EOCCO Equity partner on CCO endeavor Columbia Memorial Hospital	Integrate Care, Continuity of Care, Coordination of Care, Emergency Department Utilization Strategies	Build/strengthen existing partnership, share data
Hospital and primary care service provider	Equity partner on CCO endeavor Adventist Health – Tillamook Regional Medical Center	Integrate Care, Continuity of Care, Coordination of Care, Emergency Department Utilization Strategies	Build/strengthen existing partnership, share data
Hospital and primary care service provider	Providence Seaside Hospital	Integrate Care, Continuity of Care, Coordination of Care, Emergency Department Utilization Strategies	Build/strengthen existing partnership, share data
Primary care service provider	Equity partner on CCO endeavor Northwest Medical Foundation of Tillamook dba Adventist Health Tillamook	Integrate Care, Coordination of Care, Preventative Care and Screenings, Emergency Department Utilization Strategies	Build/strengthen existing partnership, share data
Primary care service provider	Manzanita Primary & Specialty Care	Integrate Care, Coordination of Care, Preventative Care and Screenings, Emergency Department Utilization Strategies	Build/strengthen existing partnership
Primary care service provider	North County Health Center – Rockaway Beach	Integrate Care, Coordination of Care, Preventative Care and Screenings, Emergency Department Utilization Strategies	Build/strengthen existing partnership
Primary care service provider	South County Health Center - Cloverdale	Integrate Care, Coordination of Care, Preventative Care and Screenings, Emergency Department Utilization Strategies	Build/strengthen existing partnership

Primary care service provider	Tillamook Central Health Clinic - Tillamook	Integrate Care, Coordination of Care, Preventative Care and Screenings, Emergency Department Utilization Strategies	Build/strengthen existing partnership, share data
Primary care service provider	The Rhinehart Clinic & AMP Pharmacy	Integrate Care, Coordination of Care, Preventative Care and Screenings, Emergency Department Utilization Strategies	Build/strengthen existing partnership, share data
Primary care service provider	Nehalem Bay Health	Integrate Care, Coordination of Care, Preventative Care and Screenings, Emergency Department Utilization Strategies	Build/strengthen existing partnership
Primary care service provider	Pacific Family Medicine	Integrate Care, Coordination of Care, Preventative Care and Screenings, Emergency Department Utilization Strategies	Build/strengthen existing partnership
Primary care service provider	Wimahl Family Clinic	Integrate Care, Coordination of Care, Preventative Care and Screenings, Emergency Department Utilization Strategies	Build/strengthen existing partnership
Primary care service provider	A Natural Path Integrative Healthcare Services	Coordination of Care, Preventative Care and Screenings	Build/strengthen existing partnership
Primary care service provider	Partner in CCO endeavor Astoria Women's Health – Columbia Memorial Hospital	Coordination of Care, Preventative Care and Screenings, Emergency Department Utilization Strategies	Build/strengthen existing partnership, share data
Primary care service provider	Providence Health System – Providence Cannon Beach Clinic and Seaside Clinic	Integrate Care, Coordination of Care, Preventative Care and Screenings, Emergency Department Utilization Strategies	Build/strengthen existing partnership, share data
Primary care service provider	Providence Medical Group Warrenton Clinic	Integrate Care, Coordination of Care, Preventative Care and Screenings, Emergency Department Utilization Strategies	Build/strengthen existing partnership, share data
Primary care service provider	Equity partner in CCO endeavor Yakima Valley Farmworker Clinic - Coastal Family Health Center	Integrate Care, Coordination of Care, Preventative Care and Screenings, Emergency Department Utilization Strategies	Build/strengthen existing partnership, share data
Primary care service provider	Equity partner in CCO endeavor Community Health Center of	Integrate Care, Coordination of Care, Preventative Care and	Build/strengthen existing partnership, share data

	Clatskanie - Yakima Valley Farmworkers Clinic	Screenings, Emergency Department Utilization Strategies	
Primary care service provider	Clatskanie Clinic	Integrate Care, Coordination of Care, Preventative Care and Screenings, Emergency Department Utilization Strategies	Build/strengthen existing partnership
School-based health center	Equity partner in CCO endeavor Clatskanie Middle School – Yakima Valley Farmworkers Clinic School-based health center	Integrate Care, Coordination of Care, Preventative Care and Screenings	Build/strengthen existing partnership, share data
School-based health center	Spencer Health and Wellness: Vernonia Schools	Integrate Care, Coordination of Care, Preventative Care and Screenings	Build/strengthen existing partnership
Specialty service provider	Midwives – Lower Columbia Clinic	Preventative Care and Screenings	Build/strengthen existing partnership
Specialty provider	Birthdance Midwifery - Nehalem	Preventative Care	Build/strengthen existing partnership
Specialty service provider	The Oregon Clinic – Advanced Urology Associates	Preventative Care	Build/strengthen existing partnership
Providers, behavioral health, including culturally specific providers as available (list in first column below)			
Community Mental Health Provider	Clatsop Behavioral Healthcare Amy Baker; Contracted provider; represented on GOBHI BOD	Providing Community Based Care, Coordination of Care, Screenings, ED Utilization Strategies	Continue to strengthen partnership, data sharing
Community Mental Health Provider	Columbia Community Mental Health Center; Julia Jackson; Contracted provider; represented on GOBHI BOD	Providing Community Based Care, Coordination of Care, Screenings, ED Utilization Strategies	Continue to strengthen partnership, data sharing
Community Mental Health Provider	Tillamook Family Counseling Center Frank Hanna-Williams; Contracted provider; represented on GOBHI BOD	Providing Community Based Care, Coordination of Care, Screenings, ED Utilization Strategies	Continue to strengthen partnership, data sharing
Contracted Mental Health and Substance Use Disorder Provider	Choices Counseling	Providing Community Based Care, Coordination of Care, Screenings, ED Utilization Strategies	Continue to strengthen partnership
Substance Use Disorder Provider	CODA, Tim Hartnett; Working with provider to develop new MAT services	Providing Community Based Care, Coordination of Care, Screenings, ED Utilization Strategies	Continue planning and working with provider on developing MAT services in NW region
Providers, oral health, including culturally specific providers as available (list in first column below)			

DCO partner and oral health provider	ODS Community Dental : Arrow dental	Care Coordination, Screening	Strengthen existing DCO and provider partnerships, data sharing
Providers, long term services and supports, including culturally specific providers as available (list in first column below)			
Residential SUD treatment	Columbia Community Mental Health Center-Pathways, Julia Jackson; Part of existing network with GOBHI	Community Based Higher Level of Care, Care Coordination, Discharge Planning	Build upon existing partnership, data sharing
MH Respite and Residential Service Provider	Clatsop Behavioral Healthcare – North Coast Crisis Respite Center, Amy Baker; Supported development; funded infrastructure	Community Based Higher Level of Care, Care Coordination, Discharge Planning	Build upon existing partnership, data sharing
MH Residential Center	Mental health residential programs operated by Columbia Community Mental Health Center Julia Jackson; Part of existing network with GOBHI	Community Based Higher Level of Care, Care Coordination, Discharge Planning	Build upon existing partnership, data sharing
Youth Psychiatric Residential Service Provider	Jamie Vandergon, President, Trillium Family Services	Community Based Higher Level of Care, Care Coordination, Discharge Planning	Build upon existing partnership, data sharing (See letter of support.)
Providers, traditional health workers, including culturally specific providers as available (list in first column below)			
GOBHI's contracted peer support specialists in Clatsop, Columbia and Tillamook Counties (CMHPs)	Amy Baker, Julia Jackson and Frank Hanna-Williams	Peer Support Specialists for SUD recovery	Continue partnership; review data from providers quarterly and collaborate on quality improvement activities
Wraparound Process Peer Supports	Family and peer navigators within all Wraparound programs throughout Clatsop, Columbia and Tillamook Counties	Peer and family supports for children/youth/families involved in Wraparound.	Continue existing partnership; explore successes and challenges and share information and data.
Family and youth supports provider	Sandy Bumpus, Oregon Family Support Network	Family navigators and supports for families with children who have significant behavioral health needs and are multi-system involved	Continue partnership; continue to meet regularly (See letter of support.)
CHW training program	Moda Health in partnership with OSU, Ann Custer at OSU	Training, reimbursement, community support, provider support	Strengthen existing partnership with OSU to offer CHW certification training to NWCCO members/clinic staff. Expand CHW billing policy.

Providers, health care interpreters (list in first column below)			
CCO's contracted interpretation vendor	Passport to Languages	Telephonic and in-person interpreter service personnel	Expand and strengthen existing partnership
GOBHI's contracted interpretation vendor	Language Line	Telephonic and in-person interpreter service personnel	Expand and strengthen existing partnership
Early learning hubs (list in first column below)			
Northwest Early Learning Hub	Dorothy Spence; active partner	Early learning hub for the region	Mature existing partnership exists; build upon partnership to ensure engagement with CACs
Local public health authorities (list in first column below)			
Clatsop Public Health Department	Clatsop County Health and Human Services, Clatsop County Department of Public Health Michael McNickle; History of partnering on grant applications; housing proposal for women's supportive housing	Public and environmental health services Primary care Home Visiting Programs	Build upon existing partnership; strengthen collaboration and engage in CAC, data sharing
Columbia Public Health Department	Columbia County – Columbia Health Services Columbia County Public Health Clatskanie Health Center Rainier Health Center Sacagawea Health Center – Lewis and Clark Elementary School Spencer Health and Wellness Sherrie Ford;	Public and environmental health services Primary care School-based health services WIC Home Visiting Programs	Build upon existing partnership; strengthen collaboration and engage in CAC, data sharing
Tillamook Public Health Department	Tillamook County Community Health Center Tillamook Central Health Department and Centers for Family Health North County Health Center South County Health Center	Public and environmental health services Primary care clinics Home Visiting Programs	Build upon existing partnership; strengthen collaboration and engage in CAC, data sharing
Local mental health authorities (list in first column below)			
Clatsop LMHA	Clatsop County Clatsop Behavioral Healthcare Amy Baker; active partnership and contractual relationship	Community Mental Health Provider (CMHP), Coordination of Care, Crisis Response, Screenings, ED Utilization Strategies	Continue to build upon existing partnership and formal contractual relationship with new CCO entity structure

Columbia LMHA	Columbia County Columbia Community Mental Health Center Julia Jackson; active partnership and contractual relationship	Community Mental Health Provider (CMHP), Coordination of Care, Crisis Response, Screenings, ED Utilization Strategies	Continue to build upon existing partnership and formal contractual relationship with new CCO entity structure
Tillamook LMHA	Tillamook Family Counseling Center Frank Hanna-Williams; active partnership and contractual relationship	Community Mental Health Provider (CMHP), Coordination of Care, Crisis Response, Screenings, ED Utilization Strategies	Continue to build upon existing partnership and formal contractual relationship with new CCO entity structure
Other local government (list in first column below)			
Tribes, if present in the service area (list in first column below)			
No tribes in service area	NA	NA	NA
Regional Health Equity Coalitions, if present in the service area (list in first column below)			
None.	NA	NA	NA
Add additional stakeholder types here (list in first column below)			
Add additional stakeholder types here (list in first column below)			
Developmental disability service provider	Coast Rehabilitation Services – developmental disability services Bill Coker, Executive Director	Care Coordination	Build upon existing partnership
Developmental disability service provider	Clatsop County Developmental Disability Services Office	Care Coordination	Develop partnership
Developmental disability service provider	Clatsop Care Center	Care Coordination	Develop partnership
Developmental disability service provider	Northwest Senior and Disability Services	Care Coordination	Develop partnership
Developmental disability service provider	Columbia Community Mental Health and Disability Services	Care Coordination	Develop partnership
Developmental disability service provider	Senior and Disabled Services – St. Helens	Care Coordination	Develop partnership
Developmental disability service provider	Columbia County Aging and Disability Resource Center	Care Coordination	Develop partnership
Developmental disability service provider	Marie Mills Center, Inc.	Care Coordination	Develop partnership
Developmental disability service provider	Tillamook Family Counseling Center	Care Coordination	Develop partnership

Add additional stakeholder types here (list in first column below)			
Advocacy and prevention re: Opioid Use Disorders	Jordan's Hope - advocacy re: opioid use/misuse History of partnership on opioid use/misuse prevention	Prevention, Community Education	Continue existing partnership
Add additional stakeholder types here (list in first column below)			
Transportation provider	Astoria Senior Center – transportation	Access to care	Develop partnership
Transportation provider	Astoria Transit Center/Northwest Ride Center	Access to care	Develop partnership
Transportation provider	Tillamook County Transportation District	Access to care	Develop partnership
Transportation provider	Marie Mills Center, Inc.	Access to care	Develop partnership
Add additional stakeholder types here (list in first column below)			
Medical supply	Avada Oregon Hearing Center	Care coordination	Develop partnership
Medical supply	Bayside Audiology	Care coordination	Develop partnership
In home care	North Coast Home Care	Care coordination	Develop partnership
Medical supply	Pacific Coast Medical Supply, Inc.	Care coordination	Develop partnership
Add additional stakeholder types here (list in first column below)			
Advocacy organization focused on individuals and families impacted by mental illness	National Alliance on Mental Illness (NAMI) of Oregon	Coordination on projects and advocacy work.	Continue existing partnership; strengthen focus of partnership in NW region (See letter of support.)
Center of Excellence - EASA	Tamara Sale, Director, OHSU-PSU School of Public Health	Coordination and technical assistance on fidelity EASA programs in the region.	Continue existing partnership; strengthen focus of partnership in NW region (See letter of support.)
Statewide advocacy organization focused on early childhood emotional health and wellbeing	Dr. Sherri Alderman, President, Oregon Infant Mental Health Association (ORIMHA)	Planning re: communications, messaging, and outreach to families with children five and under; early brain development and parenting	Continue existing partnership; strengthen focus of partnership in NW region (See letter of support.)

Table 2: Major activities and deliverables for which the CCO will engage the community	
All applicants must complete this full table.	
Part 2a. List and describe the five to eight major projects, programs and decisions for which the CCO will engage the community.	**Part 2b.** Identify the level of community engagement for each project, program and decision. Answers* must be 1) inform/communicate, 2) consult, 3) involve, 4) collaborate, or 5) shared decision-making. Applicant may include more than one level of engagement for each project, program or decision to account for differences among stakeholder groups.
1. Implement and sustain trauma-informed care across all sectors	Consult with all partners and stakeholders implementing trauma-informed care (behavioral health, primary care, education, early learning) regarding what is working and what is needed to move this effort forward. Collaborate and coordinate with Trauma Informed Oregon and trauma-informed care trainers on delivering training as needed in the region based on input from stakeholders.
2. Nutrition and food access – Veggie RX	Share decision-making with LCACs on use of Community Benefit Reinvestment funds. Consult with local farmer's markets regarding participating in the Double Up Food Bucks program. Develop a Veggie Rx Advisory Council and share decision-making with the Advisory Council, comprised of counties where Veggie Rx is operated. Inform Oregon Food Bank of food insecurity screenings that are to take place and potential increase in referrals to food banks. Inform community gardens about the opportunities to participate in these efforts through in-person conversations.
3. Prevent alcohol, other drug and tobacco misuse/abuse	We will collaborate with local prevention specialists and local public health in each county who are responsible for overseeing community SUD and tobacco prevention plans and services. We will facilitate information sharing for both CAC and non-CAC community members so there is a good understanding of the framework guiding prevention services and funding in the region. Opportunities for collaboration, coordination and capacity building will be explored and documented.
4. Community Health Worker expansion to EDs	Consult and share decision making with current community health workers that are providing services in the ED to determine best practices. Provide technical assistance to hospital systems with EDs to encourage use of CHWs as well as provide training on NWCCO's billing policy. We are working to expand the current billing policy to include telephonic services. Additionally, NWCCO plans to collaborate with OSU to implement a CHW continued education course around the role of CHWs in the ED. NWCCO will utilize the THW liaison for support in creating training materials in consultation with the THW Commission.

5. Develop affordable housing for people with complex health and behavioral health needs	We will build upon successful collaboration with NOHA in developing affordable and supportive housing in the region. We will facilitate engagement and collaboration between NOHA, other agencies providing housing supports, and the CACs through the CAC agendas and informal connection events specific to the topic of housing. Shared decision-making with NOHA will be facilitated through project-specific funding opportunities and a statement of mutual goals and objectives. CACs and NOHA will be consulted regarding the best approach to documenting shared goals and objectives.
6. Mental Health First Aid (Suicide prevention)	Through our existing MHFA training experts and collaborators from the Association of Oregon Community Mental Health Programs (AOCMHP), we will expand MHFA training (both adult and adolescent versions) throughout the region in an effort to reduce stigma associated with seeking help for mental health and to reduce suicidal ideation at a population level. We will consult with and collaborate with CMHPs in the region. We will also collaborate with the LCACs, RCAC, local public health authorities, primary care clinics, hospitals, schools, early learning and family service providers among others to ensure that the trainings are reaching the right audiences, publicized accordingly and to monitor progress meeting mutually identified objectives.
7. Expand tele-health and tele-behavioral health (Bonnie)	Tele-behavioral health services delivery was started in January 2019. Expansion of services will take place throughout 2019, with additional HRSA grant funding available in Fall of 2020 and 2021. Consult with CACs, CMHPs, SUD providers and PCPCHs on ideas on how to best utilize technology. Involve care delivery partners on how to best design, develop and roll-out tele-behavioral health services with goals of improving access, decreasing barriers to care, and reducing costs. Collaborate with Members and partners on innovative ways to utilize tele-behavioral health.
8. Provider data progress reports and support	In keeping with our value of true transparency, we will provide data progress reports monthly to the entire provider network. We will inform providers about the structure of these reports and technical assistance available to them in using the data. We will keep the LCACs and RCAC informed of this activity and offer to provide summary information to them.

*****

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

Table 3: Engagement with other agencies in the service area that have responsibility for developing community health assessments and community health improvement plans					
All applicants must complete this full table. Applicants may add rows as needed.					
Part 1. Applicants with an existing CCO CHA and CHP will submit their most recent CHA and CHP with the community engagement plan.					
Part 2. List of all local public health authorities, non-profit hospitals, other CCOs that share a portion of the service area, and any federally recognized tribe in the service area that is developing or has a CHA/CHP. Add additional rows as needed.	**Part 3.** The extent to which each organization was involved in the development of the Applicant's current CHA and CHP. Answers***** must be a) competition and cooperation, b) coordination, c) collaboration, or d) not applicable (NA).******	**Part 4.** For any organization that is a collaborator for a shared CHA and shared CHP priorities and strategies, the applicant will list the shared priorities and strategies.******	**Part 5.** For any organization that is not a collaborator for a shared CHA and shared CHP priorities and strategies, the applicant will describe the current state of the relationship between the applicant and the organization(s), including gaps.	**Part 6.** For any organization that is not a collaborator for a shared CHA and shared CHP priorities and strategies, the applicant will describe the steps the applicant will take to address gaps prior to developing the next CHA and CHP, and the dates by which the applicant will complete key tasks.*******	**Part 7.** Applicants **without an existing CHA and CHP or that intend to change their service area** will demonstrate that they have reviewed CHAs and CHPs developed by these other organizations. List the health priorities from existing plans.
Local public health authorities (list in this column below)					
Clatsop County Health and Human Services	NA	NA	NA	NA	Reviewed documents. Identified priorities: Prevent disability and provide adaptive services; Prevent and manage chronic diseases; Prevent SUD; Reduce crime; Promote education and school retention; Improve housing and incomes; Improve access to healthcare; Plan for environmental changes

Columbia County Public Health	NA	NA	NA	NA	Reviewed documents. Identified priorities: Chronic disease prevention (obesity focus; tobacco focus); mental health promotion and SUD prevention (prescription drug abuse focus) ; Arthropod-Borne illness prevention; Occupational injury prevention
Tillamook Central Health Department and Centers for Family Health	NA	NA	NA	NA	Reviewed documents. Identified priorities: Access to medical care; access to oral health care; access to behavioral health care; childhood obesity; provider capacity/human resources; capacity for prevention/health promotion
Non-profit hospitals (list in this column below)					
Adventist Health Tillamook	NA	NA	NA	NA	Reviewed documents. Identified needs: Access to Healthcare; Chronic disease prevention; Behavioral health with emphasis on SUD; Children's health

Columbia Memorial Hospital and Providence Seaside Hospital	NA	NA	NA	NA	Reviewed documents (combined Community Health Needs Assessment); Identified needs: Access to care; Behavioral health; Chronic conditions; Social determinants of health and well-being
Current coordinated care organizations, as of 2019 (list in this column below)					
Columbia Pacific CCO	NA	NA	NA	NA	Reviewed and have been engaged in CHA/CHP development. Identified and emerging needs: Reduce rate of obesity; improve mental health outcomes and reduce SUD; preventing suicide; Creating resiliency in children; Increasing healthy activities
Federally recognized tribes that have or are developing a CHA/CHP (list in this column below)					
None	NA	NA	NA	NA	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.**	
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.					
No federally recognized tribes in region.	NA	NA	NA	NA	NA
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.					
No health equity coalitions.	NA	NA	NA	NA	NA
Local government, including counties					
Clatsop County Department of Public Health (Community Health Advocacy and Resource Team (CHART) – impact policy, system and environmental system to improve health of Clatsop County residents.)				Unknown	Presenting at their "Places Matters" conference in June 2019. Engage group in discussion regarding CAC process and CCO before end of December 2019.
Columbia County Public Health				Unknown	Reach out to establish partnership by December 31, 2019; Following up regarding engagement with CAC or other mechanism by February 28, 2020.

Tillamook County Community Health Center – Tillamook Central Health Department (public health)				Unknown	Reach out to establish partnership by December 31, 2019; Following up regarding engagement with CAC or other mechanism by February 28, 2020.
Organizations that address the four key domains of social determinants of health* (list in this column below).					
Northwest Oregon Housing Authority (NOHA)				Unknown	Active partnership exists; Continue meeting monthly; discuss CCO and CAC engagement by December 31, 2019.
Columbia Community Action Team (C.A.T.) (All three counties)				The organization was explicitly involved in developing one or more CHAs or CHPs.	Active partnership exists; build upon partnership by engaging in CAC by end of December 2019.
Clatsop Community Action (basic needs; regional food bank)				Unknown	Active partnership exists re early learning; Meet with leadership re: CCO engagement by February 28, 2020.
Community Action Resource Enterprises (CARE), Inc.				Unknown	Reach out to establish connection by December 31, 2019; Meet with leadership by February 28, 2020.
Helping Hands (recovery housing provider)				Unknown	Active partnership exists; connect with leadership re: CCO and CAC engagement by February 28, 2020.

DHS District One: Child Welfare and Self Sufficiency				Unknown	Active partnership exists; Continue monthly meetings.
Worksource Oregon				Unknown	Reach out to establish connection by December 31, 2019; Meet with leadership by February 28, 2020.
Migrant Education Programs in all counties				Unknown	Reach out to partners and engage them by February 28, 2020.
NW Early Learning Hub				The organization was explicitly involved in developing one or more CHAs or CHPs.	Active partnership exists; build upon partnership by engaging in CAC by end of December 2019.
Rob Saxton, School Superintendent of NW Regional ESD				Unknown	Active partnership exists through early learning hub governance; Begin discussions regarding NWCCO by April 30, 2019; Follow-up re: CCO engagement by December 31, 2109.
Northwest Senior and Disability Services				Unknown	Reach out to partners and engage them by February 28, 2020.
Northwest Ride Center				Unknown	Reach out re: CCO and CAC engagement by February 28, 2020.

Traditional Health Workers (THWs) affiliated with organizations listed in OAR 410-141-3145 (list in this column).					
Clatsop Behavioral Healthcare Peer Support Specialists including Wraparound peer and family supports				Unknown	Recruit peers interested in serving on CAC by February 28, 2020.
Columbia Community Mental Health Peer Support Specialists including Wraparound peer and family supports				Unknown	Recruit peers interested in serving on CAC by February 28, 2020.
Tillamook Family Counseling Peer Support Specialists				Unknown	Recruit peers interested in serving on CAC by February 28, 2020.
GOBHI Wraparound Peer and Family Supports in Columbia County, St. Helens				The organization was explicitly involved in developing one or more CHAs or CHPs.	GOBHI is an equity partner in this CCO endeavor as well as the Wraparound service provider in Columbia County.
Moda Health in partnership with OSU				The organization was not explicitly involved in developing a CHA or CHP.	Reach out to OSU about offering CHW training to NWCCO member/clinic staff by December 31, 2019.

Culturally specific organizations and organizations that work with underserved or at-risk populations (list in this column below).					
Lower Columbia Hispanic Council	NA	NA	NA	Unknown	Active partnership exists through NW Early Learning; Contact Jorge Guttierez before December 31, 2019. Engage in CAC or explore other regular connection through meetings, etc…
Lower Columbia Q Center				Unknown	Reach out to build connection by December 31, 2019
Other organizations (list in this column below).					
***The four key domains of social determinants of health are economic stability, education, neighborhood and built environment, and social and community health.					
****Engagement activities **must** begin by March 31, 2020 and applicant will report on progress through the June 2020 CCO CHP progress report.					

Table 5: Assessment of existing social determinants of health priorities and process to select Year 1 social determinants of health priorities		
All applicants must complete this full table to describe how the applicant will identify social determinants of health ("SDOH-HE") priorities to meet the CCO SDOH-HE spending requirements. Housing must be included as one of the SDOH-HE spending priorities.		
Part 1. List of existing SDOH-HE CHP priorities* in applicant's proposed service area from its own CHP or other existing CCO, local hospital, local public health authority and/or tribal CHPs, if applicable. Add additional rows as needed.	**Part 1a.** Source for priority (i.e. which CHP it came from).	**Part 1b.** Whether priority describes a health outcome goal (i.e. addressing food insecurity to address obesity as a health issue) **or** priority populations (i.e. addressing early childhood education for children as a priority population) **or** other.
Affordable, safe and habitable housing	CCO CHP; Clatsop County Health and Human Services (public health); Columbia Memorial Hospital	Health Issue: affordable, safe housing linked to better health outcomes
Nutrition and food access	CCO CHP; Columbia County Public Health	Health Issue: improving nutrition and health food access linked to better health outcomes
Increasing access to healthy activities	CCO CHP; Columbia County Public Health	Health Issue: increased time spent in healthy activities promotes better health outcomes
Creating Resiliency in Children / Addressing ACEs	CCO CHP, Adventist Health Tillamook; Columbia Memorial Hospital	Health Issue: mitigating the impact of toxic stress associated with better health outcomes
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.		
NWCCO Process to Identify and Vet SDOH-HE Priorities: **July – August 2019:** **(Notice of Intent to Award – July 2019)** Implementation activities related to CAC structure for NWCCO Review updated CHA/CHP from existing CAC efforts associated with CPCCO including SDOH-HE priorities **August – September 2019:** Continue recruiting and developing CAC structure for NWCCO		

Conduct outreach to new partners and stakeholders representing underserved populations; use a modified focus group method similar to our protocol in EOCCO to identify new or emerging SDOH-HE needs that have not yet been identified **September – October 2019:** Finalize CAC structure and formal documents/charters Complete focus groups with underserved populations/service providers working with these populations Reach out to housing authority and community action agencies regarding CAC engagement **November – December 2019**: Compile findings from stakeholder process Refresh and augment data from existing CHA/CHP in areas related to SDOH-HE **January – February 2020:** Include housing topic on all CAC agendas; engage NOHA and Community Action Agencies in meetings Consult with CACs on SDOH-HE priorities **March – April 2020:** March 15 – submit SDOH-HE priorities per OHA guidance
*****Applicants must include description of housing priority if already identified in CHPs. (e.g. housing overall, housing for targeted populations).
******The four key domains of social determinants of health are economic stability, education, neighborhood and built environment, and social and community health. Refer to the Social Determinants of Health and Health Equity Glossary reference document.

NWCCO Community Engagement Plan

1.0 General Component:

NWCCO, through our equity partner GOBHI, has built significant, meaningful partnerships with a wide range of community partners in the region since inception of the Coordinated Care Model in 2012. Moving forward as a new CCO, we will continue to strengthen collaboration and outreach to OHP Members, local government, healthcare providers, and community-based organizations to understand the continually changing needs of our Members. We will formalize our community engagement by creating and supporting infrastructure for three Local Community Advisory Councils (LCAC) serving Clatsop, Columbia, and Tillamook Counties and a Regional Community Advisory Council (RCAC) serving the region.

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

NWCCO will engage community stakeholders in the region representing health, wellness and Social Determinants of Health/Health Equity (SDOH-HE) needs of our Members. In addition to the LCAC structure, which includes OHP Member representation, we will continue to collaborate directly with all the entities referenced in Table 1. This includes stakeholders addressing SDOH-HE through indirect healthcare services for the most vulnerable people in the region, including housing, food, child care, transportation, and social and economic advancement. We will also continue to support a consumer caucus comprised of people with lived experience in the mental health area. NWCCO will support a field team, comprised of community engagement and integration specialists living in the service area, to build and nurture the LCAC, RCAC and broader community engagement strategy (See CAC Component 2.0 below). Efforts will build upon our existing community engagement activities including continued involvement with the Northwest Early Learning Hub Governance Council, ongoing partnership with Northwest Oregon Housing Authority on housing development projects, and engagement with local community safety and justice partners to best meet the needs of people who are involved, or at risk of involvement, in the justice system to name a few. We are encouraged by cross sector efforts to implement and sustain trauma-informed care in this region and will continue to promote and support this work.

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

As community partnerships within the NWCCO region continue to evolve in tandem with the dynamic nature of an organizations' infrastructure and leadership, so too will our relationship and engagement by our NWCCO teams. We will engage in future collaborations that move the priorities forward as defined by the community during stakeholder processes recently conducted, including implementing trauma-informed care across all sectors; improving nutrition and food access; preventing substance use / misuse including tobacco; and preventing suicide. In addition, we will continue to strengthen our collaboration with organizations addressing housing and basic needs, primary health providers, faith-based organizations and entities working to advance social and economic conditions for vulnerable and underserved people in the region.

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

The NWCCO process for gathering input from LCAC and non-LCAC members (healthcare providers, other community partners, broader community) will be standardized through

LCAC policies and by-laws. We believe true transparency is essential to health system transformation. All LCAC and LCAC subcommittee meetings will be open to the public and dates, times, locations of meetings, past meeting minutes, current CHA and CHP documents will be published on the NWCCO website. Representatives from each of the three LCACs will meet quarterly on an RCAC to discuss more regionally based engagement and concerns. Two representatives of the RCAC will be members of the NWCCO Board of Directors and represent the "voice" of the three LCACs. One of these RCAC members will be an OHP Member or parent/guardian. The RCAC will also provide representation and formal input to the Board of Directors through an Annual Report (submitted yearly in June), which will highlight positive efforts within the NWCCO region as well as areas and recommendations for improvement. The Annual Report, presented by one of the delegated RCAC members, helping to influence policy changes and guide adjustments to how OHP resource/services are implemented.

1.4. Member voice:

NWCCO strives to embody the concept of *"nothing about me without me"* as a mantra within the CCO model of care. Consumer input is vital to meeting the Triple Aim, ensuring health equity, and driving meaningful change. This requires targeted engagement strategies designed to remove participation barriers and increase member understanding of health system transformation. Our Consumer Caucus will act as an advisory group providing feedback regarding proposed new programs, changes within the delivery system, or ideas for improvement. Formal complaints and appeals collected from the NWCCO will be summarized and reported annually to the RCAC. This exchange of information will ensure that any changes in NWCCO workflows will be effectively vetted and communicated to the RCAC, LCAC and ultimately shared with our community partners and OHP consumers on a regular basis.

1.5 Addressing barriers to community engagement:

NWCCO will employ qualified, trusted local members of the NWCCO team to provide "boots on the ground" engagement within the community on a regular basis. Each LCAC will engage community partners by sharing local, regional and statewide health trend data, helping to inform service needs and barriers to quality care in their community. To maintain consistency and continuity of LCAC membership (including OHP membership) and meetings, each of the three counties will initially be allocated $10,000 annually to support an LCAC coordinator dedicated to overseeing the day to day functioning of the LCAC and recruitment of OHP Members. Additionally, OHP Members participating in LCAC meetings are, and will continue to be, offered a monthly $35 stipend, including mileage reimbursement and childcare, as an incentive to reduce the barrier of LCAC attendance. When transformation or quality pool bonus dollars become available to NWCCO, additional funding can be made available to support LCAC-driven initiatives, similar to the EOCCO model of LCAC program funding. NWCCO values the diversity of its consumer members and understands the importance of equity, therefore all of the meeting spaces will be accessible to individuals with disabilities and accommodate language needs. LCAC orientation sessions have been developed to provide appropriate literacy level information to help consumers understand the organization and operations of the NWCCO.

1.6 Quality improvement:

The quality improvement process for the NWCCO LCACs is an iterative process, operating on multiple levels; at the local level through LCACs and at the regional level through the

RCAC. Data will be shared at the individual, clinic, and CCO level to facilitate improvement. One of the yearly directives tasked to each of the three LCACs will be to establish and/or review each LCACs Community Health Plan (CHP) based on information from local data sources (i.e. Hospital Community Health Assessment, Public Health Needs Assessment, CCO Community Health Assessment) and community partner or member input. NWCCO will also assign Community Benefit Initiative Reinvestment (CBIR) funds to each LCAC to support programs in alignment with the communities CHP and/or CCO Incentive Measures. A less formal quality improvement approach is to establish time during the LCAC meetings to address OHP consumer concerns. These concerns, if not resolved locally in collaboration with community partners, will be elevated and will be included in the Annual Report to the NWCCO Board of Directors.

2.0 CAC Component:

2.1.a. The NWCCO service area includes three counties varying in population: Tillamook - 25,920; Clatsop – 38,225; and, Columbia - 50,795 for a combined total population of 114,940. The territory covers roughly 3,105 square miles and is bounded on the north and east by the Columbia River and on the west by the Pacific Ocean. Because each of the counties in the service area are vastly unique, the NWCCO will establish three LCACs which will meet monthly and one RCAC which will meet at least quarterly. Each LCAC will be represented on the RCAC, and the Chair is a voting member. LCACs are intended to represent the diversity of their community, including race/ethnicity, age, gender identity, sexual orientation, socio-economic and geographic location. A charter will govern each LCAC. Our model in Eastern Oregon will be used as a template, and will include the following language:

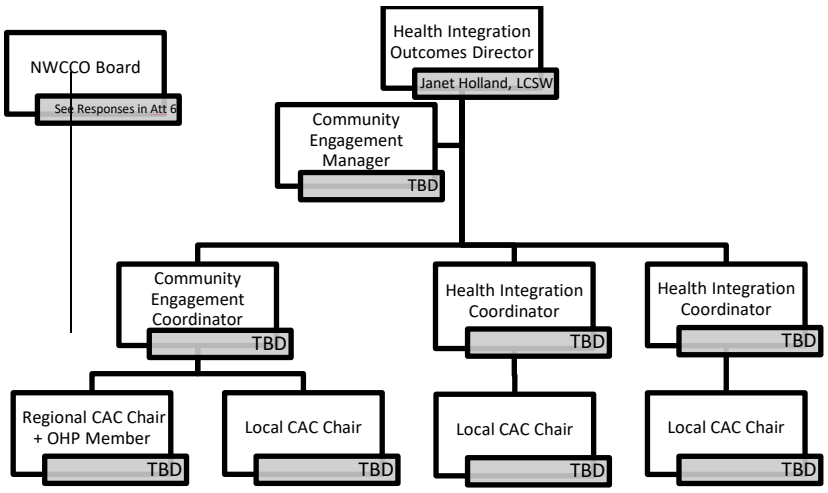
"…to the greatest extent possible, membership should reflect individuals or agencies representing the; healthcare provider community (for example a physician, nurse, dentist, etc.); social service agencies including DHS, hospice, local school districts; public health services; publicly funded mental health and substance use treatment; someone representing county government and general community members. For Medicaid members we have age/ gender, zip code (geography) and preferred language."

The recruitment/retention strategies for the LCACs will include dedicated NWCCO staff working locally to recruit local healthcare partners (physical, mental and oral), service agencies, early learning partners, OHP members and other community partners who service the OHP population. Each LCAC will devise strategies to incorporate OHP consumer members into the LCAC and manage meaningful engagement of all community partners. Some of these strategies include the following: 1) Provide visual displays, public promotion and use of social media to engage membership and understanding of LCAC, 2) development of OHP consumer subcommittees to discuss service/resource issues in each community, 3) alternating meeting schedules to accommodate all LCAC members and 4) alternating locations to allow for a more diverse approach to outreach (i.e. input from outlying communities in a rural, underserved area). These approaches have been used in our other service areas such as EOCCO to allow greater opportunity for LCAC members to contribute and stay engaged in the CHP prioritization process, input of services/resources, funding discussions for CBIR funds and other tasks as required by the CCO and Oregon Health Authority.

2.1.c. At least two RCAC representatives, at least one of whom is an OHP member, will serve on the NWCCO Board of Directors. We will partner the OHP RCAC Member with a fellow RCAC Member to act as a mentor. This partnership will allow for a more succinct understanding of health system transformation and the CCO model, promoting empowerment for OHP consumer members through this process. While there are no federally recognized tribes in the region, we will make efforts to include tribal representation on the CACs

2.1.d. NWCCO will ensure collaboration between CACs if there are multiple CCOs covering the region. This will be formally structured through the LCAC charters, the RCAC charter, and through joint efforts related to data and information sharing, and collaboration in the development of the CHA and CHP.

Illustration 1: Proposed Community Engagement Structure for NWCCO



3. Description of CHA/CHP Component:

NWCCO plans to serve the three-county region and will submit the Community Health Plan to the OHA according to established timeframes for a new CCO. NWCCO, through our equity partner GOBHI, has been operating in this region for roughly 20 years and provided staff to lead the CHA analysis, community presentations, and community engagement processes in all three NWCCO counties. Therefore, we are intimately familiar with the region and the quantitative and qualitative data used to build the CHA and CHP. Further, as at least 3 NWCCO partners are also EOCCO partners, best practices for that region will be considered and adjusted to the NW Oregon region. After seeking additional input and confirmation of the priorities identified through the LCACs and RCAC, NWCCO will adopt and revise the CHA and CHP accordingly.

eocco EASTERN OREGON COORDINATED CARE ORGANIZATION		**Policy & Procedure**			
Company:	EOCCO	**Department Name:**		EOCCO Quality Improvement Committee	
Subject:	Interpreter Services for Non-English Speaking Members				
P & P Original Effective Date:	9/2012	**P &P Origination Date:**	**9/2012**	**P & P Published Date:**	**04/2015**
P & P Revision Effective Date:	8/12/16; 10/13/17	**P & P Revision Published Date:**		8/12/16; 10/13/17; 10/12/18	
Reference Number:	CCO-12	**Next Annual Review Date:**		10/2019	
Division:					

State (select all boxes applicable to this policy)

☐ Alaska ☒Oregon

Product (check all boxes applicable to this policy)

☒Dental ☒ Medical ☐ Pharmacy ☒ Behavior Health

Type of Business (check all boxes applicable to this policy)

☒EOCCO ☒ OHP

I. Policy Statement and Purpose

Eastern Oregon Coordinated Care Organization (EOCCO) and its subcontractors provide access to qualified interpreters for non-English speaking members when communicating telephonically or in-person with respective staff and to on-site interpreter services for member appointments at no charge to the member. EOCCO and its subcontractors translate required written material into the prevalent non-English languages identified in its CCO enrollment.

II. Definitions

A. Prevalent non-English language – all non-English languages that are identified as the preferred written language by the lesser of either 5% of a CCO's total OHP enrollment or 1,000 of the CCO's members.

B. Participating Provider – any practitioner that provides medical, behavioral health or dental services to EOCCO members.

C. Subcontractor – Any individual, partner, entity, facility or organization that has entered into a subcontract or administrative services agreement with EOCCO, or one of its partner organizations, for any portion of work under EOCCO's contract with OHA.

III. Procedures

A. Telephonic or in-person Interpreter Services at the CCO or subcontractor locations:

1. Qualified interpreters are available to communicate in the primary language of non-English speaking members. Such interpreters are linguistically appropriate and are capable of communicating in English and the primary language of the member and are able to translate clinical information effectively.
2. Through respective business agreements with multilingual and multicultural language services agencies, Moda Health, GOBHI and DCOs provide telephonic interpreter services during regular business hours. When a member calls Member Services and requires language assistance, the Member Service representative will access the interpreter services agency where a language service representative will assist in the call to optimize communication.
3. EOCCO and subcontractors also may have Member Services representatives who are bi-lingual and able to translate clinical information effectively.

B. Person-to-Person Interpreter Services at the Provider's Office:
1. EOCCO and its subcontractors have respective contracted person-to-person interpreter services for on-site provider office visits for members whose preferred language is other than English. The provider's office calls customer service at Moda Health, GOBHI or the DCO to schedule an interpreter at the provider's office. In some cases, the provider can call the language service agency directly to schedule an interpreter.

2. Provider offices may also have employees who are able to provide linguistically appropriate interpretation during an office visit. These employees are capable of communicating in English and the primary language of the member and are able to translate clinical information. While not a requirement for employees, EOCCO supports the completion of state medical interpreter qualification or certification exams.

C. Translated Written Materials:
1. EOCCO and its subcontractors translate written material into the prevalent non-English languages identified in the CCO enrollment. Practitioner directories remain in English as names, numbers, streets, cities, etc., are frequently either learned or referred to in English.

   Monthly, EOCCO and its subcontractors monitor the number of prevalent non-English languages in their enrollment to determine the languages that meet the criteria for translation of written material. EOCCO and its subcontractors contract respectively with multilingual and multicultural language services agencies to translate written material.

2. In the event EOCCO and its subcontractors receive member correspondence, such as general correspondence, appeals and complaints, written in the member's primary language that is not English, EOCCO and its subcontractors will respond accordingly in the member's primary language by accessing their contracted multilingual and multicultural language services agencies for translation.

IV. Communicating the Availability of Interpreter Services

EOCCO and subcontractor member handbooks and participating provider manuals include information and instructions on how to request interpreter services, and the timeframes involved.

V. Monitoring

The EOCCO Quality Improvement committee review member complaints quarterly for persistent or significant problems regarding access to interpreter services. The committee identifies areas for improvement and implements appropriate interventions.

VI. Related Policies & Procedures, Forms and References

VII. Revision Activity

New P & P /Change / Revision and Rationale	Final Review/Approval	Approval date	Effective Date of Policy/Change
Revised to EOCCO policy	EOCCO Quality Improvement Committee	04/10/15	04/10/15
Annual review	EOCCO Quality Improvement Committee	08/12/16	08/12/16
Annual review; updated to make more inclusive	EOCCO Quality Improvement Committee	10/13/17	10/13/17
Annual review; updated definitions: removed provider partner and replaced with participating provider and subcontractor definitions; updated text with new definitions	EOCCO Quality Improvement Committee	10/12/18	10/12/18

VIII. Affected Departments:

Request for Applications

LCAC Community Benefit Initiative Reinvestments

Table of Contents

Application Deadline: January 31, 2019

Background

Thanks to successful efforts in 2017 to improve care, Eastern Oregon Coordinated Care Organization (EOCCO) met 14 of the 17 CCO quality measures enabling the Board of Directors to reinvest approximately $726,000 in Local Community Advisory Council projects (see Appendix 2 for allocated amounts by county). Your LCAC can use this funding to develop and implement an innovative project to improve the health of your community.

Focus Area: 60 – 70 % of each LCAC's funds may be allocated to be used on projects that address the LCAC's CHP plan, including CHP-identified projects that address social determinants of health needs and enrollment in health insurance. 30 – 40% of each LCAC's funds must be allocated to be used to address CCO incentive measures, must focus on at least one incentive measure that the county isn't meeting, and must include a description of how the LCAC plans to address that deficiency.

Proposed projects must be distinct from all other applications. See **Appendix 4** for the latest EOCCO results by county on the incentive measures. A collaborative approach should be used to develop these proposals with the LCAC working to reach consensus on key issues using the LCAC Charter as a guideline.

Timeline: The earliest start date for projects is March 15, 2019 and all projects should end by March 14, 2020.

Application Instructions

Requirements for all Applications

1. Proposals that are not fully described or are otherwise incomplete may be returned to the applicant.

2. Proposals that substantially overlap in purpose and budget will not be considered for funding. A committee appointed by the EOCCO Board will make the final funding decisions, subject to approval by the EOCCO Board.

3. Support from the CBI program can be used to establish new roles within a community that are substantially devoted to improving the health and health care of EOCCO members. These positions should not be primarily administrative, with the exception of administrative support of LCAC activities. Grantees will be required to request decreasing amounts of funds over time and funds for such positions will not be provided beyond three grant cycles unless applicants can document the position is directly related to successful performance on EOCCO initiatives.

Submission Process:

1. **Application Forms:** To request EOCCO reinvestment funds, please follow the directions in this Request for Applications (RFA). Applications should include the Application Coversheet, a Project Narrative covering all questions described in the RFA, a Budget and a Budget Justification, and any required Letters of Commitment.

2. **Submission:** Send your full application in a **single** PDF to Sankirtana Danner at danners@ohsu.edu and Anne King at kinga@ohsu.edu **by 5 pm PDT on January 31, 2019**.

Important Note: You will receive an email indicating that your application has been received. If you do not receive that email within 24 hours, please contact Sankirtana or Anne.

3. **Timeline:** Applicants should hear about the status of their requests in March 2019. The earliest start date for projects is March 15, 2019 and all projects should end by March 14, 2020. A committee appointed by the EOCCO board will make the final funding decisions subject to approval by the EOCCO Board.

4. **Technical Assistance:** OHSU staff members are available to answer questions and to provide feedback on your project design and evaluation plan. Please contact Sankirtana Danner danners@ohsu.edu or Anne King kinga@ohsu.edu and they will provide help or find the best person to provide assistance.

LCAC Community Benefit Initiative Project Application Coversheet

Name of LCAC: _____

Project Director (person who will be responsible for the overall project):

Name: _____

Title: _____

Organization: _____

Address: _____

Phone Number: _____ Email: _____

Name of Organization to Receive and Manage Funds:

Organization Name: _____

Address: _____

Name of Employee Managing Funds: _____

Phone Number: _____ Email: _____

County Coordinator Name: _____ Email: _____

Total Amount Requested (can be less than the amount allocated, but not more): **$**_____

Project Title: _____

Start Date: _____/_____/_____ **End Date:** _____/_____/_____

Project Purpose (do not exceed space below):

Signatures:

I hereby certify that this proposal has been developed and fully approved by our LCAC for submission to the EOCCO. The statements contained in this application are true and complete to the best of the applicant's knowledge and the applicant accepts as a condition of the grant the obligation to comply with all applicable state and federal requirements, policies, standards, and regulations.

Signature of LCAC Chair: _____

Name: _____ Date: _____

Phone: _____ Email: _____

LCAC Community Benefit Initiative Project Narrative

*Please follow the instructions below to complete your project narrative, providing complete answers to each question. Project narratives may be **up to 5 pages**.*

A. Provide a detailed description of the project plan, including:

I. Project goals
II. Targeted incentive measures and CHIP goals. *Note:* at least one incentive measure that the county has historically struggled to meet must be addressed.
III. A detailed description of the planned activities
IV. A detailed timeline of activities

B. Describe the data you will collect to measure success of your project and how you will obtain the data. **Note:** If funded, you will be required to report on these data on interim progress reports and a year-end final report. Applicants must report on the **number of EOCCO and non-EOCCO members served**.

C. Complete the table below, including baseline data and goals you will use to measure success.
Note: This table has been revised from prior years. Please be sure to include actual available baseline data and create goals that take into account available data, such as your county's prior year rate, the numerator and denominator of patients if available, EOCCO targets, and the estimated number of members needed to reach the EOCCO target. Baseline data should be the prior year's final rate for the target population.

Targeted Metric	**Activity Planned**	**Metrics**	
EXAMPLE: *Dental sealants*	*AWC event with onsite dental sealant services*	*Baseline* *20/150 (number of kids who received sealants last year out of number eligible)*	*Goal* *75/150 (number of kids you aim to receive sealants this year out of number eligible)*
		Baseline	*Goal*
		Baseline	*Goal*
		Baseline	*Goal*

D. Please list each member of the project team, their organization (if applicable), and thoroughly describe their roles and responsibilities on the project. All activities that are proposed in Question A should be represented.

E. What could cause this project to have trouble or fail and how could you reduce this risk?

F. Please list the any collaborating organizations involved in your project and submit a Letter of Commitment from each collaborating organization. Any organization that is listed must submit a letter (see Appendix 3 for a template)

G. Describe a detailed plan for sustaining this effort once the project ends.

Appendix 1: LCAC Community Benefit Initiative Budget Template

Please use the template below for your budget. Funded activities may include, but are not limited to: personnel, travel expenses, meetings and supplies and consultants. Indirect costs are capped at 10%. Non-project related indirect expenses, funds for capital expenditures (e.g. major non-technology equipment, building renovations) and costs related to enhancing reimbursements or supporting state-covered services cannot be funded through these grants.

Note that 30-40% of funds must be used toward incentive measure(s) and 60-70% may be used toward CHIP related activities. **In the budget table below, indicate if this is an IM or CHIP related expense**.

Start date of project: _____ ***End date of project:*** _____

Budget Table

Budget									
Personnel:						**In-Kind Cash Contribution**	**In-Kind non-Cash Contribution**	**IM**	**CHIP**
Name	**Role**	**FTE**	**Salary Requested**	**Benefits Requested**	**Total Requested**				
Example: Jane Smith	*MA*	*.10*	*$5000*		*$5000*			*X*	
Equipment and Supplies:									
Name of Item	**Description**				**Total Requested**				
Travel:									
Location	**Description**				**Total Requested**				
Other Expenses:									
Name of Item	**Description**				**Total Requested**				
Total IM									

Funds						
Total CHIP Funds						
GRAND TOTAL		**$**				

Budget Justification

Please provide a narrative budget justification detailing the costs included in your budget. If in-kind contributions are budgeted, please provide a list of the source of each contribution, the name of the organization providing it and whether the donation is in cash or non-cash (e.g. labor, etc.)

Appendix 2: 2019 LCAC Funding Amounts

County	Membership as of 6/1/18	40% Distributed Equally	60% Membership Distribution	Totals
Baker	XXXX	$24,211	$35,115	**$59,326**
Gilliam	XXX	$24,211	$3,083	**$27,294**
Grant	XXXX	$24,211	$12,909	**$37,120**
Harney	XXXX	$24,211	$18,129	**$42,339**
Lake	XXXX	$24,211	$16,039	**$40,250**
Malheur	XXXX	$24,211	$89,297	**$113,507**
Morrow	XXXX	$24,211	$25,373	**$49,583**
Sherman	XXX	$24,211	$2,879	**$27,090**
Umatilla	XXXX	$24,211	$161,356	**$185,567**
Union	XXXX	$24,211	$53,922	**$78,132**
Wallowa	XXXX	$24,211	$15,055	**$39,265**
Wheeler	XXX	$24,211	$2,638	**$26,848**
TOTALS	**XXXXX**	**$290,529**	**$435,794**	**$726,323**

Appendix 3: Letter of Commitment Template

Agreement to Participate in EOCCO Project

Dear ***Name of project director,***

We look forward to participating in the ***Project Name*** starting ***date*** and ending ***date.***

Our organization agrees to ***describe what the collaborating organization is expected to do including any staff responsibilities.*** We understand that we will receive ***list any funds being provided to the collaborating organization.***

Thank you for including us in this important project.

Sincerely,

Signature
Name spelled out
Organization name
Email address
Phone number

Appendix 4: EOCCO 2017 Incentive Measure Performance by County

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Progress Report- County Summary

2017 Final Results

Current Reporting Period: Services Incurred 1/1/2017-12/31/2017 as of 3/31/2018

Prior Reporting Period: Services Incurred 1/1/2017-12/31/2016 as of 3/31/2017

Measure Compliance Rate								
County	Adolescent Well Care Visits	Childhood Immunizations	Colorectal Cancer Screening	Dental Sealants	Developmental Screening	Effective Contraceptive Use	Ambulatory Care & ED Utilization	Alcohol and Drug Misuse
Baker	33.1%	84.0%	41.7%	29.1%	69.1%	54.6%	51.1	11.0%
Gilliam	50.0%	85.7%	29.6%	32.2%	50.0%	30.3%	37.3	8.4%
Grant	29.8%	66.7%	25.1%	40.6%	43.3%	44.1%	63.0	5.3%
Harney	36.5%	79.2%	48.4%	42.5%	90.0%	51.3%	45.8	17.2%
Lake	36.4%	77.3%	45.1%	32.1%	39.7%	56.9%	40.1	18.1%
Malheur	36.7%	82.4%	43.6%	23.0%	84.0%	47.0%	55.7	13.4%
Morrow	46.2%	68.8%	40.5%	24.4%	43.6%	49.6%	50.0	24.0%
Sherman	42.2%	50.0%	41.9%	30.4%	62.5%	33.3%	32.1	17.8%
Umatilla	39.5%	79.1%	44.1%	24.0%	47.2%	49.1%	53.6	15.1%
Union	39.0%	66.7%	39.1%	17.8%	82.8%	48.2%	62.8	21.7%
Wallowa	47.9%	78.3%	53.7%	16.8%	80.0%	44.7%	30.7	7.6%
Wheeler	24.0%	50.0%	41.0%	62.5%	80.0%	63.3%	35.1	38.5%
EOCCO Rate	38.6%	77.3%	42.7%	24.6%	62.8%	49.0%	53.1	15.3%
EOCCO 2017 Target Rate	37.3%	72.9%	43.9%	20.0%	57.3%	48.1%	51.8	15.0%

Numerator/Denominator Counts								
County	Adolescent Well Care Visits	Childhood Immunizations	Colorectal Cancer Screening	Dental Sealants	Developmental Screening	Effective Contraceptive Use	Ambulatory Care & ED Utilization	Alcohol and Drug Misuse
Baker	145/438	42/50	149/357	173/595	123/178	219/401	2283/44668	235/2142
Gilliam	17/34	6/7	8/27	19/59	6/12	10/33	147/3937	17/202
Grant	57/191	14/21	42/167	78/192	26/60	67/152	1095/17379	50/936
Harney	69/189	19/24	92/190	99/233	99/110	100/195	1004/21899	127/739
Lake	67/184	17/22	78/173	72/224	31/78	99/174	809/20197	138/764
Malheur	489/1334	136/165	252/578	397/1728	488/581	439/935	6130/110109	670/5001
Morrow	180/390	44/64	68/168	109/447	92/211	117/236	1547/30927	284/1185
Sherman	19/45	1/2	13/31	14/46	5/8	10/30	125/3898	37/208
Umatilla	942/2384	258/326	482/1094	725/3027	532/1126	833/1697	11127/207517	1290/8521
Union	299/767	64/96	149/381	179/1007	280/338	326/677	4394/69962	655/3020
Wallowa	90/188	18/23	102/190	40/238	52/65	68/152	593/19302	83/1088
Wheeler	6/25	1/2	16/39	20/32	12/15	19/30	115/3278	77/200
Total	2380/6169	620/802	1451/3395	1925/7828	1746/2782	2307/4712	29369/553073	3663/24006

Progress Report- Baker County
2017 Progress

Current Reporting Period: Services Incurred 1/1/2017-12/31/2017 as of 3/31/2018
Prior Reporting Period: Services Incurred 1/1/2017-12/31/2016 as of 3/31/2017

Measure	2017 Target	Rate	Numerator/ Denominator	Member count needed to meet target*
Adolescent Well Care Visits	37.3%	33.1%	145/438	18
Childhood Immunizations	72.9%	84.0%	42/50	-
Colorectal Cancer Screening	43.9%	41.7%	149/357	8
Dental Sealants	20.0%	29.1%	173/595	-
Developmental Screening	57.3%	69.1%	123/178	-
Effective Contraceptive Use	48.1%	54.6%	219/401	-
Ambulatory Care & ED Utilization	51.8	51.11	2283/44668	
Alcohol and Drug Misuse	15.0%	11.0%	235/2142	86

**For all measures except ED Utilization, this represents the estimated number of additional members needed in the numerator to meet the target.*

Progress Report- Gilliam County

2017 Progress

Current Reporting Period: Services Incurred 1/1/2017-12/31/2017 as of 3/31/2018

Prior Reporting Period: Services Incurred 1/1/2017-12/31/2016 as of 3/31/2017

Measure	2017 Target	Rate	Numerator/ Denominator	Member count needed to meet target*
Adolescent Well Care Visits	37.3%	50.0%	17/34	-
Childhood Immunizations	72.9%	85.7%	6/7	-
Colorectal Cancer Screening	43.9%	29.6%	8/27	4
Dental Sealants	20.0%	32.2%	19/59	-
Developmental Screening	57.3%	50.0%	6/12	1
Effective Contraceptive Use	48.1%	30.3%	10/33	6
Ambulatory Care & ED Utilization	51.8	37.34	147/3937	
Alcohol and Drug Misuse	15.0%	8.4%	17/202	13

**For all measures except ED Utilization, this represents the estimated number of additional members needed in the numerator to meet the target.*

Progress Report- Grant County

2017 Progress

Current Reporting Period: Services Incurred 1/1/2017-12/31/2017 as of 3/31/2018
Prior Reporting Period: Services Incurred 1/1/2017-12/31/2016 as of 3/31/2017

Measure	2017 Target	Rate	Numerator/ Denominator	Member count needed to meet target*
Adolescent Well Care Visits	37.3%	29.8%	57/191	14
Childhood Immunizations	72.9%	66.7%	14/21	1
Colorectal Cancer Screening	43.9%	25.1%	42/167	31
Dental Sealants	20.0%	40.6%	78/192	-
Developmental Screening	57.3%	43.3%	26/60	8
Effective Contraceptive Use	48.1%	44.1%	67/152	6
Ambulatory Care & ED Utilization	51.8	63.01	1095/17379	
Alcohol and Drug Misuse	15.0%	5.3%	50/936	90

**For all measures except ED Utilization, this represents the estimated number of additional members needed in the numerator to meet the target.*

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Progress Report- Harney County
2017 Progress

Current Reporting Period: Services Incurred 1/1/2017-12/31/2017 as of 3/31/2018
Prior Reporting Period: Services Incurred 1/1/2017-12/31/2016 as of 3/31/2017

Measure	2017 Target	Rate	Numerator/ Denominator	Member count needed to meet target*
Adolescent Well Care Visits	37.3%	36.5%	69/189	1
Childhood Immunizations	72.9%	79.2%	19/24	-
Colorectal Cancer Screening	43.9%	48.4%	92/190	-
Dental Sealants	20.0%	42.5%	99/233	-
Developmental Screening	57.3%	90.0%	99/110	-
Effective Contraceptive Use	48.1%	51.3%	100/195	-
Ambulatory Care & ED Utilization	51.8	45.85	1004/21899	
Alcohol and Drug Misuse	15.0%	17.2%	127/739	-

**For all measures except ED Utilization, this represents the estimated number of additional members needed in the numerator to meet the target.*

Progress Report- Lake County
2017 Progress

Current Reporting Period: Services Incurred 1/1/2017-12/31/2017 as of 3/31/2018
Prior Reporting Period: Services Incurred 1/1/2017-12/31/2016 as of 3/31/2017

Measure	2017 Target	Rate	Numerator/ Denominator	Member count needed to meet target*
Adolescent Well Care Visits	37.3%	36.4%	67/184	2
Childhood Immunizations	72.9%	77.3%	17/22	-
Colorectal Cancer Screening	43.9%	45.1%	78/173	-
Dental Sealants	20.0%	32.1%	72/224	-
Developmental Screening	57.3%	39.7%	31/78	14
Effective Contraceptive Use	48.1%	56.9%	99/174	-
Ambulatory Care & ED Utilization	51.8	40.06	809/20197	
Alcohol and Drug Misuse	15.0%	18.1%	138/764	-

**For all measures except ED Utilization, this represents the estimated number of additional members needed in the numerator to meet the target.*

Progress Report- Malheur County
2017 Progress

Current Reporting Period: Services Incurred 1/1/2017-12/31/2017 as of 3/31/2018
Prior Reporting Period: Services Incurred 1/1/2017-12/31/2016 as of 3/31/2017

Measure	2017 Target	Rate	Numerator/ Denominator	Member count needed to meet target*
Adolescent Well Care Visits	37.3%	36.7%	489/1334	9
Childhood Immunizations	72.9%	82.4%	136/165	-
Colorectal Cancer Screening	43.9%	43.6%	252/578	2
Dental Sealants	20.0%	23.0%	397/1728	-
Developmental Screening	57.3%	84.0%	488/581	-
Effective Contraceptive Use	48.1%	47.0%	439/935	11
Ambulatory Care & ED Utilization	51.8	55.67	6130/110109	
Alcohol and Drug Misuse	15.0%	13.4%	670/5001	80

**For all measures except ED Utilization, this represents the estimated number of additional members needed in the numerator to meet the target.*

EASTERN OREGON COORDINATED CARE ORGANIZATION

Progress Report- Morrow County

2017 Progress

Current Reporting Period: Services Incurred 1/1/2017-12/31/2017 as of 3/31/2018

Prior Reporting Period: Services Incurred 1/1/2017-12/31/2016 as of 3/31/2017

Measure	2017 Target	Rate	Numerator/ Denominator	Member count needed to meet target*
Adolescent Well Care Visits	37.3%	46.2%	180/390	-
Childhood Immunizations	72.9%	68.8%	44/64	3
Colorectal Cancer Screening	43.9%	40.5%	68/168	6
Dental Sealants	20.0%	24.4%	109/447	-
Developmental Screening	57.3%	43.6%	92/211	29
Effective Contraceptive Use	48.1%	49.6%	117/236	-
Ambulatory Care & ED Utilization	51.8	50.02	1547/30927	
Alcohol and Drug Misuse	15.0%	24.0%	284/1185	-

**For all measures except ED Utilization, this represents the estimated number of additional members needed in the numerator to meet the target.*

Progress Report- Sherman County

2017 Progress

Current Reporting Period: Services Incurred 1/1/2017-12/31/2017 as of 3/31/2018

Prior Reporting Period: Services Incurred 1/1/2017-12/31/2016 as of 3/31/2017

Measure	2017 Target	Rate	Numerator/ Denominator	Member count needed to meet target*
Adolescent Well Care Visits	37.3%	42.2%	19/45	-
Childhood Immunizations	72.9%	50.0%	1/2	1
Colorectal Cancer Screening	43.9%	41.9%	13/31	1
Dental Sealants	20.0%	30.4%	14/46	-
Developmental Screening	57.3%	62.5%	5/8	-
Effective Contraceptive Use	48.1%	33.3%	10/30	4
Ambulatory Care & ED Utilization	51.8	32.07	125/3898	
Alcohol and Drug Misuse	15.0%	17.8%	37/208	-

**For all measures except ED Utilization, this represents the estimated number of additional members needed in the numerator to meet the target.*

Progress Report- Umatilla County

2017 Progress

Current Reporting Period: Services Incurred 1/1/2017-12/31/2017 as of 3/31/2018

Prior Reporting Period: Services Incurred 1/1/2017-12/31/2016 as of 3/31/2017

Measure	2017 Target	Rate	Numerator/ Denominator	Member count needed to meet target*
Adolescent Well Care Visits	37.3%	39.5%	942/2384	-
Childhood Immunizations	72.9%	79.1%	258/326	-
Colorectal Cancer Screening	43.9%	44.1%	482/1094	-
Dental Sealants	20.0%	24.0%	725/3027	-
Developmental Screening	57.3%	47.2%	532/1126	113
Effective Contraceptive Use	48.1%	49.1%	833/1697	-
Ambulatory Care & ED Utilization	51.8	53.62	11127/207517	
Alcohol and Drug Misuse	15.0%	15.1%	1290/8521	-

**For all measures except ED Utilization, this represents the estimated number of additional members needed in the numerator to meet the target.*

EASTERN OREGON COORDINATED CARE ORGANIZATION

Progress Report- Union County

2017 Progress

Current Reporting Period: Services Incurred 1/1/2017-12/31/2017 as of 3/31/2018

Prior Reporting Period: Services Incurred 1/1/2017-12/31/2016 as of 3/31/2017

Measure	2017 Target	Rate	Numerator/ Denominator	Member count needed to meet target*
Adolescent Well Care Visits	37.3%	39.0%	299/767	-
Childhood Immunizations	72.9%	66.7%	64/96	6
Colorectal Cancer Screening	43.9%	39.1%	149/381	18
Dental Sealants	20.0%	17.8%	179/1007	22
Developmental Screening	57.3%	82.8%	280/338	-
Effective Contraceptive Use	48.1%	48.2%	326/677	-
Ambulatory Care & ED Utilization	51.8	62.81	4394/69962	
Alcohol and Drug Misuse	15.0%	21.7%	655/3020	-

**For all measures except ED Utilization, this represents the estimated number of additional members needed in the numerator to meet the target.*

Progress Report- Wallowa County

2017 Progress

Current Reporting Period: Services Incurred 1/1/2017-12/31/2017 as of 3/31/2018
Prior Reporting Period: Services Incurred 1/1/2017-12/31/2016 as of 3/31/2017

Measure	2017 Target	Rate	Numerator/ Denominator	Member count needed to meet target*
Adolescent Well Care Visits	37.3%	47.9%	90/188	-
Childhood Immunizations	72.9%	78.3%	18/23	-
Colorectal Cancer Screening	43.9%	53.7%	102/190	-
Dental Sealants	20.0%	16.8%	40/238	8
Developmental Screening	57.3%	80.0%	52/65	-
Effective Contraceptive Use	48.1%	44.7%	68/152	5
Ambulatory Care & ED Utilization	51.8	30.72	593/19302	
Alcohol and Drug Misuse	15.0%	7.6%	83/1088	80

**For all measures except ED Utilization, this represents the estimated number of additional members needed in the numerator to meet the target.*

Progress Report- Wheeler County

2017 Progress

Current Reporting Period: Services Incurred 1/1/2017-12/31/2017 as of 3/31/2018

Prior Reporting Period: Services Incurred 1/1/2017-12/31/2016 as of 3/31/2017

Measure	2017 Target	Rate	Numerator/ Denominator	Member count needed to meet target*
Adolescent Well Care Visits	37.3%	24.0%	6/25	3
Childhood Immunizations	72.9%	50.0%	1/2	1
Colorectal Cancer Screening	43.9%	41.0%	16/39	1
Dental Sealants	20.0%	62.5%	20/32	-
Developmental Screening	57.3%	80.0%	12/15	-
Effective Contraceptive Use	48.1%	63.3%	19/30	-
Ambulatory Care & ED Utilization	51.8	35.08	115/3278	
Alcohol and Drug Misuse	15.0%	38.5%	77/200	-

**For all measures except ED Utilization, this represents the estimated number of additional members needed in the numerator to meet the target.*

Traditional Health Worker (THW) Integration and Utilization Plan

Background – Building regional capacity

NWCCO is dedicated to the support, reimbursement and continuous training of THWs to help improve member outcomes and provide sustainable support to the communities they serve. NWCCO will not employ THWs or Community Health Workers (CHWs) but instead support their local employment as needed. This provides for local support and expertise, while creating jobs within the region.

NWCCO will build on EOCCO's early success with THWs through dedicated funding for THW initiatives, including reimbursement at a fee-for-service (FFS) basis and funding for the development of a regional OHA certified CHW training program. As a result, EOCCO developed a CHW billing and payment policy to help ensure a sustainable revenue source for the EOCCO provider partners that employ CHWs. We expect to follow this model for support.

Because NWCCO expects that THWs will be employed locally by community partners, clinics and hospitals, member communication and engagement must be focused at the community level. NWCCO's care coordination team and case management team will work with clinics, through multiple channels, including the county multi-disciplinary teams, to work on referring members to resources within their communities, including the availability of THWs.

CCO 2.0 and the future of THWs

THW Integration into the delivery system

NWCCO will build successful integration of THWs into the service area through the following activities:

- Locally employing THWs as needed
- Hiring a THW Liaison
  - THW Liaison will convene THWs across the NWCCO service area to provide support and resources
- Offering CHW training courses, continuing education and leadership certification in partnership with OSU
- Utilizing best practices learned through the THW Commission

Member communication of benefits and availability of services

- NWCCO will continue to focus member communication of benefits and availability of services at the local community level and collaborate with THWs in the service area.
- NWCCO will publish THWs in the provider directory.
- NWCCO will support the use of THWs through care coordination and case management services available to members.

- The NWCCO THW Liaison will promote the network of THWs in the service area at local Community Advisory Councils, the Regional Community Advisory Councils, as well as health fairs and other community events.

Increase THW Utilization

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

Additionally, NWCCO will work on implementing a model to pay Public Health and provider clinics a per member per month (PMPM) to perform THW services. The contract will include the requirement to that the entity provides data using the THW Minimum Reporting Requirements Template, in lieu of traditional encounter claims billing.

NWCCO will survey partners to identify the number of THWs, utilization trends and to identify clinics with additional support/needs.

Implementation of THW Commission best practices

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

NWCCO THW Liaison will also share learnings from the THW Commission at Community Advisory Councils, as well as health fairs and other community events.

NWCCO will focus our approach for implementation by limiting new areas to 1-2 best practices each year for the region. This will allow the THW Liaison to evaluate the efficacy of the best practice and have the THWs focus on key areas of implementation. However, the THW Liaison will deploy best practices at the individual level, as needed by a specific THW employer.

Baseline utilization and performance measurement

NWCCO expect to track utilization and claim encounters as part of our Transformation and Quality Strategy (TQS). In 2020-2024, NWCCO plans to collect the following measurements:

- Track encounter claims and data reported by providers on the THW Minimum Reporting Requirements Template
- Conduct annual THW survey, after obtaining baseline data in 2020. The survey will also incorporate the fields of the THW Minimum Reporting Requirements Template
- Incorporate the THW Minimum Reporting Requirements Template into the contract for Public Health, to ensure proper reporting
- Continue to utilize the evaluations from the CHW training
- Monitor grievance and appeals for any reports of inappropriate use and accessibility of THWs
- Annual reporting to the NWCCO Board related to the THW survey

Utilization of THW Liaison to increase recruitment and retention

NWCCO will hire a THW Liaison to participate in the THW Commission, and certify as a CHW. The THW Liaison will be charged with holding at least annual listening tours in the NWCCO service area to best understand the challenges and success; and to provide support to the THW workforce.

The THW Liaison will also collaborate and be a point of contact for all THWs in the service area. In an effort to retain and build local support, the position will provide billing support, recruitment best practices, implement THW Commission best practices, and help support providers.

Attachment 10 — Social Determinants of Health and Health Equity

A. Community Engagement

1. Evaluation Questions

a. Did Applicant obtain Community involvement in the development of the?

While we look forward to continued collaboration and partnership, NWCCO partners have engaged the community in the development of this application. That work is reflected in the Community engagement plan, discussed below. In addition to the Clatsop, Columbia, and Tillamook county community meetings, noted below. NWCCO partners will continue to engage the community in the geographic service areas to increase participation, partnership, and collaboration with providers, community organizations and residents of the region throughout 2019. Proposed interventions and CHIP priorities will be presented and proposed changes/updates will be integrated into plans launching on 1/1/2020.

Date	Location/Method	Summary of Participants
March 15, 2019	Astoria / In Person	All potential equity partners meeting/visioning: Moda, GOBHI, Adventist Health, Columbia Memorial Hospital, Rinehart Clinic, Yakima Valley Farm Workers
April 2, 2019	Mail	Letter to behavioral health providers
April 5, 2019	E-mail message	Columbia County Local Community Advisory Council
April 12, 2019	NWESD Offices / In person	Met with school superintendent and Northwest Educational Service District staff

b. Applicant will submit a plan via the RFA Community Engagement Plan for engaging key stakeholders, including OHP consumers, Community-based organizations that address disparities and the social determinants of health, providers, local public health authorities, Tribes, and others, in its work. The Plan will include strategies for engaging its Community Advisory Council and developing shared Community Health Assessments and Community Health Improvement Plan priorities and strategies.

NWCCO will support three Local Community Advisory Councils (LCAC) and one Regional CAC. We expect these bodies to represent a broad set of stakeholders including local government, public health, OHP members, and health and human service focused non-profit organizations dedicated to meeting the social, educational, and cultural needs for people of all ages and backgrounds in the region. We will support a process for continued development of the Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) to include all LCACs and the RCAC. Please refer to the Community Engagement Plan and required tables for details.

2. **Requested Documents**
   Completed RFA Community Engagement Plan, including all required elements as described in RFA Community Engagement Plan Requirement Components and attaching required Tables in RFA Community Engagement Plan Required Tables (page limit: 4 pages, excluding tables)

   See NWCCO Community Engagement Plan and required tables included with our submission.

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

1. Informational Questions

a. Does Applicant currently hold any agreements or MOUs with entities that meet the definition of SDOH-HE partners, including housing partners? If yes, please describe the agreement.

Housing: NWCCO, through GOBHI, is partnering with Clatsop County to increase supportive housing options for women in SUD recovery. Clatsop County's donation of property is key to this effort. Funding and programmatic resources for this project are part of a collaboration between Oregon Housing and Community Services (OHCS), GOBHI, and many other community, public and private philanthropic funds. The initial development will house up to 6 single, pregnant/parenting women with peer mentoring and comprehensive health and addiction recovery services provided by Clatsop Behavioral Healthcare (CBH). The Northwest Oregon Housing Authority (NOHA) has committed project-based subsidies for extremely low income residents. Written agreements are in place with NOHA for property and HUD voucher management. We are working on an official operating agreement with partners to effectively define roles, execute programs, and sustain operational and fiscal resources.

Using this and other successful housing models NWCCO will work with community partners to identify local areas of need and develop additional partnerships to increase housing resources, support individuals who face housing insecurity, and to provide whole-person wellness support at home that is accessible to people with transportation or mobility issues.

Early Learning: A NWCCO partner currently, sits on the NorthWest Early Learning Governance Council. The Council oversees the work of the Early Learning Hub and, with the feedback and input of county advisory councils, provides insight and feedback on how best to meet the needs of young children and families in Clatsop, Columbia, and Tillamook counties.

Children's System of Care (SOC) Wraparound: NWCCO partner, GOBHI, has agreements with all NW local branches of DHS (child welfare and self-sufficiency), juvenile departments, OYA, ESDs, school districts, and developmental disabilities to sit on Wraparound Review Committees, Practice Level Workgroups, and Executive Steering Committees. GOBHI also has agreements that are often not typically available within other CCOs, but show a positive impact on social determinants and health equity. Examples include: Therapeutic Foster Care, Applied Behavior Analysis (ABA), and Regional Developmental Disability program.

As a result of this decade-long close relationship with DHS Child Welfare, GOBHI is working with a local DHS branch to share a family support worker for NWCCO families with high risk youth. This discussion emerged as a result of problem solving meetings with Child Welfare about a shared concern of youth leaving hospital episodes of care on Fridays and

parents/caregivers feeling ill equipped and fearful about the weekend to come. This family support worker will provide skills training, parent consultation, and crisis prevention services on a Thursday through Monday schedule, with flexible hours of work to respond in the evenings as needed to support children and families.

Youth and Family Grant Funding: We currently hold agreements with the following programs with funding from GOBHI's (NWCCO partner) Youth and Family grant program:

- *Tillamook Trauma Behavior Classroom:* The behavior/therapy classroom is designed for students grades K-3, targeting from 4 to 8 students. The overall goal is to increase access to education for these behaviorally at risk students who have not been successful in regular classrooms. Without appropriate behavioral interventions, these students pose a safety and learning risk to themselves and other students. The project aims to provide students with a therapeutic classroom setting developing the social/emotional skills to re-integrate into a regular education classroom setting within 6-9 months.
- *Reach Out Oregon:* A new initiative of the Oregon Family Support Network (OFSN), uses online outreach to build a more informed and engaged community network supporting families who are raising children and youth, ages 0-21, with behavioral and mental health challenges. Through web-based tools and social media, the project aims to promote healing, prevent isolation, and increase mental health support for Oregon families. Reach Out Oregon will recruit community volunteers to augment its existing pool of trained peers. The proposed investment supports implementation of Reach Out Oregon in Clatsop, Columbia, and Tillamook counties, as part of a pilot pool of six Oregon Counties in 2018, followed by rapid expansion to all of the state of Oregon by end of 2020.
- *Follow-up Pathways for Young Children Identified in Primary Care at-risk for Social-Emotional Delays:* The aim of this project is to develop and pilot implementation of specific tools and strategies meant to increase the number of young children and their families (target population) who receive behavioral health and specialty infant and early childhood supports. The key partners in this project are two primary care sites (OHSU Family Medicine Clinic – Scappoose and Columbia Memorial Hospital- Pediatric Office) who serve young children and their families, and two mental health agencies (Columbia County Mental Health (CCMH) and Clatsop Behavioral Health (CBH)) who have specific staff that provide specialty infant and early childhood mental health services.

Use of Peers for SUD Engagement: We provide infrastructure support by funding peer recovery coaching, outreach and engagement capacity in Clatsop, Columbia and Tillamook Counties through agreements with Community Mental Health Programs. The aim of this effort is to increase engagement in SUD services among individuals who have not yet accessed services, but exhibit indicators of emerging and serious life challenges associated with substance use/misuse. This effort is consistent with the OHA intent to expand access to SUD services based upon prevalence vs. historical utilization or penetration rates.

b. Does Applicant currently have performance milestones and/or metrics in place related to SDOH-HE? These milestones/metrics may be at the plan level or Provider level. If yes, please describe.

Because each community within the NWCCO service area faces significantly different challenges, we will utilize LCACs to identify and support locally-identified initiatives. This

means that each county/community identifies its most pressing issues through its LCAC and NWCCO funds projects to address them. At the regional level, NWCCO will support SDOH-HE issues to address transportation, housing, early learning and food insecurity.

Dedicated dollars will be committed only for the NWCCO counties as opposed to current CCO grant opportunities that are competitive across the full statewide footprint.

We expect processes to reflect our learnings through EOCCO but confirmed through NWCCO partnership collaboration:

1) Partner projects and programs use performance metrics created at the local level and must submit three progress reports each year, including a final report;
2) NWCCO SDOH-HE regional activities are measured by RCAC performance metrics, and reviewed mid-way to ensure enough time has passed to collect adequate data.

We expect performance metrics for partner programs to be created at the project level, and we will work collaboratively with partners to establish performance expectations and then review the results together quarterly. Successful projects will be considered for scope and scale expansion and those that do not meet measurement objectives will be reengineered or discontinued. For example, our Frontier Veggie Rx project in the EOCCO region was initially funded for one county. We worked with the county to create metrics for taking a count of the number of patients who were screened for food insecurity; the number receiving Veggie Rx "prescriptions"; and the number who redeemed those vouchers. In 2018, a total of 1,707 bags of fresh vegetables were redeemed. After the data was reviewed and the project deemed successful, we expanded it to two additional counties the following year, and have plans to add more counties in the future.

c. Does Applicant have a current policy in place defining the role of the CAC in tracking, reviewing and determining how SDOH-HE spending occurs? If yes, please attach current policy. If no, please describe how Applicant intends to define the role of the CAC in directing, tracking, and reviewing SDOH-HE spending.

NWCCO will adopt the policy currently used in EOCCO on the SDOH-HE CAC responsibilities for tracking, reviewing and determining SDOH-HE spending. This includes the requirement that 60-70% of allotted CAC funds be spent on SDOH-HE needs (see LCAC CBIR Application included with our submission). With this policy in mind, EOCCO is in the fifth year of its Community Benefits Initiative Reinvestment (CBIR) program. CBIR is a policy approved by the EOCCO Board to allocate 6% of each year's quality pool funding to CACs. The CACs are then responsible for determining how to use these funds for SDOH-HE and transformation projects that connect to their Community Health Improvement Plans (CHIPs), and how much of their funding allotment to spend on each project. CACs are then required to write up a summary plan which is submitted for feedback and approval. We are attaching the EOCCO documents that CACs use to apply for the CBIR funds including: 1) LCAC CBIR Application; 2) the CBIR Review Template; and 3) the CBIR Final Report Template. We expect NWCCO to replicate this process.

NWCCO plans that the amounts allocated to the LCACs will be calculated by adding a base funding amount plus an amount per member residing in the county. We have a robust policy and practice in our other service area for working with our LCACS in each county first to identify SDOH-HE needs; and then the RCAC reviews and approves spending.

For EOCCO, we have contracted for the past five years with the Oregon Rural Practice Based Research Network (ORPRN) to manage the CBIR program and provide feedback as well as Technical Assistance (TA) to LCACs and additional applicants. NWCCO expects to use the same process. TA often includes how to select appropriate interventions, evaluation metrics, and methods to measure impact. ORPRN then tracks these metrics as the LCACs report on their projects on a quarterly basis. This process will enable us and ORPRN to provide additional support to struggling projects and to continuously build the capacity of grantees to do transformation work. Each year ORPRN will work with our leadership to develop and review RFPs for LCAC and Transformation Grants (see LCAC CBIR Application included with our submission). NWCCO will continuously work to improve the process and increase the program's impact.

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

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

We plan to use the same outside agency that we use for EOCCO to set guidelines for the application and funding process of the SDOH-HE projects. Through an established review process, qualified personnel read and score each proposal using an established rubric. The current rubric guides reviewers to assess proposals using the domains of: Significance, Approach, Community and Staff, Impact and Sustainability, Strengths, Weaknesses, and Suggestions for Improvements and Technical Assistance (see CBIR Review Template included with our submission). Reviewers must not have conflicts of interest with the CCO, NW Oregon, or the applicants, and are not eligible to apply for funding. Reviewers are paired and practice scoring sample grants and discussing scores across the reviewer teams to improve inter-rater reliability. The two scores assigned by reviewer pairs are averaged prior to the final scores being submitted to the CBIR Subcommittee. At the beginning of each CBIR scoring Subcommittee meeting, all members disclose any conflicts of interest. Those with conflicts abstain from discussion and voting on those proposals. Once the CBIR Subcommittee completes its assessment, it makes recommendations to the Board which votes on approval or denial of funding.

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

We will ensure a transparent process for funding SDOH-HE projects through the RFP and review processes (see B.1.c. and B.1.d.(1).). This process will ensures that potential applicants are aware of the availability of funds, know how and when to apply, are assured that conflicts of interest are avoided, and are aware of how and when decisions are made. We will provide reviewer feedback to applicants, regardless of the outcome of their proposals. Reviewers of diverse backgrounds will be available to discuss and help applicants either improve upon their funded grant projects or hone their ideas for an application the following year. Finally, amounts of all awarded grants will be published on our website along with highlights about each funded project so that all applicants and community members know where funds have been committed.

All of the CBIR funding will be reinvested into the NWCCO service region. Six percent of these funds will be allocated to the LCACs in non-competitive funding. In addition, funds will be set aside for "opt in" projects and "new ideas" which are managed through the outside agency with the process referenced above. In addition, the NWCCO Board may make infrastructure investments that benefit the entire provider network. Two examples of this type of infrastructure

investment from our EOCCO region include an investment in Community Health Worker training through the Oregon State University Community Health Worker Training Program and the purchase of PreManage for the provider network.

To ensure an equitable process across all community organizations, we will use a straight-forward application form with brief questions written in plain language. This enables community-based organizations to develop and submit grants that can compete equally with health systems and clinics. Reviewers will be instructed to ignore things like poor grammar and spelling in proposals and work to understand the crux of each proposal, knowing that many issues can be addressed in technical assistance after an award. Additionally, NWCCO will provide each LCAC a minimum of $10,000 for LCAC Coordination. Part of the role of the LCAC Coordinator is to ensure that underrepresented or marginalized groups have representation on the LCACs. This diverse membership helps to ensure a more equitable process of decision making regarding which projects to propose each year for funding through LCAC dollars.

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

Applicants will be required to propose appropriate process and/or outcome metrics and report on metrics through two interim reports aimed at identifying and helping to address issues and a final report. After the award, ORPRN will work with grantees to provide feedback on their metrics, sometimes suggesting metrics that are more directly attributable to grantee projects or more impactful for assessing project results. In addition to the selected project-specific metrics, grantees will be required to report on overall project activities, how activities aligned with goals, number of NWCCO and non-NWCCO members served, significant changes to the project as planned, challenges and barriers and how they were addressed, expenditures, the most important outcomes of the project, and stories that capture the impact of the project (CBIR Final Report Template attached). Outcome metrics and project reports are then taken into consideration to refund future projects.

Outcomes of funded projects described above will be shared in a variety of ways with members, SDOH-HE partners and other key stakeholders. NWCCO LCACs will share the results of their projects with Members, SDOH-HE organizations, and other key stakeholders at monthly meetings, and minutes of these meetings are published online. Results of funded projects will also be shared across communities through quarterly RCAC meetings, which allows for learning and best practices to spread. Many projects will also be highlighted in the media which reaches a greater audience than the LCACs. The NWCCO Board of Directors, including an NWCCO Member, LCAC and community partner representatives, will receive presentations on the outcomes of funded projects delivered by staff and grantees at their meetings. Other presentations of project outcomes will be provided at NWCCO-sponsored meetings in participating communities. We have piloted a brief annual report in our other service area on the outcomes of funded projects with the Board of Directors and have plans to refine this document so that it can be shared more broadly.

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

NWCCO will use the following measures for making targeted investments in housing and assessing the impact:

- Pre- and post-housing Emergency Room Visits – Measuring from baseline to the end of the first year in supportive/ supported housing
- Housing Stability - Based on self-reporting for pre-placement as compared to placement length
- Residential and inpatient utilization – Similar as above, with desired outcome of reduced utilization
- Hospital bed days – Measuring from baseline to the end of the first year in supportive/supported housing
- Population specific outcome metrics would also be advantageous to collect as related to housing. This includes, but is not limited to, child welfare and legal involvement.
- Initiation of either SUD treatment or co-occurring treatment services
- Increased primary care utilization upon accessing affordable housing

2. Evaluation Questions

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

NWCCO will select SDOH-HE partners by identifying community-based entities who effectively deliver services and impact systems change related to SDOH-HE, and who address SDOH-HE priorities identified by the LCACs (see Required Tables; Table 1. and 4.). The LCACs will serve as subject matter experts in identifying organizations within their appropriate counties who support Members and may be interested in partnerships. This will include community based social and human service organizations such as local housing authorities and food banks. Culturally-specific organizations and government associated entities including neighboring tribes will also be identified as potential SDOH-HE partners. NWCCO has three public health entities and one Early Learning Hub with whom we currently partner. All are influential in addressing SDOH-HE and will be potential partners for new initiatives.

When determining which new or existing SDOH-HE partners to invest resources in, NWCCO will follow a similar approach to that of its CBIR program by engaging Members, LCACs, contracted providers and community organizations in identifying areas of need, releasing RFPs for organizations to respond to, and following a non-conflicted process to vet and select organizations to support. Also similar to the CBIR program, NWCCO will work with partners to select performance metrics and review progress toward project goals on a regular basis. Additional criteria may include: Historical performance with other contracts with GOBHI or NWCCO equity partners; Organizational capacity; and Interest and willingness to work with NWCCO staff in a collaborative manner.

b. Please describe how Applicant will broadly communicate the following information to the public and through its network of partners: its SDOH-HE spending priorities, the availability of funding for projects, how interested parties can apply for consideration, and the project selection process.

NWCCO will communicate SDOH-HE spending priorities, funding availability, application procedure, and project selection process similarly to how we currently communicate our CBIR funding. Spending priorities will be established by the Grant Subcommittee of the Board of Directors with input from LCACs and community partners. We will publish these priorities in RFPs released on the NWCCO website and through our email lists which, in the future, will include SDOH-HE organizations identified through the 211info inventory of community-based organizations plus any others identified by LCACs. RFPs will specify funds available in total

and by priority, how interested organizations can apply for consideration, and how the selection process will occur. Selection criteria will be included in the RFPs and applicants will be asked to select process and outcome metrics appropriate to the projects.

c. Please describe how Applicant will track and report SDOH-HE expenses and outcomes, including technological capacity and process for sharing and collecting data, financial systems, and methods for data collection.

Currently, we use a combination of claims, authorizations, EHR data, encounter data, EDIE/PreManage, member assessments/surveys, and more to perform risk stratification, measure health outcomes, calculate quality metrics, and provide reporting to providers. Since November 2015, we have been working with Arcadia Healthcare Solutions, a healthcare data aggregation and analytics company focused on equipping provider and payer organizations with integrated data, reporting, and analytics. Arcadia's core data aggregation platform Data Connect collects, normalizes, and stores clinical and claims data in a warehouse for advanced analytics and reporting. Arcadia also offers the Arcadia Analytics platform, a web-based population health management and analytics platform. More information can be found at www.arcadiasolutions.com. The Arcadia Analytics platform aggregates data from all of the different EHRs, claims software, and utilization management systems. This platform provides information on individual, organizational and CCO (population health) levels. Data is turned into actionable information through dashboards, alerts, gap in service notifications, report writing capabilities, and trend charts. Information can be filtered based on a variety of criteria, allowing for specific operational questions to be analyzed, including information regarding SDOH-HE population-specific indicators.

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

Specifically, NWCCO plans to administer an annual survey to all members. The survey tool will include validated questions regarding SDOH-HE needs. Once we receive outcome data we will incorporate it into our Analytics Data Warehouse (ADW). The ADW generates monthly provider progress reports which will be disseminated to all NWCCO clinics. This will encompass survey outcomes data including: housing status and quality, food insecurity, transportation needs for both medical and SDOH purposes, utility needs, safety, employment, and education. This data will provide clinics with additional opportunities to coordinate care beyond the medical setting. We will also share the NWCCO wide data with our SDOH-HE partners to stratify risk and complexities across patient panels and populations. These data will also be used to determine areas of SDOH-HE investments.

NWCCO will track SDOH-HE spending using quarterly cost and utilization reports. These reports are shared bi-annually with the EOCCO Board of Directors as well as the Clinical Advisory Panel. Additionally, we will track spending using the HRS funds that are allotted to SDOH-HE projects. Lastly, CBIR funding related to SDOH-HE will be tracked and reported by ORPRN.

d. Applicant will submit a plan for selecting Community SDOH-HE spending priorities in line with existing CHP priorities and the statewide priority on Housing-Related Services and Supports via the RFA Community Engagement Plan, as referenced in section A.

As referenced under A. 1. b., each CAC will review its Community Health Plan annually for relevancy and progress. A component of this work is to identify where there are opportunities to align the Community Benefit Reinvestment dollars assigned to the Local CAC with meeting Incentive Measures and/or implementing some portion of the Community Health Plan. Please see the NWCCO Community Engagement Plan for additional information.

C. Health-Related Services (HRS)

1. Informational Questions

a. Please describe how HRS Community benefit investment decisions will be made, including the types of entities eligible for funding, how entities may apply, the process for how funding will be awarded, the role of the CAC (and Tribes/tribal advisory committee if applicable) in determining how investment decisions are made, and how HRS spending will align with CHP priorities.

In addition to the CBRIs (see section B.1.c.), we will use HRS funding for needs that are unique to each community as identified through the CHP process. Apart from the CHP process, needs are identified by primary care and other entities. We currently utilize these funds in other service areas for adolescent well care incentives including backpacks for children as well as gift cards for adolescents who complete a wellness visit. Primary care clinics and other entities within our existing service area frequently submit requests for health related services for which they need funding. We also utilize the HRS funding for a Cribs for Kids program for which all counties will be eligible. We will share information about Cribs for Kids program at multiple LCAC meetings so that community members and local healthcare organizations are aware of the program and post information on our web site.

D. Community Advisory Council membership and role

1. Informational Questions

a. Please identify the data source(s) Applicant proposes to use when defining the demographic composition of Medicaid Members in the Applicant's Service Area.

We utilize demographic information from the XXX enrollment files. We also use the Portland State University (PSU), Center for Population Research as our base for defining the population. For Medicaid members, we collect information on age, gender, zip code (geography) and preferred language. The U.S. Census data along with data from the Department of Human Services, DHS Office of Forecasting, Research and Analysis identifies poverty hot spots as contiguous census tracts with poverty rates of 20% or more for two predetermined measurements. This data will be consulted as we work with community stakeholders and CACs on addressing SDOH-HE priorities.

In addition to using these data sources, we will also seek cultural understanding from people of all ethnic and cultural groups in the NWCCO service area through targeted outreach and engagement. People of Hispanic/Latino origin represent the fastest growing ethnic group in the region (population ranges from 4% in Columbia to 9% in Tillamook). While there are no

federally recognized tribes in the NWCCO region, there are Native American people (1% of the region's population) who are both affiliated and unaffiliated with federally recognized tribes as well as Native American people who belong to unrecognized tribes residing in the three-county region of Clatsop, Columbia and Tillamook counties.

2. Evaluation Questions

a. Applicant will submit a plan via the RFA Community Engagement Plan, as referenced in Section A, for engaging CAC representatives that align with CHP priorities and membership demographics, how it will meaningfully engage OHP consumer(s) on the CCO board and describe how it will meaningfully engage Tribes and/or tribal advisory committee (if applicable). Applicant may refer to guidance document CAC Member Assessment Recruitment Matrix.

Please see the NWCCO Community Engagement Plan included in our submission for information on the planned membership and role of the CAC.

E. Health Equity Assessment and Health Equity Plan

1. Informational Questions

a. Please briefly describe the Applicant's current organizational capacity to develop, administer, and monitor completion of training material to organizational staff and contractors, including whether the Applicant currently requires its Providers or Subcontractors to complete training topics on health and Health Equity.

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

Our partner dental care organizations provide annual cultural competency training to their staff as well. We evaluate which employees have been trained in workplace diversity and cultural competency. We expect that 100% of NWCCO team members who are NWCCO member interfacing receive the training on an annual basis.

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

In addition to including diversity and equity training as part of the mandatory onboarding training for all new employees, NWCCO's partner, Moda, offers regular instructor-led diversity trainings through the year and three diversity classes (cultural competence, Implicit Bias and Working in an inclusive environment) through its online platform Moda University. Moda is working to develop workplace strategies to identify racial and ethnic disparities through our Equity Compass 360° program. This includes collecting and analyzing race, ethnicity and language data from a portion of our members to better recognize and understand our member populations; and adopting a company-wide set of Cultural Sensitivity and Health Literacy (CSHL) standards to better communicate with Moda's members.

We are also currently assessing cultural competency and health equity trainings delivered among our behavioral health provider network based on a commonly used, web-based training tool to ascertain whether or not they match Oregon's Criteria for Cultural Competence Continuing Education training. If so, NWCCO and our behavioral health providers will be updating the

Health Equity Plan and add this as a tool for lower level cognitive domain learnings. In that matter, it can also be used to help track a portion of employee training and compliance with the Health Equity Plan.

We conduct an annual provider training across the service area for all contracted clinic staff. This training includes topics such as health related services, community health workers, language assistance, and compliance. We are also currently in the development phase of optimizing the online training platform that our equity partner Moda uses in order to create training modules for all contracted providers. These online modules will comprise of a variety of health related topics including cultural competence, healthy equity, and implicit bias. We would like to offer these courses to the Board of Directors as well as all CAC members. Additionally, we hold an annual clinician summit with contracted providers and partner organizations.

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

We will collect the REAL+D data provided via the XXX enrollment file. We will import this data into our system to identify the population. We will then utilize this data to assist in claims adjudication and for targeted member outreach and care coordination.

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

a. Please provide a general description of the Applicant's organizational practices, related to the provision of culturally and linguistically appropriate services. Include description of data collection procedures and how data informs the provision of such services, if applicable.

We are committed to eliminating health disparities and providing the highest quality of care to all NWCCO members, regardless of race, ethnicity or primary language. To provide culturally and linguistically appropriate services to NWCCO members, we will stratify data from multiple sources including the member eligibility files from the state, internal data, and CAHPS survey data. The NWCCO's monthly provider progress reports will contain information on incentive measure rates as well as demographic information on NWCCO members. This includes both race and ethnicity data. This will allow clinics to minimize gaps in care while also outreaching and delivering services in a culturally competent manner. NWCCO will analyze this data to reveal health disparities among certain cultural and ethnic groups. NWCCO will analyze claims data and compare OHA race and ethnicity data to identify trends in underutilized services. Assets within the NWCCO communities will be identified as well in order to enhance current capabilities. All of this data will drive quality improvement initiatives as well as the provision of services.

b. Please describe the strategies used to recruit, retain, and promote at all levels, diverse personnel and leadership that are representative of the demographic characteristics of the Service Area.

NWCCO will utilize Portland State University, Center for Population Research as our base strategy for defining the population that makes-up NWCCO, and our effort for effective and diverse recruitment and operation of each Local CACs (LCACs). We will also support a RCAC for which we also seek diversity based on the unique population demographics and socio-economics in each of NWCCO's three counties. Additionally, the NWCCO Charter for CACs

will require the CACs to be reflective of the local community and community partners that they serve.

c. Please describe how Applicant will ensure the provision of linguistically appropriate services to Members, including the use of bilingual personnel, qualified and certified interpreter services, translation of notices in languages other than English, including the use of alternate formats. Applicant should describe how services can be accessed by the Member, staff, and Provider, and how Applicant intends to measure and/or evaluate the quality of language services.

We recognize that providing linguistically appropriate healthcare in both verbal and written forms plays a crucial role in effectively delivering healthcare services. Quarterly, NWCCO and its delegated entities will verify the languages of the substantial population from the declared languages reported on the 834 eligibility files. As needed, NWCCO will adjust translated member materials for significant new languages in the NWCCO membership. Our NWCCO member informational materials will be assessed using the Flesch-Kincaid Readability Statistics to ensure that member materials are written between a sixth and seventh grade reading level. Member materials and notices will be sent to the member through the mail. Member handbooks will include a tag line on the first page that offers the handbook in alternate languages and formats. The handbooks will also be made available on the NWCCO website in both English and Spanish.

NWCCO will provide multilingual customer service. NWCCO is prepared to meet the special health care needs of members who are hearing and visually impaired. NWCCO will arrange for interpreter services at members' medical provider appointments when clinics don't have bilingual services. NWCCO member handbooks and participating provider manuals will include instructions on how to request these services. This information will also be made available on the NWCCO website. NWCCO intends to evaluate the number of utilized interpreter services at medical office visits and implement strategies to increase utilization among members who identified a primary language other than English.

d. Please describe how Applicant will ensure Members with disabilities will have access to auxiliary aids and services at no cost as required in 42 CFR 438.10, 42 CFR part 92, and Section 1557 of the Affordable Care Act. Response should include a description of how Applicant plans to monitor access for Members with disabilities with all contracted providers.

NWCCO will notify members in the member handbook of the availability of auxiliary aids. For example, we will provide the member handbook and other letters in other languages, large print, a computer disk, audio tape, spoken presentation or Braille. NWCCO will also ensure all communications provide toll free customer service numbers which will tell TTY users to dial 711. NWCCO will monitor the availability of these services through the grievance and appeal process for both internal and provider concerns. Additionally, monitoring is done through the care coordinators and case managers to ensure availability to our providers.

3. **Requested Documents**
   Policies and procedures describing language access services, practices, evaluation, and monitoring for appropriateness and quality.

   Policies and procedures related to the provision of culturally and linguistically appropriate services.

NWCCO expects to adopt policies that are similar to those of EOCCO. We have included the EOCCO Policy & Procedure for Interpreter Services as our example.

F. Traditional Health Workers (THW) Utilization and Integration

1. **Informational Questions**

   a. **Does Applicant currently utilize THWs in any capacity? If yes, please describe how they are utilized, how performance is measured and evaluated, and identify the number of THWs (by THW type) in the Applicant's workforce.**

NWCCO expects to capitalize on the investments of EOCCO in the promotion and use of Community Health Workers. Beginning with a pilot project through transformation grants, EOCCO saw early success and began dedicating funding for THW initiatives, including reimbursement at a Fee-For-Service basis and funding for the development of a regional OHA certified Community Health Worker (CHW) training program. As a result, EOCCO developed a CHW billing and payment policy to help ensure a sustainable revenue source for the EOCCO provider partners that employ CHWs. We expect to replicate this sustainable funding source in NWCCO.

NWCCO believes that THWs play an important role in helping patients navigate and use the healthcare system more efficiently by developing relationships with patients, arranging appointments, improving provider/patient communication, reducing healthcare disparities and helping locate community resources.

We will utilize THW's within the Wraparound Process and for youth who receive Intensive Care Coordination (ICC). Performance will be measured and evaluated utilizing encounter data, CANS scores and Peer Support Competencies Assessment Tool. Additionally, these positions are subject to the same chart audits as all other staff, clinical and non-clinical. There are four (4) Family Peer Support Specialists – specialty code (606); and two (2) Youth Support Specialists – specialty code (607).

NWCCO will build additional THW workforce capacity in the coming years. We currently provide capacity funding for peer delivered services including peer recovery coaching, outreach and engagement in Clatsop, Columbia and Tillamook Counties through agreements with Community Mental Health Programs. We will also invest in the development of OHA-approved CHW continuing education training programs in partnership with Oregon State University and continued improvement to the billing and payment policy for certified CHWs. CHWs can be reimbursed for time spent with NWCCO members. Examples of reimbursable services include face-to-face time spent with members to address SDOH-HE, assistance navigating community resources and obtaining assistance with food or housing. See RFA Community Engagement Plan Tables: Table 4; and the THW Integration and Utilization Plan included in our submission for more information.

b. If Applicant currently utilizes THWs, please describe the payment methodology used to reimburse for THW services, including any alternative payment structures.

Through our equity partner GOBHI, NWCCO currently has grant funded positions for personal heath navigators and community health workers in this service area. We also reimburse THWs on a fee-for-service basis. By the end of 2020, we plan to implement a reimbursement model that provides qualified providers a PMPM reimbursement.

2. Evaluation Questions

a. Please submit a THW Integration and Utilization Plan which describes:

- **Applicant's proposed plan for integrating THWs into the delivery of services;**
- **How Applicant proposes to communicate to Members about the benefits and availability of THW services;**
- **How Applicant intends to increase THW utilization;**
- **How Applicant intends to implement THW Commission best practices;**
- **How Applicant proposes to measure baseline utilization and performance over time;**
- **How Applicant proposes to utilize the THW Liaison position to improve access to Members and increase recruitment and retention of THWs in its operations.**

See the THW Integration and Utilization Plan included in our submission for this response.

3. Requested Documents
Completed THW Integration and Utilization Plan (page limit: 5 pages)

See the THW Integration and Utilization Plan included in our submission for this response.

G. Community Health Assessment and Community Health Improvement Plan

1. Evaluation Questions

a. Applicant will submit a proposal via the RFA Community Engagement Plan, referenced in Section A, describing how it intends to engage key stakeholders, including OHP consumers, Providers, local public health authorities, including local health departments, Tribes, Community-based organizations that address disparities and the social determinants of health, and others, in its work. The Plan should detail the Applicant's strategies for engaging its Community Advisory Council, its process for developing and conducting a Community Health Assessment, and development of the resultant Community Health Improvement Plan priorities and strategies. The Plan should specify how the Applicant's strategy for health-related services links to the CHP. Applicants should include information on approaches to coordinate care across the spectrum of services, as well as to encourage prevention and health promotion to create healthier communities.

Please see the Community Engagement Plan as required for this response.

Attachment 11 - Behavioral Health Questionnaire

A. Behavioral Health Benefit

1. **How does Applicant plan to ensure that Behavioral Health, oral health and physical health services are seamlessly integrated so that Members are unaware of any differences in how the benefits are managed?**

   NWCCO is built on the foundation of community partnership. As a testament to this belief, the NWCCO equity partners will be joining together, both financially and in spirit, to provide a seamless network for our Members. By working together, we strengthen the care we provide to our communities. This core value is our foundation for ensuring fully integrated services in a manner that is seamless for NWCCO Members. Our goals are for NWCCO Members to be proud to be a part of NWCCO; and that all of their interactions are coordinated, collaborated, and integrated in a way that reduces confusion, and ensures their voice is heard across the care continuum. On a practical level this will be evident through:

   - An integrated NWCCO handbook that describes all of the Members benefits (physical, behavior and oral health as well as transportation).
   - Customer service staff that answer Member inquiries about all services.
   - External member communications branded for the NWCCO.
   - A NWCCO integrated website, including a combined behavioral, physical and dental provider searches.
   - Pilot projects and compensation models designed so that Members can receive services in one location.
   - Care coordination services that provide a single point of contact for a Member and their family
   - Data that is available to all NWCCO partners, to improve communication and coordination, reduce redundancies, and drive performance improvement.

2. **How will Applicant manage the Global Budget (as defined in ORS 414.025) in a fully integrated manner meaning that Applicant will not identify a pre-defined cap on Behavioral Health spending, nor separate funding for Behavioral Health and physical health care by delegating the benefit coverage to separate entities that do not coordinate or integrate?**

   NWCCO will be structured as a limited liability company (LLC) with equity partners that include Moda Health, GOBHI, Columbia Memorial Hospital, Adventist Health System and Yakima Valley Farmworkers, and other provider organizations within the community. The equity partners will take full responsibility for the entire benefit package, including behavioral health. NWCCO will fully fund behavioral health provided in a primary care setting and will fully fund primary care delivered in a behavioral health setting.

   Under this governance structure each of the partners will share all of the risks and some of the savings that result from NWCCO's performance in relation to the Global Budget. On an annual basis NWCCO's financial and actuarial teams will develop a global budget which will be approved by the NWCCO Board. The global budget will be developed using a

ground-up approach to ensure adequate funding is available to cover all services we are required to provide to the NWCCO population. NWCCO will produce cost and utilization reports that show spending and utilization patterns by member category and by service category including behavioral health care on a routine basis. This reporting is one tool used to ensure oversight of the behavioral health benefit. The cost and utilization reports are also used to inform NWCCO's annual global budget to ensure the appropriate allocation of funding for all covered services.

NWCCO's governance structure will allow for close integration and coordination of service to its members, while benefitting from the expertise provided by the partner organizations. To optimize Behavioral Health service, GOHBI, a NCQA Accredited Managed Behavioral Health Care Organization and an equity owner of NWCCO, will oversee the network of behavioral health providers, provide utilization management of behavioral health and transportation benefits, supervise/monitor behavioral health services provided at PCPCHs or school based clinics through the Collaborative Care model, and will have a dedicated "field team" consisting of at least 3 FTEs working with all NWCCO primary care providers and community advisory councils, throughout Clatsop, Columbia and Tillamook Counties. This care delivery model is based on assuring integration of services, as well as facilitating coordination of services across all healthcare providers (not just medical needs).

NWCCO will develop a payment methodology to assure that behavioral health services delivered in a primary care setting, and primary care delivered in a behavioral health setting will be reimbursed utilizing a structure that aligns with our VBP goals. Incentives (quality-based value-based payments, additional PMPM payments, grant funds, etc.) and support, are provided for those clinics that deliver co-located and integrated services.

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

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

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

NWCCO will assure that the parity requirements established in 42 CFR 438.910 are addressed by utilizing evaluation standards that ensure funding to mental health/substance

use disorder (MH/SUD) is at a minimum comparable to funding for medical/surgical (M/S) benefit in the same classification.

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

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

4. **How will Applicant monitor the need for Behavioral Health services and fund Behavioral Health to address prevalence rather than historical regional spend? How will Applicant monitor cost and utilization of the Behavioral Health benefit?**

   Prevalence will be monitored through a variety of real time and retrospective reviews including: requests for authorizations, emergency department notifications, out-of-network usage, single case agreements, complaints and grievances, Collaborative Care Model (behavioral services provided in PCPCH) data collection and claims data. Benchmark data is also reviewed for comparisons regarding penetration rates (reach), costs per member, and types of services provided. Real time analytics are used to determine if screenings and preventative care are being delivered according to best practices. Utilization is viewed at the individual, provider and system levels to look for improvement opportunities. Data reviews include: viewing difference in utilization based on demographics, gaps during transitions of care, areas of need within the Network.

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

   On an annual basis we will utilize this data to help develop a global budget for approval by the NWCCO Board. The global budget is developed using a ground up approach to ensure adequate funding is available to cover all services we are required to provide to the NWCCO population.

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

5. **How will Applicant contract for Behavioral Health services in primary care service delivery locations, contract for physical health services in Behavioral Health care service delivery locations, reimburse for the complete Behavioral Health Benefit Package, and ensure Providers integrate Behavioral Health services and physical health services?**

NWCCO will expand access to behavioral health care and provide a more person centered approach to care by supporting integrated behavioral health and physical health in a variety of ways. We will use a prospective primary care payment system in which clinics will receive an enhanced payment up front for agreeing to provide integrated behavioral health services and adhering to a set of evidence-based standards for providing that care. These standards will include universal screening and referral to brief behavioral health interventions as well as bridges to higher levels of care when indicated. We will make available technical support and consultation when needed to improve the quality of care and effective implementation of integration.

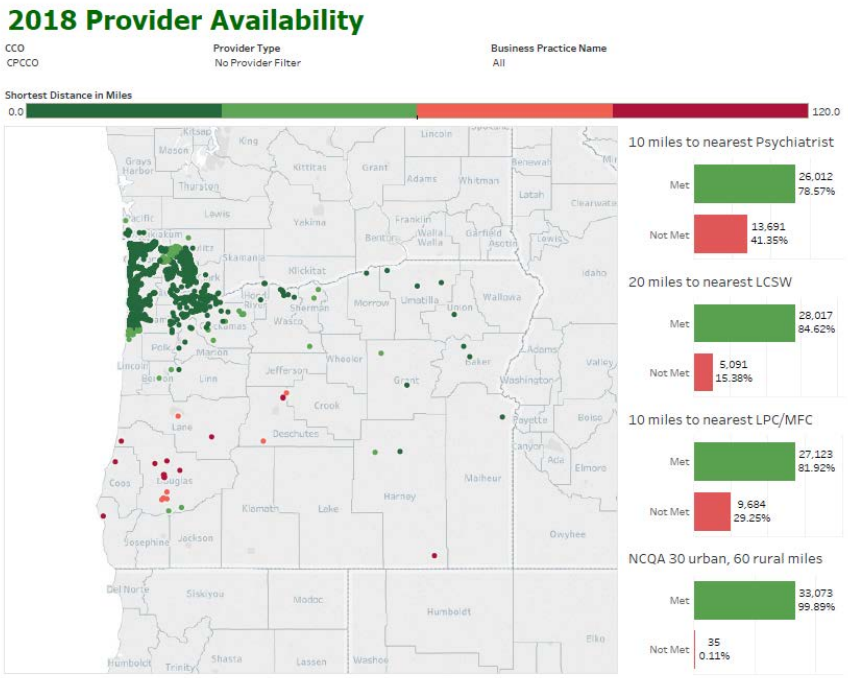
	US Preventative Services Grade (See Key)	Cost Effectiveness[2] (2007 dollar amounts)	CCBHC1	CCBHC2	CCBHC3	Average CCBHCs	Average Non-CCBHC (CMHPs)
Outcomes: (Medicaid population) [1]							
% BMI under 30			63%	63%	75%	70%	64%
% Controlled High Blood Pressure			69%	64%	58%	67%	67%
%Diabetes Mellitus BP Control			65%	74%	70%	69%	63%
% DM Ha1c Under 9%			56%	55%	70%	61%	45%
Screenings: % who had each assessment/screening							
Adult BMI Screening	B (Behavioral Weight Loss Interventions to Prevent Obesity-Related Morbidity and Mortality in Adults)	$42,000 - $200,000	63%	95%	95%	84%	81%
Cervical Cancer Screening	A	$21,000 - $41,000 (per life year)	26%	34%	52%	37%	18%
Colorectal Cancer Screening	A	$2,000 - $36,000 (per life year)	35%	62%	51%	48%	19%
Depression Screening/Follow-up	B	$200,000 - $540,000	23%	36%	59%	38%	22%
Ha1c testing	B (Diabetes screening)	$44,000 - $540,000	71%	68%	80%	75%	58%
Tobacco Screening	A		60%	52%	88%	67%	44%

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

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

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

- Anticipated Medicaid enrollment and anticipated enrollment of Fully Dual Eligible individuals
- Appropriate range of preventive and specialty services for the population enrolled or expected to enroll
- Expected utilization of services, the characteristics and healthcare needs of enrollees
- Numbers and types (training, experience, specialization) of providers required to furnish the contracted Medicaid services
- Identified clinical, cultural, linguistic, demographic, risk characteristics and expressed special or cultural needs or preferences of individuals and communities being served.
- Recognized clinical risks including physical or developmental disabilities, serious mental illness, multiple chronic conditions and severe injuries that need to be cared for.
- Number of network providers not accepting new Medicaid patients
- Geographic location of participating providers and Medicaid enrollees (including distance, travel time, means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities)
- The Provider Network sufficiency in numbers and areas of practice and geographically distributed in a manner that the covered services are reasonably accessible to enrollees as stated in ORS 414.736



- Ability of care to be integrated and coordinated (i.e., availability of PCPCHs, CCBHCs, etc.)
- Complaints and grievance trends related to access or quality of care

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

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

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

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

   NWCCO will collect wait times for contracted Behavioral Health care providers to monitor timely access to behavioral health services. An annual Member survey is also utilized to obtain feedback regarding access to services. Data is separated between Youth (0-17) and adult (18+), and Mental Health and Substance Use Disorder services. The total number of Members who were seen for requested service within specified timeframes is divided by total number of Members requesting the service, with a goal of 90% receiving services within the goal timeframes: Emergency care Members shall be seen within 24-hours or as indicated in initial screening; Urgent Care shall be seen within 48 hours or as indicated in initial screening; Non-Urgent Care needs shall be seen for an intake assessment within two weeks from date of request. Other data collected includes: average number of days after initial visit to scheduled routine follow-up; average time from LMP (prescriber) appointment request to date of first available appointment; and average time between initial crisis call and start of crisis assessment. Data (claims-based) submitted by providers is also analyzed for average timelines from assessment to service plan, and from service plan to first delivered follow-up appointment.

8. **How will Applicant ensure that Members can receive Behavioral Health services out of the Service Area, due to lack of access within the Service Area, and that Applicant will remain responsible for arranging and paying for such out-of-service-area care?**

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

   NWCCO Members will have access to all medically appropriate, behavioral health services that are covered under the Oregon Health Plan or NWCCO's behavioral health benefit. NWCCO will coordinate timely and adequate access to the benefit. If an in network provider is unavailable, or there is a need for the Member to utilize an out-of-network provider, NWCCO will work with the Member to find those services. Out-of-network services that are medically appropriate, delivered by a qualified professional and billed

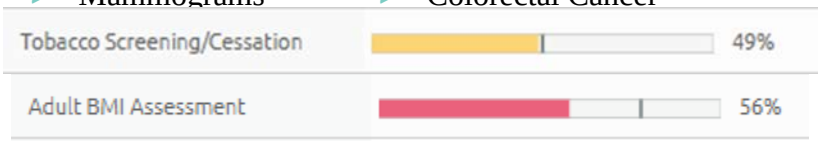
with codes that are consistent with the behavioral health fee schedule published by OHA) are paid for by NWCCO.

NWCCO assures that services for Members traveling outside NWCCO service area will be paid for if they are medically necessary, urgent, or emergent.

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

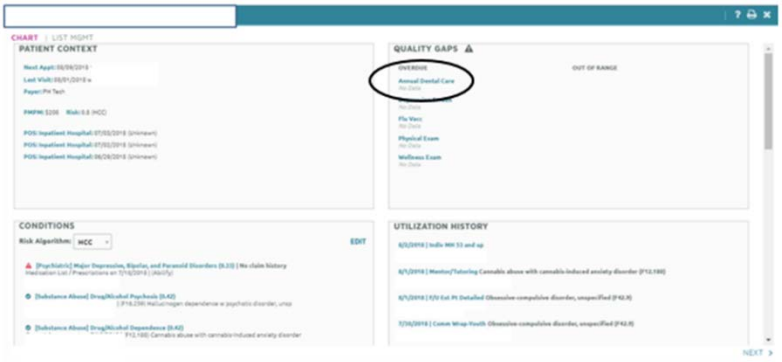
Contracted providers are required to complete comprehensive screening tools during the intake/admission process for Members who are seeking behavioral healthcare. Some of the screening tools include:

- SBIRT
- BMI
- DAST
- Diabetes
- Depression
- PROMIS
- Tobacco Use
- Mammograms
- GAD-7
- Infectious Disease Risk Screening
- Unhealthy Alcohol Use Screening
- Colorectal Cancer



NWCCO providers will utilize an HIE (Arcadia) and other data analytics tools to collect near real time information on the completion of comprehensive screenings.

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



NWCCO will work with the local CMHPs to streamline and standardize intake packets. This review is designed to assure compliance with OARs and standardize screening tools to assure adequate and useful data collection. NWCCO will also review clinical charts from all providers at least once every three years for contracted providers, and annually for CMHPS. Charts are chosen at random from encounter data based on encounters for assessments and services rendered. All contracted providers are required to sign an

NWCCO attestation at least once every three years ensuring that they are completing screenings upon intake and throughout a member's care.

10. How will Applicant ensure access to Mobile Crisis Services for all Members to promote stabilization in a Community setting rather than arrest, presentation to an Emergency Department, or admission to an Acute Care Psychiatric Hospital, in accordance with OAR 309- 019-0105, 309-019-0150, 309-019-0242, and 309-019-0300 to 309-019-0320?

NWCCO will contractually require each risk bearing provider to utilize Mobile Crisis Service as their 24/7 crisis standard. This will be a continuation of the current standard of care that exists in each county within the NWCCO region.

NWCCO will require each contracted provider to respond to behavioral health crises at the location within the community where the crisis arises. The contracted provider will be monitored in how they assist the member in resolving the crisis: were services provided in the most integrated setting possible; and did the intervention avoid unnecessary hospitalizations inpatient treatment, civil commitment, and/or arrest or incarceration? The later objectives will be monitored to ensure higher levels of care or arrest/incarceration were clinically and legally appropriate and necessary.

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

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

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

NWCCO believes in the power of peer services in assisting people with behavioral health conditions to achieve recovery and build resilience. NWCCO's behavioral health program through GOBHI has overseen a peer delivery system that has provided services to 240 mental health enrollees and 51 substance use disorder enrollees during the last full reporting year of 2017/2018 for the three counties comprising NWCCO. NWCCO will utilize certified peers in the delivery of care for both adolescents and adults. There are currently 10 peers supporting Members in MH, SUD and Wraparound programs in the NWCCO network. Peer services are available in-person through local CMHPs and through direct to Member, HIPAA compliant, tele-behavioral health software.

NWCCO utilizes peers as community engagement specialist. These specialists are out in the community working on the streets getting to know our Members. They walk alongside Members building relationships, so when the day comes that a Member wants/needs help there will be someone they know by their side to journey with them on the road to recovery.

NWCCO also utilizes certified peers for the delivery of care to individuals 18 years of age or older with a diagnosed severe and persistent mental illness (SPMI), though all enrolled adult members have these services available to them. The utilization of peer delivered services (PDS) is arranged on a per contracted provider basis depending on demographics, population, and the community health assessment and/or community health integration plan.

NWCCO does not guarantee that all locations will have certified peer specialists, but PDS services will be available throughout the service area. At a minimum, PDS assist members with community engagement needs, getting to appointments, negotiating public benefits, and assurances of person-centered planning. The full array, though not guaranteed in all locations, will include certified peers engaged with ACT, crisis services, and warm handoffs from inpatient levels of care.

NWCCO will utilize a Consumer Caucus to provide support and training for Members who wish to become Peer Specialists. Two Members from this group will sit on the Behavioral Health Board of Directors and one Member will sit on the Behavioral Health Quality Improvement Committee.

12. **How will Applicant ensure access to a diversity of integrated community supports that mitigate SDOH-HE, increase individuals' integration into the community, and ensure all Members access to Peer services and networks**

NWCCO will give oversight responsibility for the utilization of Social Determinates of Health (SDOH) to the Local Community Advisory Council's (LCAC). The LCAC's will authorize, based on the NWCCO Governing Boards allocation, reimbursement processes for SDOH entities within their communities. Each LCAC will receive dedicated funds, as well as the opportunity to apply for grants, to support projects designed to meet Community Health Improvement Plan (CHIP) and CCO Incentive Measure goals. NWCCO will also provide administrative staffing, LCAC engagement training, and project support for each LCAC. This includes using encounterable Traditional/Community Health Workers (THW or CHWs) and Certified Peer Specialists (CPS) for connecting members to needed SDOH entities or services that exist within the member's community. Both THW and CPS workers are authorized to connect members to educational, employment, health care, housing, transportation, social supports, and other identified SDOH targeted within their communities. These workers support members with integrating, mitigating, and overcoming identified limitations within their communities for a period of time determined by the member.

B. Billing System and Policy Barriers to Integration

1. **Please describe Applicant's process to provide Warm Handoffs, any potential barriers to ensuring Warm Handoffs occur and are documented, and how Applicant plans to address them.**

As a reminder, NWCCO partner GOBHI has been providing Behavioral Health Services in this region as a sub-contractor under the CCO 1.0 contract. Because GOBHI has had contracts and relationships with all of the Behavioral health care providers and community partners in this region for years, the answers to these questions will reflect past practices as well as future plans.

NWCCO providers strive to assure there are warm handoffs across our provider network and with other CCO's when members relocate to other areas.

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

Example 1

- NWCCO through GOBHI will also continue to provide and support PreManage, a software platform, to document care plans and recommendations so that each of the Member's caregivers has a way to communicate with others on the care team.
- Within the network, members 0-5 and their caregivers will be referred from pediatricians, family practice physician, and early intervention, DHS and Head Start. NWCCO via GOBHI will continue to provide funding to Oregon Pediatric Improvement Partnership (housed at OHSU), to create referral tools and feedback forms for the above referral sources in order to address the barrier that this population experiences when trying to obtain mental health services.
- The Follow-up and Referral Pathways for Young Children at Risk for Developmental, Behavioral and Social Delays program, aims to develop and pilot implementation of specific tools and strategies meant to increase the number of young children and their families (target population) who receive behavioral health and specialty infant and early childhood supports.
- For youth that are eligible for Wraparound and decline to participate in the process, there is a warm handoff to intensive care coordination services, so that youth and families are aware that they can still access the service needed at any time. If youth are currently receiving wraparound services, there is a wraparound transfer protocol used that details documentation requirements of both the sending and receiving counties. NWCCO systems of care manager continually works to address the barrier of transferring youth to other CCO's through quarterly SOCWI site lead meetings, and by working with PSU system of care institute.
- The NWCCO EASA program also encourages flexibility for clinicians that allow clients to receive warm handoffs with immediate access. EASA teams coordinate services and conduct warm handoffs through consultation calls, and are actively participating in the EASA center for excellence. NWCCO through GOBHI honors automatic acceptance when members transfer into NWCCO from another CCO.
- Mend is a telehealth platform used to connect providers and members with services, such as psychotherapy, case coordination, and medication management. This platform can be utilized by members through an APP or low bandwidth web browser, which is extremely important to our members in rural areas who often do not have adequate

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

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

2. **How does Applicant plan to assess for need and utilization of in-home care services (Behavioral Health services delivered in the Member's home) for Members?**

   NWCCO works with each Member to determine needed behavioral health services. When appropriate and desired NWCCO will provide a variety of in-home behavioral health care services.

   - Through an HRSA supported grant: we will supply direct-to-Member, HIPAA complaint, tele-health software to all NWCCO CMHPs. The software allows Members to receive behavioral health and SUD services in their homes. Services currently provided via tele-health include assessments, therapy, warm handoffs with PCPCH patients, medication management and psychiatrist appointments. Group therapy appointments will be trialed in Spring 2019. Future tele-behavioral health services to be implemented include Peer Delivered Services and Intake visits.
   - NWCCO will develop a reimbursement structure for Traditional Healthcare Workers (THWs), such as state certified Community Health Workers (CHW) that can provide in-home behavioral health services. Examples of CHW in-home service offerings include: tobacco cessation counseling, weight management and nutrition counseling and linkages to other social service needs. NWCCO contracts with the Oregon State University College of Public Health & Human Sciences to support state certified CHWs and THWs. Examples of CHW in-home service offerings include: tobacco cessation counseling, weight management and nutrition counseling and linkages to other social service needs.
   - In-home Applied Behavioral Analysis (ABA) services for NWCCO members in Therapeutic Foster Care and/or with Wraparound supports will be available to members in their home. Services allow for direct assessment, therapy, parent training, and other services all within a location and schedule that is flexible to meet the needs of the family. Staff receive extensive training on therapy techniques and strategy on working in the home with children, with emphasis on social and integration settings.
   - NWCCO hopes to partner with local public health departments to implement a universal screening and nurse home visiting program for providing in home services for infant and maternal health.
   - Additionally, NWCCO provides case management funding for primary care practices certified as a Patient Centered Primary Care Home (PCPCH) Tier 3 or higher, who

offer a level of integrated behavioral health care services, including same day consults, Warm Handoffs and in-home visits (as needed). PCPCH's at Tier 3 (or higher) are eligible for a per-member/per month contract for behavioral health services delivered to NWCCO members.

As a complement to in-home services and supports, NWCCO will explore opportunities, in partnership with the LCACs, for individuals providing home visits to screen for social determinants of health needs of members. With members' consent, THWs or other staff can ask a few basic questions and provide input from visual inspection of areas of the home that they see as a regular course of a home visit to inform NWCCO if a member may be in need of housing support, minor home repairs to support improved health outcomes, or other concerns related to conditions like food insecurity or transportation and safety needs.

3. **Please describe Applicant's process for discharge planning, noting that discharge planning begins at the beginning of an Episode of Care and must be included in the care plan. Discharge Planning involves the transition of a patient's care from one level of care to the next or Episode of Care. Treatment team and the patient and/or the patient's representative participate in discharge planning activities.**

   NWCCO will require our provider network initiates to discharge planning at the beginning of an episode of care. In Wraparound, the team will create a mission statement that utilizes the plan of care, individual goals, and includes a statement of what success would look like for that individual. In addition, the team will use a Wraparound Transition Checklist to assist members in their discharge planning. From the beginning of services through the transition, Youth Partner and Family Partners are engaged and supporting members through the process.

   EASA starts the discharge planning 3- 6 months prior to the client completing the 2 year EASA program. The clinician meets with the client and family review the transition check-list. A wellness plan, a relapse prevention plan, and a Crisis & Safety plan is created. Warm handoffs are completed to primary and continued outpatient mental health support.

   NWCCO will collaborate with Community Mental Health Programs (CMHP) in discharge planning involving all members moving between levels of care and Episodes of Care. NWCCO Utilization Management (UM) monitors PreManage daily and notifies the CMHP the same day of an admission. The Intensive Care Coordinator (ICC) immediately begins the discharge planning process and communicates the plan with NWCCO Care Manager (CM) within one to two days. The patient or patient's representative are included in the discharge process. Throughout the discharge planning process, open communication and close collaboration occurs among the CMHP, NWCCO UM and NWCCO CM to ensure a timely and successful discharge.

4. **Please describe Applicant's plan to coordinate Behavioral Health care for Fully Dual Eligible Members with Medicare providers and Medicare plans, including ensuring proper billing for Medicare covered services and addressing barriers to Fully Dual Eligibles accessing OHP Covered Services.**

   NWCCO will establish practices and policies, such as Medicare by-pass allowances and out-of-network policies, to allow all members, including the fully dual eligible (In 2018 this was 1,635 members), to receive all benefits covered under the Oregon Health Plan. In

collaboration with its affiliated Medicare Advantage Plan, NWCCO will establish processes that ensure all enrolled fully dual eligible members are properly cared for and services are properly billed. There are no barriers to covered services for fully dual eligible members because we will utilize regulatory allowances and provide technical assistance to network providers on billing for behavioral health care under OHP. For out-of-network providers, we will have policies via GOBHI which allow for services to be paid expeditiously without inconvenience to either provider or member.

C. MOU with Community Mental Health Program (CMHP)

NWCCO through GOBHI has executed MOUs under CCO 1.0 with both the Local Mental Health Authorities and the local Community Mental Health Programs in each county served. MOUs are in place with the following CMHPs: Tillamook Family Counseling Center, Clatsop Behavioral Healthcare and Columbia Community Mental Health.

In order to facilitate the local Behavioral Health Plan, and outline shared goals commensurate with CCO 2.0, MOUs will be reviewed and amended after initiation of the new contract to be effective by January 1, 2020 per the contract template provided in the RFA. Applicant will enter a MOU with Local Mental Health Authority that will be enforced and honored. Improved health outcomes and increased access to services through coordination of safety net services and Medicaid services.

1. **Describe how Applicant plans to develop a comprehensive Behavioral Health plan for Applicant's Service Area. Please include dates, milestones, and Community partners.**

Our "Applicant Service Area" is comprised of Columbia, Clatsop, and Tillamook counties in NorthwestOregon. The NWCCO is structured to recognize the uniqueness of such a diverse set of counties. Therefore, NWCCO will establish 3 Local Community Advisory Councils (LCAC) which focus on the needs of each local county. To address the entire service area, NWCCO will also create a Regional Community Advisory Council (RCAC).

The RCAC membership will be comprised of a representative from county government and the Chair of the LCAC from each of the three counties. Additional interested parties will also be invited. Each LCAC will create a Community Health Improvement Plan (CHIP) and the RCAC will have a Regional CHIP. Therefore the comprehensive Behavioral Health plan will be embedded in the Regional CHP

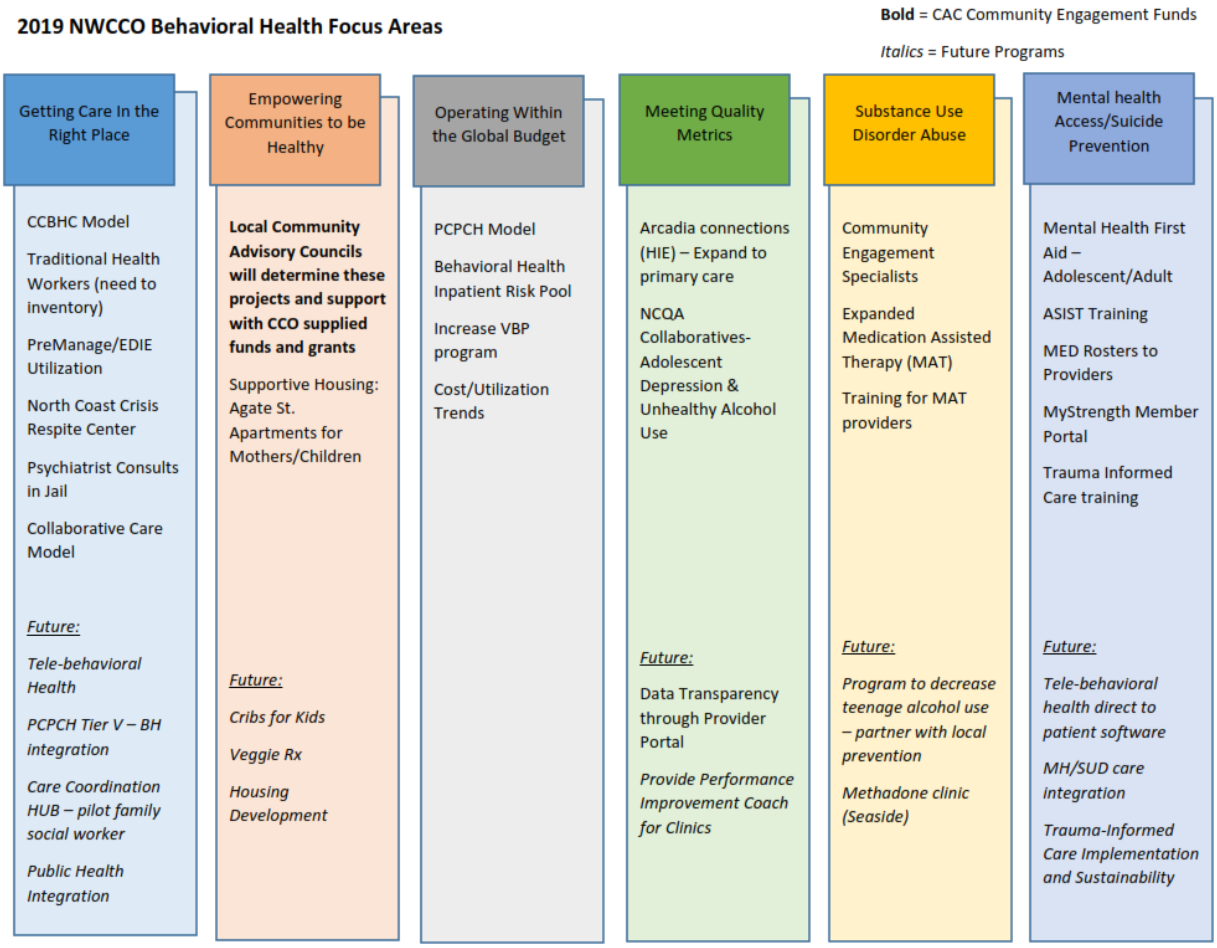
Under CCO 2.0 we will deliver a CHP by June 30, 2021. This is the date when the comprehensive Behavioral Health plan will be submitted. To meet that date the following milestones will be met:

An assessment of the level of behavioral health integration will be undertaken using Kessler's Practice Integration Profile model. Each primary care practice and community mental health program will be evaluated to determine how much behavioral and mental health is being delivered in primary care and the referrals needed to the CMHP. This includes involvement of Certified Community Behavioral Health Clinics (CCBHC) and Patient Centered Primary Care Homes (PCPCH). **Completion: June 30, 2020.**

Review of the assessment results across all three counties. Common strength and weakness areas will be determined. Appropriate strategies will be developed across the entire Applicant Service area and within individual counties. **Completion: December 31, 2020.**

The Regional CAC will approve the Behavioral Health plan and forward to the NWCCO Board of Directors. **Completion: March 31, 2021.**

NWCCO Board will review, edit and approve the Behavioral Health plan and submits to the Oregon Health Authority. **Completion: June 30, 2021**.



2. **Describe how Applicant plans to collaborate and coordinate with the Local Mental Health Authority in the development of the CHP. Please include dates and milestones.**

   NWCCO will collaborate with Local Mental Health Authorities (LMHA) through regular meetings of the LCACs. County Government representatives will be included in the LMHA on all of the LCACs. LCACS also include a CMHP representative. The CHIP results from the broad assessment of community health including health status, health behaviors, vital records, social determinants of health measures, demographics, socioeconomics, health system needs and qualitative input.

   Because we will support CACs in each county within our service area, a representative from each LMHA has the opportunity and direct responsibility for examining the qualitative and quantitative data prepared as part of the CHP process. Data representing population health indicators as well as aggregated, de-identified data from claims and encounters will be shared. Progress measurement on CCO metrics will also be examined as part of this process.

We will also share data and commit staff for involvement in the local behavioral health plan required by OHA from LMHAs as described below to ensure synergy between the plans.

Where possible the CHP assessments provide results over multiple years to demonstrate trends and compare local data to the State of Oregon results. Comprehensive Community Health Assessments will be prepared by NWCCO and presented to the LCACs by October 2020. In order to ensure that each LMHA has the opportunity to review and provide comment on the CHP, we will offer assigned staff to share information and updates, as requested, by the LMHA.

3. **Describe how Applicant plans to collaborate and coordinate with the Local Mental Health Authority in the development of the local plan. Please include dates and milestones.**

   NWCCO will meaningfully engage in collaboration and coordination with local mental health authorities (LMHA), acting through Community Mental Health Programs, in the development of a comprehensive local plan as adopted under ORS 430.630. These plans, as requested by OHA, provide the service and funding framework for a continuum of non-Medicaid service elements (including services for individuals with serious and persistent mental illness who are under Civil Commitment, Aid and Assist/.370, and Psychiatric Security Review Board) supported by State General Funds, block grants, and Other Funds to be implemented during the biennium beginning July 1st of odd numbered years. The following milestones reflect work that NWCCO will do related to this effort beginning January 2020 (dates subject to revision once guidance is provided by OHA):

   - February -April 2019: Collect and review local plans currently in effect.
   - July 2019-December 2020: Meeting with local community partners and Members to start planning, so the LCAC will be ready to go in January 2020.
   - January-April 2020: Provide a primer on local plans including statutory references and sample plan information from a local plan to all LCACs. Invite representative from LMHA and/or CMHP to share information with LCAC.
   - April/May 2020: Review guidance on local plan development, if available, from OHA.
   - May/June 2020: Ensure at least one representative from each LCAC is assigned to participate in the local planning process.
   - June 2020 (or soon after OHA guidance is released): Develop a summary of aggregate, de-identified data, owned by NWCCO, for each LMHA region that would be helpful to individuals working on the local plan. Develop a process for sharing this data as described in the revised MOUs with each LMHA.
   - July 2020 and through Local Plan submission: Include local plan development on the agendas for each LCAC and the RCAC. This includes presentations by representatives from each LMHA or CMHP acting on behalf of the LMHA about the needs, gaps, opportunities for better coordination, shared goals toward the advancement of the triple aim, and ultimately the final plan as approved by the LMHAs.

4. **Does Applicant expect any challenges or barriers to executing the written plan or MOU extension with the Local Mental Health Authority? If yes, please describe.**

   NWCCO through GOBHI already has strong relationships with LMHAs (County Government) and CMHPs. These organizations are well represented at the LCAC and RCAC. We do not expect any challenges or barriers to executing the plan or MOUs.

D. Provision of Covered Services

1. **Please provide a report on the Behavioral Health needs in Applicant's Service Area.**

   Through close coordination with the LCACs, CMHPs, Early Learning Hubs, educational services districts, local justice partners, hospitals, primary care clinics and data analysis strategy, we will strive to maintain a constant pulse on the behavioral health needs in the region. NWCCO's capacity to monitor its behavioral health service provider network has grown and become increasingly rigorous. NWCCO adheres to the standards required by the Managed Behavioral Health Care Organization (MBHO) by the National Committee on Quality Assurance (NCQA). These standards require that organizations regularly conduct: (a) Membership Profiles that examine demographics, behavioral and physical healthcare needs, as well as cost and service utilization patterns through the integration of OHP enrollment, behavioral health claims, and health plan data; (b) Community Health Assessments that cover behavioral and physical health needs as well as health risks such as Social Determinants of Health (SDOH); (c) Provider Network analyses and Directory updates; and (d) Provider to Population Ratios.

   In analyses carried out with integrated health plan data for the NWCCO region, we found that among adults with behavioral health conditions, Serious and Persistent Mental Illness (SPMI) is the highest category: among adult individuals eligible for SPMI, approximately 700 had an SPMI diagnosis for all NWCCO counties. Through GOBHI, we have played an active leadership role in meeting the needs of individuals with SPMI in the region. One example is the creation of "Caring for Clatsop Coalition," a joint venture between Clatsop County, Columbia Memorial Hospital, GOBHI and Providence-Seaside Hospital, to open the North Coast Respite Facility.

   In recent analyses, we have found that 41% had a chronic health condition and 34% had a SUD. Notably the likelihood of having either of these two conditions was higher compared to the rest of NWCCO Members by a factor of 2 or more. In light of the increased prevalence of opioid use disorders and lack of safe, affordable, recovery friendly housing – particularly for women, we have provided leadership for the development of supportive housing for women/women with children in SUD recovery in Clatsop County, a project that will open May 2019. We are also in the process of assisting CODA, a Portland-based comprehensive SUD program, to implement an opioid treatment program (OTP) in this region.

   Among the three counties, Columbia County has historically had the highest number of children in foster care. Through GOBHI, we currently operate children's System of Care-Wraparound in Columbia County, meeting the needs of children and adolescents who are multi-system involved. Most of these children/youth need additional social support, including opportunities for a sense of belonging and attachment to a caring adult. GOBHI

developed a day camp for children and adolescents involved in the SOC-Wraparound program to help meet this need.

The NWCCO region has identified addressing the impact of trauma and building resilience as one of the priority needs for community mental health. We have supported trauma-informed training and technical assistance in this region to meet that need and build capacity in this area.

Behavioral Health Needs in NWCCO's 3-County Service Area

In our recent Membership Profile reports, we stratified the NWCCO population by demographic, clinical and utilization patterns in detail and with special attention to vulnerable populations. For the purpose of this section on behavioral health service coverage, we briefly report on the NWCCO Membership by County, demographics, linguistic/cultural background and its SPMI sub-population. We largely use OHP enrollment and behavioral claims data for **January 1, 2017 to December 31, 2017** because they have been verified across data sources.

	Total Enrollees	% of Total NWCCO	% BH users by county OHP enrollees
Clatsop	12,633	36.7	11.2
Columbia	13,502	39.3	14.5
Tillamook	8,245	24.0	9.2

Table 1. Total Annual NWCCO Enrollment and Percent of users of behavioral health services by county

Following OHP enrollment data: throughout 2017 there were 34,380 OHP Members enrolled across the 3 NWCCO counties. Clatsop and Columbia had over one-third (37 to 39%) and Tillamook under one-quarter of the Members.

Following encounter-claims data: **unduplicated individuals' usage of behavioral health services among OHP enrollees per county ranged** between 9.2% and 14.5%.

Analyses of demographics for the entire NWCCO region reveal that gender was evenly divided—46% were female and 54% male. Regarding age - only a minor fraction were in the 65 years plus bracket (3%). The Children / Youth 18 years or younger bracket consisted of 40% of NWCCO region Members while the adult age bracket between 19 and 64 years 57% of Members. The Ethnic background of NWCCO region enrollees was led by individuals with a European-White (Non-Hispanic) background (73% of members). Among ethnic minorities, 8.3% were Hispanic/ Latinx, 1.4% Native American, 1.1% Asian American or Pacific Islander, and 0.9% African American (14.1% of enrollees had an "undetermined" ethnic membership and 1.1% "other"). The large majority of Members (90%) report that English is their preferred language, 4% reported Spanish, and 0.1% "other" (for 6.6% language was undetermined).

2. Please provide an analysis of the capacity of Applicant's workforce to provide needed services that will lead to better health, based on existing Behavioral Health needs of the population in Applicant's Service Area.

NWCCO region conducts regular analytics on provider type and availability to Membership. The current analysis shows that NWCCO region has one (1) psychiatrist for every 1,990 enrolled Members, with a best practice ratio of 1: 2,000. This pattern exists for LCSW's, current ratio of 1: 995, with best practice ratio of 1: 1,000, and for MFC/LPC's current ratio of 1: 1,170, with a best practice ratio of 1: 3,000. NWCCO utilizes industry establish practitioner to member ratios in determining workforce shortage areas and hiring practices.

Practitioner Type	Network	CPCCO	EOCCO
ABA Behavioral Analyst Interventionist	8	1	7
ABA Board Certified Behavioral Analyst (BCBA)	1	1	0
Behavior Analysis Practitioners:	**9**	**2**	**7**
Certified Alcohol Drug Counselor (CADC) I	77	6	71
Certified Alcohol Drug Counselor (CADC) II	44	2	42
Certified Alcohol Drug Counselor (CADC) III	5	1	4
LPC Master Addiction Counselor (MAC) CADC I	1	1	0
Addictions Counselors (non-MH services):	**127**	**10**	**117**
Clinical Social Work Associate (CSWA)	13	8	5
CSWA CADC I	1	1	0
CSWA CADC III	1	0	1
Licensed Clinical Social Worker (LCSW)	79	22	57
LCSW CADC I	4	0	4
LCSW CADC II	1	0	1
LCSW CADC III	2	0	2
LCSW RN	1	1	0
Licensed Master of Social Work (LMSW)	5	0	5
LSW CADC I	2	1	1
Licensed Social Worker (unspecified)	3	1	2
Social Workers:	**112**	**34**	**78**
Licensed Marriage and Family Therapist (LMFT)	4	1	3
LMFT CADC I	2	1	1
Licensed Professional Counselor (LPC)	70	18	52
LPC CADC I	2	0	2
LPC CADC II	3	1	2
LPC CADC III	2	0	2
LPC LMFT	1	1	0
Licensed Professional Counselors and Therapists:	**84**	**22**	**62**

Practitioner Type	CPCCO
MD Child Psychiatrist	1
MD Emergency Med Practitioner	0
MD Family Practitioner	1
MD Internist	0
MD Neurologist	0
MD Pediatrics	1
MD Preventative Medicine	0
MD Psychiatrist	4
MD Psychologist - Neuropsychologist	0
Nurse Practitioner Family	0
Psychiatric Mental Health Nurse Practitioner (PMHNP)	6
Physician Assistant (PA)	0
Licensed Medical Professional (prescribers):	**13**
Peer Support Specialist	7
Peer Support Specialist QMHA	2
Peer Wellness Specialist	1
Peer Support Specialists:	**10**
Qualified Mental Health Associate (QMHA)	74
QMHA CADC I	2
QMHA CADC II	0
QMHA RN	2
Certified Recovery Mentor QMHA	1
QMHA:	**79**
Qualified Mental Health Professional (QMHP)	49
QMHP - Psychologist	0
QMHP CADC I	6
QMHP CADC II	0
QMHP CADC III	0
QMHP RN	2
MSW QMHP	1
QMHP:	**58**
Registered Nurse (RN)	11
RN:	**11**
Total by Line of Business:	**239**

The same analytics are conducted on the location of practitioner types (psychiatrist, LCSW, MFC/LPC) to Members within the geographic coverage area. NWCCO region currently has over 99% of all practitioner types within 60 miles of each known member. With approximately 80% of all enrollees being within ten (10) to twenty (20) miles of each of these practitioner types. These reviews are done at least quarterly to ensure adequate access to covered benefits by all enrolled Members.

NWCCO through GOBHI has a feedback loop with our network providers as we rely on those these providers to share with us on a daily and/or weekly basis their recruiting needs. As will discuss in questions #3 & #5 of this section, NWCCO through GOBHI coordinates

recruitment with network providers to maximize range of recruitment and qualifications of candidates. We then work with network providers to address shortages within their coverage areas. This requires them to develop capacity to either reduce the ratio of practitioner type to enrolled Members to meet our standards and/or to locate practitioner types in specific areas to ease access for Members.

NWCCO through GOBHI also relies on network management to assist in finding contractors to fill positions on an interim basis in order to ensure service delivery needs are being met. This can include contracting with practitioners for the delivery of care if underperformance in meeting ratio or proximity requirements is chronic and cannot or has not been remedied.

Strategies to continuously strengthen our workforce include: (a) supporting providers in recruiting other providers through a central recruiting and hiring hub; (b) maintaining partnerships with the State's higher education and research institutions that include traineeship programs; (c) implementing and disseminating programs that increase the reach of evidenced-based behavioral services; and (d) training to update and increase the breadth of skills of its existing behavioral provider workforce.

3. **How does Applicant plan to work with Applicant's local communities and local and state educational resources to develop an action plan to ensure the workforce is prepared to provide Behavioral Health services to Applicant's Members?**

NWCCO through GOBHI will continue to refine its' current efforts, to ensure our workforce is prepared to meet the covered services appropriate to our membership. The following represents both formal and informal action plan agreements between NWCCO network providers, and community partners.

- Ongoing recruitment in service areas: In 2018 NWCCO via GOBHI assisted Providers to hire six (6) professionals for either newly created or vacant position. This ranged from therapist, clinicians, DD coordinators, and a controller. We also work in a complementary role with the Provider Organization, in that we assist with advertising, salary surveys, candidate searches, screening, and establishing interviews, but not in interviewing or selecting candidates.
- Training: Training is the largest part of NWCCO region efforts. NWCCO through GOBHI sponsors two annual state wide conferences, the GOBHI Spring Conference in Bend which has featured speakers such as Rep. Patrick Kennedy, Dr. Bruce Perry, and Dr. Gabor Mate, and the Behavioral Health & Education Summit in Pendleton that is targeted for educators, early learning providers, and all who work with young children and families. Both of these events draw from 350 to 500 participants each year from around the State.
- Partner trainings: NWCCO via GOBHI partners currently sponsor or conduct trainings across the state on topics including but not limited to: Cultural Diversity, Child Parent Psychotherapy, Trauma Informed Care (with and without Law Enforcement), Medication Assisted Treatment, and Mental Health First Aid.
- Consultation: NWCCO through GOBHI makes available consulting psychiatrists to network providers for challenging clinical cases. These services are offered to both in and out of network providers serving NWCCO child and adult members. Psychiatrist employed by NWCCO provide numerous trainings and technical assistance on areas

ranging from medication management, Warm Handoffs back into the community, and medication assisted therapy (if appropriately credentialed).

- Collaboration with higher education: NWCCO collaborates with state educational resources including with Northwest Oregon Area Health Education Center in the submission of and subsequent awarding of a one million dollar Oregon Health & Science University (OHSU) grant entitled Healthy Oregon Workforce Training Opportunity. NWCCO is also collaborating with OHSU in admitting qualified nurses in the Nurse Practitioner distance education program and embedding/retaining graduates as licensed PMHNP at clinical practice sites. We are partnering with PSU on the effective implementation and ongoing operations for EASA services and with OSU to strengthen workforce capacity to provide quality parenting education and early learning programs.

4. What is Applicant's strategy to ensure workforce capacity meets the needs of Applicant's Members and Potential Members?

NWCCO providers are required to send quarterly practitioner lists, access reports and chart audits. These reports combined with complaints and grievance trends provide a quick snapshot into the availability and quality member care.

Network participating providers are required to submit all reports quarterly. NWCCO reviews them for compliance with current established threshold standards (established by GOBHI), like routine visits scheduled within ten (10) business days of initial request and the percentage of care delivered within these time frames. There are numerous areas that are evaluated based on regulatory requirements and other standards developed by NWCCO in conjunction with internal quality improvement committees. Acceptable threshold limits are usually established at between 90-95% depending on contracted area.

One result of these continuous evaluations and use of data warehousing platform Arcadia by NWCCO partners in northwest counties and across the state is the ability to determine the underlying cause of poor outcomes. If NWCCO notices trends of underperformance in the same areas regularly, NWCCO will, based on their progressive corrective action policy, conduct an investigation to determine the root cause. The outcome of the investigation will direct the required next steps as stipulated in the same policy.

In circumstances that involve limited workforce capacity, the network provider will be required to rectify the deficiency within an appropriate period of time, as outlined in a corrective action plan.

NWCCO recognizes that due to the rural nature of the service area that there are workforce shortages in all 3 counties. We are pro-actively providing the necessary support and technical assistance to remedy workforce shortages once identified. We have outlined in section D questions 2, 3, and 5 the processes in place to prevent such an occurrence.

We recognize that increasing network provider participation and capacity, delivering services, and/or increasing candidate incentives will likely be necessary in this region. We are confident that NWCCO enhanced PCPCH payments and behavioral health integration between behavioral and physical health delivery points will drive more appropriate utilization, thus decreasing utilization that may be duplicative outside of an integrated model, as evidenced in the outcomes seen in EOCCO. Further, an existing partnership

between NWCCO partners and OSU, has shown great ability to provide employment opportunities, increase workforce capacity, and realized better outcomes and utilization patterns through encounterable reimbursement models and CHW/THW training programs co-designed with NWCCO partners.

5. **What strategies does Applicant plan to use to support the workforce pipeline in Applicant's area?**

In addition to efforts described in response to D.3, NWCCO has ongoing human resources (HR) collaborative meetings with network participating providers. These quarterly meetings are designed to strategically assess workforce capacity with regards to recruitment, retention, and development. In addition to these collaborative efforts NWCCO has assigned staff to work with statewide resources/entities such as Mental Health & Addictions Certifications Board of Oregon (MHACBO), Children's System Advisory Council, and National Association for Health Care Recruitment (NAHCR). These efforts are to ensure our workforce have the most current information, possess the highest qualifications, and utilize the best practices.

NWCCO places priority on strategic recruitment and retention efforts for professionals that are both bi-lingual and cultural. Efforts at attracting and retaining these professionals include, advertising in publications, internet domains, and locations frequented by these professionals, along with sign-on bonuses, further education cost reimbursement, and loan repayment programs. These and other benefits are offered to entice highly qualified and competent professionals to the NWCCO region.

Further benefits include scholarships/furthering education cost reimbursement, signing bonus/loyalty bonus/quarterly bonus, Federal student loan forgiveness programs for rural Oregon, HRSA SUD loan forgiveness programs for rural Oregon, Oregon Healthcare Provider Loan repayment programs, licensure assistance, support of a remote work environment for candidate flexibility, support of strong work/life balance, and relocation reimbursement offered by some network providers. The intent is to maximize rural community's attractiveness, to encourage youth from the region to return after they finished their educational aspirations, and to retain those who are skilled and experienced to remain.

Other miscellaneous areas of workforce development involve conducting candidate satisfaction surveys. The objective is to determine the limitations in our recruitment efforts and how we can make the positions more attractive. NWCCO works to encourage word of mouth recruitment by offering Employee Referral Bonus' if a candidate they refer is offered employment. NWCCO via GOBHI and most organizations within our network offer internships to students at any of Oregon, Washington, and Idaho's universities. These efforts reflect NWCCO's commitment to promoting quality and available care for our membership.

NWCCO/GOBHI staff live and work in the communities we serve. These local staff are available to provide technical assistance and support for behavioral health work within the communities. This proximity provides an understanding of local issues that contribute to

workforce issues. It also provides for interactions with local residents who are interested in the work the NWCCO is doing. Locally placed NWCCO/GOBHI staff not only support the local behavioral health workforce, they learn from them. This front-row seat to a large variety of behavioral health services and practitioners provides opportunities to assure each community is exposed to emerging best practices.

In addition to provider workforce, please see question D.5 above relating to community health worker training programs and reimbursement.

NWCCO Behavioral Health Staff's Home Communities

6. **How will Applicant utilize the data required to be collected and reported about Members with SPMI to improve the quality of services and outcomes for this population? What other data and processes will Applicant collect and utilize for this purpose?**

Using data as a foundation for collaboration, integration and improvement is one of the foundational goals in forming the NWCCO. Three of the NWCCO partners, GOBHI, Moda and Yakima Valley Farm Workers, along with several of the local CMHPs, already benefit from sharing a HIE platform (Arcadia). Connecting the other NWCCO partners to the HIE will be a priority as we ready for the new CCO contract. Sharing actionable data in a manner that avoids duplication of services, highlights areas for improvement, and assures best practice care is delivered will help assure our Members receive the all the advantages afforded by a community of coordinated caregivers.

NWCCO's capacity via GOBHI to monitor its behavioral health service provider network has grown and become increasingly rigorous. NWCCO through GOBHI adheres to the standards required for Managed Behavioral Health Care Organization (MBHO) by the National Committee on Quality Assurance (NCQA). These standards require that organizations regularly conduct: (a) Membership Profiles that examine demographics, behavioral and physical healthcare needs, as well as cost and service utilization patterns through the integration of OHP enrollment, behavioral health claims, and health plan data; (b) Community Health Assessments that cover behavioral and physical health needs as well as health risks such as Social Determinants of Health (SDOH); (c) Provider Network analyses and Directory updates; and (d) Provider to Population Ratio analyses.

All data collected is analyzed with a focus on opportunities for improvement. Aligning these opportunities with the needs of our most vulnerable populations, including SPMI, children, and pregnant women, is a focus.

In addition to the workforce data, demographics and co-occurring data mentioned above, NWCCO through GOBHI already collects data on utilization trends (over, under, specific services, readmissions, Emergency Department, Inpatient etc.), access, crisis response times, completion of recommended screenings, screening results, quality metrics, costs trends, complaints and grievances, member safety, provider experience, member experience and patient reported outcomes.

Data, both claims based and direct feed from provider EHRs connected to the HIE, are updated daily so frontline care givers have the information they need as they interact with Members. Quarterly Improvement projects are prioritized and tracked, with regular reporting to the Quality Improvement Committee (QIC), Peer and Provider Advisory Council, and Board of Directors (all of which contain consumer representatives). Annually, the information is used to generate a number of reports according to NCQA standards that detail improvement efforts and progress toward goals. Data collected is also made available to practitioners and providers as part of this annual process improvement evaluation. This evaluation assists NWCCO and our network practitioners and providers in recognizing areas that require improvement and where services are being delivered successfully so that these best practices can be mirrored across our health network.

NWCCO through GOBHI also uses the collected data to build reports that identify members who may benefit from further coordination of services, including ICC services, help setting follow-up appointments or assistance connecting to other services for preventative care. Staff then conduct outreach based on results of the report or provide a list of identified eligible individuals to ACT teams that are the geographic proximity to the client and require ACT providers to do the outreach.

7. **What Outreach and/or collaboration has Applicant conducted with Tribes and/or other Indian Health Care Providers in Applicant's Service Area to establish plans for coordination of care, coordination of access to services (including crisis services), and coordination of patient release?**

There are no Tribal sovereign nations within the three counties that comprise NWCCO. Yet Native Americans are the third largest ethnic group within the catchment area. There are 392 identified members, with potentially more due to ethnicity being self-reported. Currently NWCCO through GOBHI informs and makes available to all Native Americans, services, and providers of those services, consistent with their preferences. NWCCO through GOBHI is working to assure Members have access to services provided by Native American providers, for both outpatient and inpatient behavioral health services. Since many of these services are located outside of the NWCCO region, efforts will be made to utilize tele-behavioral health if Members would prefer not to make the drive into Portland. NWCCO continually monitors out-of-network utilization to identify opportunities to further contract with Native American providers being utilized by our Members.

Additionally, for individuals of federally or locally recognized tribes that have members living in the area, NWCCO will be conducting outreach in 2019 with the intent to include tribe members in the CAC and other governance structures.

E. Covered Services Components

1. **Substance Use Disorder**

How will Applicant support efforts to address opioid use disorder and dependency? This includes:

a. **How will Applicant provide, in a culturally responsive and linguistically appropriate manner, SUD services to Members, including outpatient, intensive outpatient, residential, detoxification and MAT services?**

Members have access to the full array of recovery oriented SUD services including detox, outpatient, intensive outpatient, residential, MAT, crisis, outreach/engagement and peer services. Services are delivered through our credentialed and contracted provider network and are required to be culturally responsive and linguistically appropriate. To assure that Members can receive services from a Provider that is a good fit, NWCCO through GOBHI works to assure contracts are in place with Providers that serve specialized populations (i.e. Native American, non-English Speaking, LGBTQ, etc.) In some instances, other, non-local NWCCO providers (with transportation provided if needed), will be utilized for specialized services as will HIPAA compliant, tele-health software. Providers are trained on the most effective way to utilize interpretation services and will be encouraged to use face to face interpreters whenever possible. Members can utilize the NWCCO provider directory (on-line or hard copy) or call Member Services to find the best provider match to meet their needs. This information is available in English and Spanish, and includes information on how to access it in 15 additional languages.

We have worked extensively throughout this region with behavioral health and primary care partners to develop MAT services, pain management clinics and other resources to meet the needs of people with SUD. As referenced earlier, we are currently working with CODA to develop and Opioid Treatment Program (OTP) in Clatsop County. We have developed a Women's Specific SUD Supportive housing project to open in May of 2019 for women/women with children who are in SUD recovery.

b. How will Applicant provide culturally responsive and linguistically appropriate alcohol, tobacco, and other drug abuse prevention and education services that reduce Substance Use Disorders risk to Members?

Local communities and tribes employ SUD prevention specialists to provide education and preventative programming appropriate to the local cultural and community needs. The NWCCO will coordinate with communities via the LCACs and coordination with local prevention and public health workers to support these efforts. Trainings can be provided either by bilingual staff or utilizing translators to accommodate language needs. NWCCO through GOBHI also supports, via financial incentives, the implementation of screening of SUD screening utilizing SBIRT and other appropriate tools through financial incentives. Intervention for lower level use disorders or high risk behaviors is supported within the primary care clinics utilizing training for staff on motivational interviewing, scripts for tobacco cessation counseling, and integration of behavioral health consultants.

NWCCO via GOBHI, through an NCQA collaboration, is working with four other health plans scattered throughout the United States to develop best practices related to unhealthy alcohol usage. As part of this work, NWCCO CMHPs are implementing pilot programs designed to determine the most effective way to screen for at risk alcohol use.

The Women's Specific SUD Supportive Housing project is a multi-generational model, designed to improve family unity, parent-child attachment and bonding. Early learning and parenting education partners have all been included in the process to develop this resource and are eager to provide services for these women and their children in an effort to break the cycle of addiction and other behavioral health conditions for these families.

NWCCO will also provide access for all Members and Providers to myStrenths, a self-help software platform designed to "empower users with individualized pathways incorporating multiple programs to help manage and overcome co-occurring challenges."

c. How will Applicant inform Members, in a culturally responsive and linguistically appropriate manner, of SUD services, which will include outpatient, intensive outpatient, residential, detoxification and MAT services?

Many of our communities already have collaborations in place between SUD providers and referral sources via multi-disciplinary teams (referred to as HUBs in some communities) to ensure the local community and culturally specific needs are being addressed. The NWCCO provider directory will be available to find an SUD provider that best matches needs. The member handbook will be available in English and Spanish, with information on how to access it in 15 additional languages. NWCCO will also disseminate information to community Members and referral sources via a number of venues including LCACs and the CAP.

d. In collaboration with local providers and CMHPs, ensure that adequate workforce, Provider capacity, and recovery support services exist in Applicant's Service Area for individuals and families in need of opioid use disorder treatment and recovery services. This includes: sufficient up to date training of contracted Providers on the PDMP, prescribing guidelines, buprenorphine waiver eligibility, overdose reversal, and accurate data reporting on utilization and capacity.

As a newly developed CCO, NWCCO intends to model the work around opioid programs that are developed out in Eastern Oregon. NWCCO plans on engaging with local clinicians to create a multi-disciplinary team that uses data and current clinical guidelines to build programs for members in need of OUD and recovery services, as well as decrease the overall utilization of opioids.

NWCCO plans to adopt the strategy of "remove and replace" for the treatment of members with opioid use. This plan is a physician led treatment that identifies members who have high risk opioid utilization and works to remove the opioid and replace with more clinically appropriate care, such as movement therapy.

NWCCO will work to support the clinical community in various facets by providing taper plan support, peer to peer engagement, and various ways to implement current prescribing guidelines in clinical practice. NWCCO will provide ongoing analytics support to help identify areas of opportunity and provide clinics and physicians a roster of members on opioids and how the overall incidence rate benchmarks against their peers. NWCCO will encourage the use of the PDMP prior to any visit with a member who has been identified on their population roster.

To ensure adequate workforce, provider capacity, and recovery support services, NWCCO will also look to adopt new payment methodologies to provide more access to treatment. NWCCO will also look to ensure the appropriate level of Waiver X providers within the community and provide trainings for physicians if necessary.

Additionally, NWCCO is focused on meeting members where they are in terms of readiness, location, culture, and socioeconomic circumstances, and improving coordination and connection with members transitioning between levels of care.

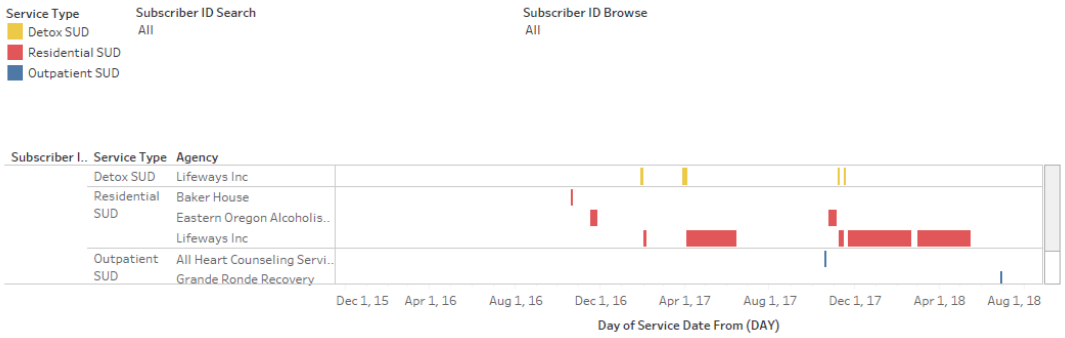
e. Coordinate with Providers to have as many eligible Providers as possible be DATA Waived so they can prescribe MAT drugs.

Efforts are ongoing to increase the availability of MAT services including encouraging providers to acquire a data waiver. MAT services are now available in all 3 NWCCO counties. Efforts will now focus on expanding availability through the creation of an OTP in a central location in the region and on increased use of telemedicine. NWCCO's opiate service planning group will work to identify the most effective locations to create new capacity in our area.

NWCCO under the OPDP Consortium will have access to MAT products, buprenorphine and naloxone, as a covered benefit without the additional barrier of a prior authorization.

f. Coordinate care with local Hospitals, Emergency Departments, law enforcement, EMS, DCOs, certified Peers, housing coordinators, and other local partners to facilitate continuum of care (prevention, treatment, recovery) for individuals and families struggling with opioid use disorder in their Community.

NWCCO through GOBHI uses data and software systems, as well as community input, to look for gaps in care. In the example provided, NWCCO looks for members with multiple trips to Residential SUD and Detox programs who did not appear to be receiving follow care in outpatient treatment. NWCCO assigns a care coordinator to work with this member to connect them to local community supports and to encourage outpatient treatment with the hopes of preventing the need for higher levels of care.



NWCCO via GOBHI, recently began funding peer support engagement specialists to conduct outreach and engagement activities with people who are in the pre-contemplative and contemplative stages of change around SUD and OUD throughout the three county region. These peers interface with the healthcare community, law enforcement, needle-exchange programs, housing providers and other community services in an effort to promote service engagement at any level that a person is willing to consider.

We have also worked with Oregon Housing and Community Services, the local housing authority, DHS-child welfare, Clatsop Behavioral Healthcare, and the early learning community to develop supportive SUD housing for women/women with children, many of whom will be in early OUD recovery. This resource opens up in May of 2019.

In partnership with OHA, we have developed the Oregon Center on Behavioral Health and Justice Integration, a statewide effort providing specialized training and technical assistance aimed at treating people who, primarily due to symptoms of serious behavioral health conditions, are at risk of incarceration or are already involved in the justice system. Through the Center, we have recently facilitated Sequential Intercept Mapping (SIM) in Clatsop and Columbia Counties, identifying priorities for their local justice planning. A majority of the priorities relate to addressing unmet behavioral health needs including SUD. We will maintain involvement with all counties in this region to promote effective strategies reducing justice involvement for people with serious behavioral health needs.

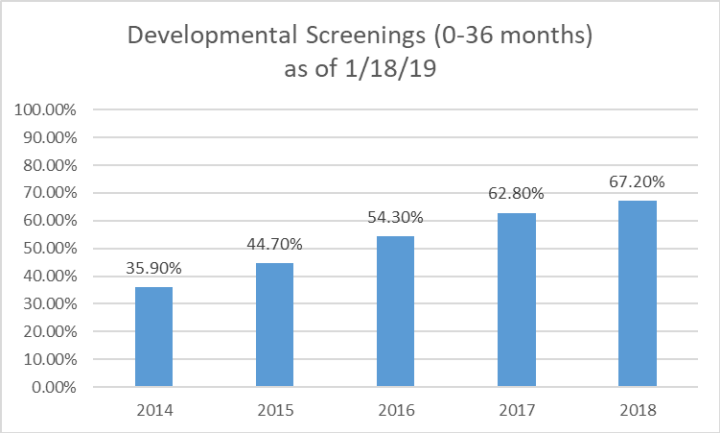
NWCCO will support an annual conference with partners including law enforcement to discuss current challenges, available resources, and coordination of efforts in prevention, treatment, and supporting recovery. Crisis workers are utilized to assist with assessment and referrals within Emergency Departments and in communities, and for non-urgent outreach, recovery mentors are utilized. Starting in 2019, NWCCO is partnering with Dr. Kenneth Minkoff (http://kenminkoff.com/index.html) to help local SUD treatment providers further develop systems of care designed to care for individuals with "dual diagnosis" and co-occurring illnesses.

g. Additional efforts to address opioid use disorder and dependency shall also include:

- **Implementation of comprehensive treatment and prevention strategies**
- **Care coordination and transitions between levels of care, especially from high levels of care such has hospitalization, withdrawal management and residential**
- **Adherence to Treatment Plans**
- **Increase rates of identification, initiation and engagement**
- **Reduction in overdoses and overdose related deaths**
  - PCPs will be sent a monthly roster that identifies all members that are on an opioid product and the report will specifically call out those that are: high risk (120 MED+), those with multiple prescribers at multiple pharmacies, those with a back pain diagnosis that would fall under the HERC guidelines, and those with concomitant use of benzodiazepines.
  - Morphine Equivalent Doses (MED) Point of Sale Edits will be utilized to alert pharmacists when prescription exceeds a 90 MED (that can be over-ridden by a pharmacist given clinical rationale), or exceeds 200 MED which requires a review by NWCCO before the prescription is filled.
  - We assisted in creating an alternative to opioid use for people with chronic pain in each of the three counties. These wellness centers host pain schools that are staffed by a multi-disciplinary team, provide group sessions that include psycho-education, movement therapy, nutrition counseling, and behavioral health support. Members enrolled in the program report a decrease in depression, anxiety, and pain interference, as well as an increase in self-confidence related to managing pain.
  - We will continue to develop additional MAT capacity and are close to the implementation of one additional OTP for the region as described above.

2. **Fewer readmissions to the same or higher level of care Prioritize Access for Pregnant Women and Children Ages Birth through Five Years**

   a. **How will Applicant ensure that periodic social-emotional screening for all children birth through five years is conducted in the primary care setting? What will take place if the screening reveals concerns?**



NWCCO has experience from the PE 30 project, Community Prevention Program, which included contracting with the Oregon Pediatric Society to provide consultation and technical assistance to individual medical clinics for all aspects of ASQ-3 and ASQ-SE clinic implementation. This project focused on children birth through 5 years old and was successful in improving the metrics for developmental screens for children 0-36 month.

Moving forward, NWCCO will ensure continued support and utilize our previously effective strategy to conduct periodic social-emotional (ASQ-SE) screening for all children 0-5 in primary care settings. Key tools and quality improvement practices will be implemented to increase two-way communication between Primary Care and Behavioral Health. Tools include: Standardized child-specific referral forms, a medical decision tree with considerations for internal behavioral health processes, and a shared decision making tool/education sheet for primary care to use with families. These tools positively impact both providers and families receiving services, advancing the discussion of mental/behavioral health options and processes in the community. The implementation of these tools help establish and standardize a clear pathway for service providers and families if concerns are identified at screening.

Beyond traditional steps to address concerns, NWCCO through GOBHI has a robust Applied Behavioral Analysis program developed over the last 3 years. This program was developed, in part, as a response to a lack of adequate training in primary care settings to assess and screen for autism related disorders. In addition to the ASQ SE, NWCCO is leading trainings for, connecting to, and building infrastructure with rural health clinics to better equip them with the knowledge and expertise to support accurate assessment for autism spectrum disorders. This additional service significantly decreases waiting times, costs to families and provides localized expertise within the NWCCO service area.

b. What screening tool(s) to assess for adverse childhood experiences (ACEs) and trauma will be used? How will Applicant assess for resiliency? How will Applicant evaluate the use of these screenings and their application to developing service and support plans?

Currently, when serving young children and their caregivers using a dyadic model, two screening and assessment tools are being used to assess ACE's and trauma: Parenting Stress Index 4 Short Form (PSI4-SF) and Eyberg Early Childhood Behavioral Inventory (ECBI). Moving forward, NWCCO will also be using the Devereaux Early Childhood Assessment for Infant & Toddlers, DECA I/T. These tools, approved and monitored by the OHA, contain pre/post scores that are submitted to the Early Childhood Mental Health Policy Specialist in our quarterly reports for data collections and evaluation purposes. For members of the Applied Behavior Analysis program, the screening tools used for resiliency are the Assessment of Basic Language and Learning Skills – Revised (ABLLS-R), the Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP), Vineland Adaptive Behavior Scales – 3, and Functional Behavior Assessments; all of which are standardized evidence-based assessments. For youth entering DHS custody, the Child and Adolescent Needs and Strengths Screening (CANS) is utilized to evaluate ACE's and Trauma. The CANS Oregon will serve as a multi-purpose tool to support decision making including level of care and service planning, to facilitate improvement initiatives, and to allow for the monitoring of outcomes of services. Additionally, NWCCO ABA programming is currently working with both Pediatricians, Diagnosing Physicians and OBGYNs to follow-up with new mothers and children in their first few years of wellness checks so that early signs of Autism may be detected and if observed, will be recognized and sent to experts for consultation and immediate follow-up to receive diagnosis and gain access to early intervention in ABA therapy as soon as possible.

NWCCO through GOBHI will continue to partner with the local CACs and community organizations in ongoing Trauma Informed Care projects. NWCCO staff and other resources are dedicated to this work based on community priorities.

c. How will Applicant support Providers in screening all (universal screening) pregnant women for Behavioral Health needs, at least once during pregnancy and post-partum?

Recognizing that all pregnant women can benefit from additional support, NWCCO plans to utilize the Family Connects model from North Carolina to create universal screening for all pregnant members. NWCCO currently utilizes the PHQ-9 to screen for behavioral health needs in primary care for all pregnant members both during pregnancy and post-partum. NWCCO will continue to partner with local Public Health Departments and other home visiting programs to build an infrastructure with the ability to provide screening and subsequent visits to every pregnant member. Additional NWCCO efforts include:

- Apply to be a pilot site for SB 526 (OHA shall study home visiting by licensed health care providers in this state) in 2020, with a goal to implement region wide within 3 years.
- Continue support for using 5 P's to screen for substance use concerns in pregnant members. Screening covers: Did any of your Parents have problems with alcohol or

drug use, Do any of your friends (Peers) have problems with alcohol or drug use, Does your Partner have a problem with alcohol or drug use, Before you were pregnant did you have problems with alcohol or drug use (Past), In the past month, did you drink beer, wine or use other drugs (Pregnancy).

- Identify and support infants/toddlers and caregivers with additional needs.
- To support our infants/toddlers and caregivers who are identified as needing additional support, we have experience with an Integrated Nurse Home Visiting Program (INHV) in several counties in Eastern Oregon. This pilot project is partnered in four eastern Oregon counties (Grant, Morrow, Umatilla, Malheur), by four public health departments, and two community mental health providers. This project is in collaboration with public heath home-visiting nurses and mental health clinician's working together to provide PHQ-9 screenings to mothers and offer additional mental health support in the home. We plan to expand this successful project in our NWCCO region.

d. How will Applicant ensure that clinical staff providing post-partum care is prepared to refer patients to appropriate Behavioral Health resources when indicated and that systems are in place to ensure follow-up for diagnosis and treatment?

NWCCO via GOBHI is supporting the Oregon Pediatric Improvement Partnership (OPIP) in a pilot project to develop pathways throughout the entire catchment area for young children identified in primary care through assessments to the referral and follow up process. This effort will develop a Primary Care Decision Tree to support primary care providers in identifying children and caregivers who should be connected to internal behavioral health supports, referred to specialty mental health, or both. Indicators will be developed across primary care sites with enhancements and customization based on child and family risk factor screening that each primary care will be utilizing. Standardized and child-specific referral forms will be used to refer children 0-5 and their caregivers from primary care to mental health agencies. This includes specific and relevant information to ensure a "Warm and informed" Handoff that the primary care provider can give to the mental health agency to guide a best-match assessment, as well as specific requests for communication feedback. Included in this referral form will be any notes about the primary care provider's impression of the family's level of engagement and specific outreach and communication strategies that may be useful. Training curriculum and on-site training to implement the tools developed through this initiative are being made available to allow the system to be maintained by the NWCCO provider community post implementation. Another focus area of this project includes decreasing the stigma of discussing and/or acknowledging the mental health of our infants and toddlers, which concurrently decreases referrals.

NWCCO will coordinate with and support home visiting programs delivered by the local public health authority. We have conducted stakeholder interviews in the NW region, seeking to understand the strength, needs and gaps in the parenting and early learning service systems. We know that inadequate capacity currently exists for home visiting through both Babies First! and CaCoon programs. Through GOBHI we are already supporting a project in our other service area integrating mental health consultation with home visiting and will bring forward lessons learned from this pilot to the NW region

through the NW ELH and other partnership engagement efforts with the early learning coalition. More details about this project are referenced in f. below.

NWCCO through GOBHI continues to transform our provider network by supporting development of additional integrated clinics. These integrated clinics increase access to behavioral health resources for members within the primary care setting, helping remove existing stigma associated with established mental health stand-alone sites, supports the warm handoffs and in-house referral process with connection to support services.

NWCCO providers will also be provided access to a tele-health solution in the fall of 2019 that allows Members to be seen in the privacy of their own home, further removing barriers to access such as transportation, child care issues, or fear of stigmatization.

e. How will evidence based Dyadic Treatment and treatment allowing children to remain living with their primary parent or guardian be defined and made available to families who need these treatments?

NWCCO through GOBHI has and will continue to support the research, training, and implementation of several dyadic treatments that allow children to remain living with their parents. We are encouraged by the research that claims the earlier we provide support and interventions, the greater possibility of early success, keeping families together and consequently lowering cost. Eighteen months ago, we launched an Early Childhood Initiative to bring awareness and decrease the stigma of infant and early childhood mental health. The goals of this initiative are to build and support already existing early childhood systems and create a public awareness campaign that highlights the importance of recognizing and caring for an infants' mental health in the same fashion we care for their physical health. In this effort, we plan to define the components of infant mental health and spread the information to the general public through popular media sources, as well as make resources available. NWCCO through GOBHI is in conversation with the Oregon Infant Mental Health Association (ORIMHA) and plans to partner with them and other community partners to create a larger impact across the entire state. The second phase of this initiative is to build on the evidence based dyadic treatments that exist in our region by defining them as available supports. Below are treatments that we continue to build in our region:

- We intend to use the existing infrastructure of the our Therapeutic Foster Care Program to incorporate evidence based Dyadic Treatment models, such as the Attachment and Bio behavioral Catch-Up Intervention (ABC) model for infants 6 to 24 months and their caregivers. The TFC infrastructure currently supports foster families who foster extremely high-risk youth, putting the program in an ideal position to partner with Child Welfare and serve the families that will be identified through the Family First Services Prevention Act. Oregon Child Welfare reports that over 45% of children removed from their homes are under age of five. Providing supportive services and evidence based Dyadic Treatment to these children and their parents reduces the likelihood of out of home placement, and encourages healthy parenting skills, child development, and attachment.
- The NWCCO partnership includes a Licensed Child Caring Agency providing Therapeutic Foster Care services. Our Planned and Crisis Respite program also provides opportunity for short term interventions to support parent education and

skill development for children while remaining a family unit. This additional service provides members an opportunity to address needs of children and families immediately and preventing higher levels of care keeping families together.

- Supporting NWCCO providers to expand evidence based dyadic treatments by obtaining available funding for Parent-Child Interaction Therapy. In 2018, Oregon Health Authority (OHA) introduced flexibility in their fidelity model to assist and encourage rural counties to apply. As a result, a provider in each of the three counties was awarded funding for start-up and training expenses. Clatsop Behavioral Health (CBH) was awarded a primary site with Tillamook Family Counseling Center (TFCC) as their satellite site. CBH was also awarded funding to operate PCIT within their local DHS office. This will increase NWCCO's capacity to serve our youngest members and their caregivers in the region.
- Six years ago when OHA announced that the only evidence based dyadic model they would be supporting was PCIT, NWCCO through GOBHI knew that this would be extremely limiting to our members. As with any mental health condition, one model cannot work for everyone, so GOBHI persisted and convinced OHA to consider other evidence based models. Consequently, OHA found a very small amount of funding for the training and ongoing consultation of Child parent Psychotherapy (CPP). For the past six years, GOBHI has supplemented this funding yearly in order to provide CPP training and consultation to a new group of clinicians. To date, we have trained over 125 clinicians, not only in our CCO region but across the state of Oregon. NWCCO is one of two CCOs that provides Child Parent Psychotherapy (CPP) training to clinicians throughout the state. CPP is an evidenced based treatment model that treats children who have experienced at least one traumatic event (death, domestic violence, maltreatment, sexual abuse), and as a result are experiencing attachment, behavior and/or mental health problems. Treatment uses the parent-child relationship to help reestablish a sense of safety and security, and is a treatment model that can be made available to families through in-home visiting, thus reducing further stress on the family to receive services in a clinic setting.
- To increase capacity and by offering several evidence based dyadic treatment models, NWCCO via GOBHI plans to support and assist in the implementation of the Attachment & Bio behavioral Catch-up Model (ABC) by partnering with home visiting and/or early childhood providers. ABC is a model is used for treating young children 6-24 months who have been exposed to trauma. Based in attachment theory, ABC intervention consists of 10 manualized sessions that addresses nurturance, synchrony, and frightening and intrusive behavior. The sessions are provided through guided discussion by a "coach", which can be care extenders, family support workers, and/or Traditional Health Workers.
- NWCCO through GOBHI plans to continue financial support and extend the Positive Parenting Program (Triple P) into the region by 12/31/19. Triple P has multiple delivery options including individual sessions, group classes, online courses, and home visits. With the vast reach at a community level and increasing intensity, Triple P has the ability to support parents with multiple existing barriers. Triple P (Umatilla County) partners with DHS to provide parent education to at risk families including parents who are currently living with their children and

those seeking reunification. Parent education coordinator works with local agencies, including pediatric/primary care offices. Parenting concerns are often initiated in pediatric/primary care setting. This promotes a direct referral to quick intervention and support, increasing the number of children remaining in the home with their primary parent.

- For children who have an autism diagnosis, NWCCO through GOBHI provides intensive (up to 30 hours a week) Applied Behavioral Analysis in the home. Due to the fidelity requirements and intensive service benefit to members who qualify for this service, GOBHI decided not to delegate this program to another agency, for the purpose of utilizing our expertise with rural communities to best meet the needs of our members.
- Merging our ABA program with the Regional Developmental Disabilities program allows us to work in the home using family advocates who create specific plans that assist parents and children with other behavioral and social concerns, especially decreasing medical emergencies. These family advocates also provide parent and Behavior Intervention Training and education. Family Advocates also provide in-home Behavioral Consultation and connection to resources and county networks to families that are on service waitlist.
- Board Certified Behavior Analysts (BCBAs) prepare Behavior Intervention Plans (BIPs) for clients who display maladaptive behaviors (i.e., aggression and self-injurious behavior) to support both child and parents with coping strategies, and complete Functional Behavior Assessments to determine ways to support child with home and academic skill learning.
- In addition, our ABA program offers training to siblings in order to teach them about triggers and how to avoid escalating their brother/sister.
- Family Advocates provide in-home Behavioral Consultation and connection to resources and county networks to families that are on service waitlist.

f. How will Applicant ensure that Providers conduct in-home Assessments for adequacy of Family Supports, and offer supportive services (for example, housing adequacy, nutrition and food, diaper needs, transportation needs, safety needs and home visiting)?

NWCCO through GOBHI provides a variety of supportive and in-home services:

- Positive Parenting Program (Triple P) parenting education can be provided in the home allowing the practitioner to identity family needs of supports and services. Triple P is currently able to provide incentives for those participating in the curriculum. Necessities include diapers, formula, gas cards, home safety supplies, etc. Triple P collaborates with the CARE program, a wraparound service helping family's access resources with the purpose of strengthening families. Many of the CARE staff are also trained in Triple P to deliver the material to parents they already serve.
- In 2019, we were approached by Hope House of Lutheran Community Services to partner in the development of a Relief Nursery in Clatsop County. This will provide specialized services to families and their very young children (up to 3 years of age) to prevent abuse and neglect and keep children out of our foster care system.

- Many counties in Eastern Oregon have provided care coordination services to children and families through the CARE Program. Through EOCCO, we have been a substantial supporter of this program since 2014, which has served over 1,000 youth and 500 families per year. Assessing for social determinants of health is a major component of this service. For years, research has shown that when children and families do not have their basic needs met, they are unable to attend to their physical and/or mental health. In order to assess the supportive needs of our families, CARE coordinators plan in-home visits at times convenient for our members' schedules. NWCCO plans to expand this program in the region by partnering with the NW Regional Educational Service District and NW Early Learning HUB.
- As NWCCO, we plan to implement findings from the Integrative Nurse Home Visiting pilot project and expand in the NWCCO region. This project is in collaboration with public heath home-visiting nurses and mental health clinician's working together to provide PHQ-9 screenings to mothers and offer additional mental health support in the home. The aim is to support early childhood health and strengthen the parent-child relationship by addressing maternal and caregiver depression and integrating behavioral/mental health services within existing home visiting programs. This service model provides in-home behavioral/mental health support services when risk factors for depression have been identified through depression screenings provided by public health home visiting programs and the Nurse Family Partnership (NFP) with families who are already receiving home visiting. When a referral is made, the mother/caregiver is not required to go to another agency, instead, the additional support is provided in the home and introduced by their home visiting nurse who they have already establish a relationship with. While it mainly addresses the attachment between child and caregiver, since the service is provided in the home, it is continually assessing whether the caregiver has the supportive services needed to allow them to focus on the mental health needs of their child.
- ABA and Family Advocates Program: Given our Family Advocates, BCBAs, and Behavior Interventionists are consistently providing support in the homes of the members. This enable them to complete site observations of the families living conditions and safety assessments for the welfare of the child. Additionally, beyond our regular communication about programming, specific parent/guardian interviewing occurs frequently throughout each quarter to discuss other challenges the family may be facing beyond the child's diagnosis. Funding support for home fumigation, GOBHI's Veggie RX program, fuel stipends, etc. are made to support local families. Lastly, GOBHI and ABA employees take our role as mandatory reporters very seriously and do what is necessary to ensure the welfare of all individuals we serve. In addition, Applied Behavior Analysis Program specifically serves members in their homes in rural settings allowing parents and primary caregivers the flexibility and accessibility to directly engage with the child's day treatment. ABA offers in-person consultation, telemedicine, phone calls and email that allow parents to directly engage, participate or observe their clinical team regularly as the child progresses through therapy. In Eastern Oregon we have recently made two clinic locations available to parents and primary caregivers,

where they can bring their child to interact in a therapeutic setting. These clinic locations are designed for increased social engagement, community involvement, and recreational activities and to support integrated peer involvement by having peer-supported therapy with both parents and interventionists of two or more families involved; with the goal of developing a community support in mind.

- As mentioned above, we will also be exploring SDOH screenings through any home visits, contacts with mandatory Medicare transition touches, and other opportunities to gather data on member needs and potential programs/partnerships to address those.

g. Describe how Applicant will meet the additional Complex Care Management and evidence-based Behavioral Health intervention needs of children 0-5, and their caregivers, with indications of ACEs and high complexity.

NWCCO will utilize Health Complexity Data provided by the OHA Transformation Center in partnership with the Oregon Pediatric Improvement Partnership (OPIP). Given that this data identifies children with medical and social complexity in our CCO population, we plan to further aggregate the data into specific counties to assist with further identification. The social complexity algorithm identified several ACEs into their list of 12 factors. To assist us with developing our implementation plan to meet the needs of children with high health complexity, NWCCO will be utilizing the technical assistance opportunities offered by OPIP. Examples of TA being offered by OPIP include: using population-level findings regarding children's health complexity to engage community-level partners and facilitate community conversations, using health complexity data to develop models of best match care coordination and case management for children with various levels of health complexity, using children's health complexity information to guide efforts with front-line health care providers.

h. How will Applicant ensure children referred to the highest levels of care (day treatment, subacute or PRTS) are able to continue Dyadic Treatment with their parents or primary caregivers whenever possible?

NWCCO will not refer Members between the ages of zero to five to residential levels of care, or partial hospitalization for day treatment. If a youth age 6 and above requires a higher level of care including day treatment, subacute, or PRTS, children and families are automatically eligible for and offered fidelity Wraparound. Regardless of the interest in the Wraparound process, the youth will be provided ICC services and supports. If a child is placed into a facility based residential treatment program, NWCCO via GOBHI contracts with service providers who are equipped with both video conferencing and other reasonable accommodations to continue treatment while in out of home placement. Once youth are enrolled in these highest levels of care, NWCCO will utilize the Wraparound model to maintain parents' participation in their child plan of care.

i. Describe Applicant's annual training plan for Applicant's staff and Providers that addresses ACEs, trauma informed approaches and practices, tools and interventions that promote healing from trauma and the creation/support of resiliency for families.

GOBHI on behalf of NWCCO has several opportunities for employees and providers to attend trainings related to trauma-informed approaches and ACEs on an annual basis, including:

- The GOBHI Spring Conference holds an agenda that includes evidence-based and emerging best practices as a training opportunity for not only staff Members but providers and other community Members. The last three conferences focused on trauma informed approaches.
- NWCCO through GOBHI is also a host and funding source for the Child Parent Psychotherapy (CPP) Training and Learning Collaborative. The collaborative spans an 18-month period and trains clinicians to address trauma though the dyadic relationship. Clinicians are also taught how to heal those who have had traumatic experiences by increasing the caregiver's attachment, knowledge of typical children's developmental milestones, and ensuring the use of trauma-informed responses when symptoms arise.
- NWCCO through GOBHI is also a strong proponent of suicide prevention and awareness in Oregon communities, and has several Mental Health First Aid trainers on staff. Youth and adult focused trainings are held annually in a variety of locations. We have certified Applied Suicide Intervention Skills Training (ASIST) trainers who train GOBHI staff in addition to community Members and the NWCCO provider network.
- NWCCO through GOBHI ensures that all therapeutic foster parents receive training in the evidence-based practice - Collaborative Problem Solving. It is a recognized trauma-informed approach to working with youth with significant behavioral issues and multiple traumas. All therapeutic foster care staff are Tier 1 trained, at a minimum, with content refresher training occurring on a minimum of a quarterly basis. Our trainers also coordinate with other CPS trainers in the state to ensure Tier 1 trainings are brought to remote places in Oregon. This ensures that providers, community Members, and GOBHI staff on behalf of NWCCO, who otherwise may have a distance barrier have an opportunity to attend. CPS Parent Group Trainings are provided to parents and legal guardians of youth involved with Wraparound and ICC to help build skills in parents and legal guardians of children in need of additional support.
- Crisis Prevention Institute, Non-Violent Crisis Intervention training is also a training provided through the Therapeutic Foster Care (TFC) program to foster parents and staff of the TFC program, Applied Behavioral Analysis staff, and Members of the GOBHI (NWCCO) provider network. This training equips individuals with skills, confidence, and an effective framework to safely manage and prevent difficult behavior. It is proven effective to support multiple populations across the lifespan, from children to older adults with dementia.

- NWCCO via GOBHI co-sponsors the Behavioral Health and Education Summit offered in Northwest Oregon. Through partnering with the Blue Mountain Early Learning Hub, and Intermountain Education District, this event is held in Umatilla County each year in October. The training is targeted towards educators, early learning providers, and all who work with young children and families. Noteworthy topics have included ACEs, resiliency, brain development and growth, and Trauma Informed Care. In the last 6 years, this summit has provided training to over 2000 individuals who serve young children and their families in Northwest Oregon.
- ABA and I/DD programs provide specialized and uniquely designed training programs for employees to become registered and licensed as Behavior Interventionists within the state of Oregon. Many of the trainings are focused on techniques involved for providing individualized ABA therapy for children with ASD, mental health and developmental disabilities. Specific trainings for ABA Behavior Interventionists and Developmental Disabilities Coordinators include: Oregon Intervention System Training (OIS), Trauma, Identity Disturbance, and Borderline Personality Disorder in Persons with I/DD, Health Care Decision Making Training, Beneath the Surface; Understanding Challenging Behavior, Overview of Autism, Ethics of Touch, Crisis Intervention Training and Getting to the Heart of Intimacy. These trainings are specifically selected to compliment the complexity of rural Oregon to support families within the home.

3. Care Coordination

a. Describe Applicant's screening and stratification processes for Care Coordination, specifically:

(1) How will Applicant determine which enrollees receive Care Coordination services?

Children and Adolescents (Child Welfare): NWCCO through GOBHI provides all children in Child Welfare and state custody with the opportunity for Care Coordination by way of the Program Eligibility Resource Codes (PERC). This weekly report is provided to local Community Mental Health Programs (CMHPS) for all youth entering Child Welfare and state custody. NWCCO utilizes our partnerships with local Child Welfare and other State agencies to facilitate engagement from legal guardians for successful Care Coordination.

Youth with SED: Every youth identified with a serious emotional disorder and are involved in two or more child serving systems qualify for Wraparound in NWCCO. If the child and family declines services through the Wraparound process, they are provided with Intensive Care Coordination (ICC). NWCCO via GOBHI is grounded in and guided by the Wraparound principles when working with all youth at this level of care, and follow the Wraparound Guiding Principles in order to provide these services in a trauma informed, culturally response, and linguistically appropriate way. Note: Wraparound services in NWCCO will be delivered utilizing a best in-class model where 17 full-time employees are available 24/7 to meet the needs of and provide support for children and their families.

SPMI population: Members with an SPMI diagnosis receive Care Coordination Services at all levels. At the local level, Members who carry an SPMI diagnosis that are at risk for rising to a higher level of care are identified and enrolled in the Choice Model program for Care Coordination services at the CMHP. At a higher level, GOBHI identifies monthly high risk individuals with an SPMI diagnosis using an objective, data-driven process through a data analytic platform, Arcadia. These individuals are invited to engage in care coordination services by GOBHI staff. In addition, referrals for care coordination services are received by the GOBHI Care Management team from across all CCO counties from a variety of sources, including providers, Members, caregivers and discharge planners. GOBHI regularly reminds its provider network of the availability of care coordination services and encourages them to make referrals as needed. GOBHI Complex Care Management team and Moda Intensive Care Management teams meet regularly to ensure processes for communication between the two teams are working well and to review and assign CM referrals received. Members will experience seamless integrated care coordination, with one portal for Care Management referrals and all Case Managers identifying themselves as NWCCO Case Managers. Finally, GOBHI will establish weekly Multi-disciplinary teams at the County level involving coordination between primary care, mental health – CMHP staff, APD, community partners and NWCCO staff to address care coordination needs of individuals with high ED utilization. High risk individuals will be identified by a data-driven process. An MOU will be established involving Moda, GOBHI, and Aging and People with Disabilities (APD).

Medication Assisted Treatment (MAT) services: Members seeking MAT come from a variety of referral sources including self, primary care, ED staff, SUD program staff, NWCCO staff etc. Every member screened and eligible for MAT services is served in a team based care model which includes an LMP, a behavioral health clinician and a care coordinator. Care coordination is considered a critical component of the model and is an essential component of the service plan. All Members enrolled in MAT services receive care coordination.

(2) How will Applicant ensure that enrollees who need Care Coordination are able to access these services?

Children and Adolescents (Child Welfare): NWCCO will ensure youth in state custody have access to care coordination services by providing access information and initiating conversation with their legal guardian. We generate weekly reports to identify youth in state custody and provide to contractors to initiate Care Coordination services. NWCCO (GOBHI) access standards (Policy 1200.10) require that individuals are seen within two weeks from date of request for an intake assessment, and within 24 hours if in an emergency situation. Children in Child Welfare custody receive two assessments within the first 60 days: 1) mental health; 2) Child & Adolescent Needs and Strengths (CANS), and offered care coordination once the assessments are complete.

Youth with SED: Youth identified with a serious emotional disorder receive individualized outreach to have their needs assessed. These enrollees are offered the opportunity to participate in Wraparound services, which are voluntary. If the enrollee

declines Wraparound services, they are provided Intensive Care Coordination to allow streamlined access to care that will meet their social, emotional, and physical needs.

MAT: All Members receiving MAT services receive care coordination as part of the basic services provided by the MAT team.

SPMI population: Members in Choice Model services are engaged at least monthly by CMHP staff to assess and address care coordination needs. Needs for housing, transportation, etc. are paid for through Choice funds to ensure a member remains stable and at the lowest level of integrated care. GOBHI staff provide daily support, as required, to CMHPs staff in meeting care coordination needs of these individuals. For individuals identified through our analytics platform, Arcadia, to meet the NCQA driven criteria of entering our Complex Care Management program, the NWCCO (GOBHI) Complex Care Management Team begins outreach telephonically. If an individual indicates they need a phone in order to engage in services, GOBHI provides the individual a mobile phone with attendant minutes. Individuals referred to the twice monthly MDTs are outreached by telephone or, if needed, in-person by CMHP staff. In addition, we are participating in a HRSA grant which provides a telehealth platform, MEND, which allows Members to receive mental health services in their home and access care coordination services as needed.

(3) How will Applicant identify enrollees who have had no utilization within the first six months of Enrollment, and what strategies will Applicant use to contact and assess these enrollees?

Children and Adolescents (Child Welfare): We run a week utilization report using PERC codes to identify children in Child Welfare and state custody. NWCCO expects this report will address lack of utilization if there is not utilization within the first month of care. Through the CANs process, all children in Child Welfare custody should be seen within their first month of care.

SPMI Population: NWCCO will continue to use an established coordinated process to welcome new members to the plan. All newly enrolled members receive a detailed welcome letter from NWCCO that explains enrollment, coverage, services and benefits. NWCCO also distributes the member rights and responsibilities statement in the welcome letter.

Transition Age Youth: NWCCO sends a letter to youth transitioning to adult services three months prior to turning 18 years old, to inform of potential changes to behavioral health services. This letter also provides contact information for members that need assistance.

MAT services: Since care coordination is an integrated service for MAT participants, staff are immediately aware when members are not participating. The care coordinator will reach out to the member to reengage them in treatment right away. If the member declines to participate, other options will be offered and a care plan will be entered into PreManage.

b. How does Applicant plan to complete initial screening and Assessment of Intensive Care Coordination (ICC) within the designated timeline? (May submit work flow chart if desirable).

NWCCO through GOBHI adheres to NCQA standards for timelines for screening and assessment of those individuals who have been identified as needing intensive care coordination. The ICC initial assessment is initiated within 30 days of the date a member is identified for ICC and completed within 60 days of that date. We assign a care coordinator to engage each member newly identified for ICC. The care coordinator initiates telephonic contact with the member within ten business days of case assignment. The care coordinator makes two telephonic attempts on different days and times of day; and one attempt by mail.

c. Please describe Applicant's proposed process for developing, monitoring the implementation of and for updating Intensive Care Coordination plans.

NWCCO (GOBHI) monitors its providers' behavioral health care plan development, completeness and updates through quarterly provider chart audits. They are annually validated to assure accuracy. If a pattern of issues is identified, we utilize performance improvement plans and progressive corrective action to work with the provider until the expected quality of care plans are achieved.

Children and Adolescents: NWCCO eligible children who require ICC participate in monthly meetings to update their plans of care.

SPMI population: NWCCO via GOBHI adheres to NCQA standards in developing, monitoring and updating Intensive Care Coordination plans. The ICC plan is developed from an initial assessment which is based on on-screen prompts in the care management module of the medical management software application. Goals in the care plan are prioritized and developed based on information gained during the assessment as well as from consideration of the member's or caregivers' goals and preferences. At least monthly, progress towards meeting the goals of the ICC plan are evaluated and documented in collaboration with the member. Goals, interventions and timelines are updated based on the member's needs. The ICC plan is updated at least annually with regular evaluation of the effectiveness of the plan by clinical staff.

MAT services: MAT team care coordinator stays in regular contact with CCM in order to coordinate with all involved staff. Communication will be scheduled with a frequency determined by the needs of the member.

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

The goal of care coordination is to connect members to resources that will improve their functioning, thereby reducing costs. NWCCO through GOBHI takes a holistic approach to care coordination services – physical, mental health, dental and SDOH needs are all assessed and addressed. SDOH assessment includes such things as transportation needs, financial concerns, housing and social supports. Care coordinators offer Member support through a variety of programs:

- Money Management Program (MMP) services: MMP assists people in maintaining independence, obtaining financial security, and prevents financial abuse. The program serves older adults, people with disabilities and veterans. Representative payees advocate for, and provide services for, individuals determined to need assistance managing their funds. Close collaboration with the Veterans Administration, the Social Security Administration, banks, landlords, family members, friends, and pension funders is required to successfully manage this program.
- Non-emergent transportation services: NWCCO through GOBHI would like to expand these services to beyond medical covered services and is looking at how this fits within current rules.
- The Frontier Veggie Rx Program: NWCCO through GOBHI plans to expand this program in which NWCCO providers can "prescribe" fresh produce that the Member can than access for free at local stores.
- Complex care consultation for older adults through a dedicated team of specialists: This team provides written recommendations to the referral agency including clinical behavioral health interventions and psychiatric medication review.
- Supportive and supported housing: We are currently engaged in developing supportive housing for women/women with children who are in early SUD recovery.
- NWCCO partners have developed rental assistance programs for Members with SPMI in Eastern Oregon. This experience and expertise will be available to help with any housing priorities identified by local CACs.

e. What is Applicant's policy for ensuring Applicant is operating in a way guided by person centered, Culturally Responsive and trauma informed principles?

Care coordination assessments assess the cultural and linguistic needs of the individual. NWCCO values culturally responsive care and our policy via GOBHI states that staff are to "be aware of, and are sensitive to, the cultural and demographic diversity of the populations served and of colleagues and stakeholders" in providing care coordination services. We provide regular staff training in cultural responsiveness as well as in the principles of trauma-informed care. NWCCO through GOBHI utilizes the 10 principles of Wraparound for children who receive Intensive Care Coordination which includes culturally responsive and trauma informed practices.

GOBHI's policy (bulleted below) requires that employees as well as contractors and subcontractors adhere to trauma informed principles including "the need for respect, information, connection, and hope for individuals, recognition of the adaptive function of any symptoms that are present; and working collaboratively and in a person-directed empowering manner with individuals who have experienced trauma." The policy also requires that development and implementation of trauma informed services follow OARs 309-018-0100, 309-019-0100, and 309-022-0100.

- Contractors and subcontractors shall provide a clearly defined process by following the Local Implementation Plan Guidelines, and examine existing practices, environment and treatment approaches to ensure trauma specific services

(see definitions) are readily available to all individuals and that such services are individualized.

- Contractors and sub-contractors will provide services in a collaborative, person-centered process, and ensure that the person receiving services and their designated support person(s) will be partners in the treatment planning process.
- Contractors and subcontractors will utilize the educational resources, toolkits and other technical assistance provided by OHA Health Systems Division to facilitate the implementation of trauma informed services.
- Contractors and subcontractors shall follow OARs 309-018-0100, 309-019-0100, and 309-022-0100 when developing and implementing trauma informed services.

f. Does Applicant plan to delegate Care Coordination outside of Applicant's organization? How does Applicant plan to enforce the Contract requirement if Care Coordination delegation is chosen?

Care coordination is provided at a variety of levels throughout the NWCCO delivery service network, depending on the complexity of the Member's needs. For care coordination delegated to the local CMHP, contracts include care coordination requirements. GOBHI (NWCCO) enforces contract requirements by conducting annual reviews of all high capacity behavioral health providers. Reviews can be peer-based (review of charts that the agency have themselves reviewed) or based on randomized member selection based on encounter data. Reviews include member-specific charts with attention to documentation (assessments – coordination of information to determine medical necessity, service plans – service interventions and coordination, service notes – delivery of services and coordination of care) and Quality (care coordination during treatment and transitional processes and documented follow up on coordinated care). Feedback on reviews is given to providers with potential for corrective action plans (CAPs), technical assistance, or additional monitoring. NWCCO utilizes a progressive corrective action if a provider is unable to deliver the expected level of care coordination.

g. For Fully Dual Eligibles, describe any specific Care Coordination partnerships with your Affiliated Medicare Advantage plan for Behavioral Health issues.

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

Moda Health Plan, Inc.'s Medicare Advantage plan is NWCCO's Affiliated Medicare Advantage plan partner. If the provider is contracted with NWCCO, coordination will occur through the normal payment procedures. NWCCO Case Management staff work within the same department, in the same location, as the case managers that work on the affiliate Medicare Advantage plan. When an NWCCO member is dually enrolled in both, the case managers have an in-person consultation to assess and manage the member's health. Additionally, the same operating systems are used between both case management teach which allows an NWCCO Case Manager to view and assess the course of treatment that is occurring and refer to additional treatment, if necessary, including behavioral health services.

h. What is Applicant's strategy for engaging specialized and ICC populations? What is Applicant's plan for addressing engagement barriers with ICC populations?

Children and Adolescents: NWCCO through GOBHI incorporates family partners and youth partners into our delivery model to engage members in specialized populations. Many members in these populations have historically had negative experience with behavioral health service providers. In an effort to engage in a culturally responsive and trauma informed way, NWCCO utilizes the Wraparound principles of outreach and engagement to break down barriers or resistance to accepting services from behavioral health organizations.

WrapServices for Mother & Child: NWCCO through GOBHI intends to launch a new program offering wrap services for Mothers with babies or young children. Because Moms in recovery with babies or young children face a tremendous shift in responsibility: expectations are high to stay clean, to try to get a job that overlooks the felony from drug use, and to be a mom. Offering CCM or Care Coordination for both mom and child could lessen barriers. Often the child is born with developmental issues secondary to mom's substance use and needs specialized supports and services. NWCCO believes that providing wrap services for the mom and child as a unit could directly impact the health of both.

SPMI population: NWCCO through GOBHI adheres to NCQA standards in efforts to engage the SPMI ICC population. Outreach occurs telephonically and through letters. As needed, outreach occurs in-person through CMHP staff. Explaining how NWCCO and CMHPs can assist in helping an individual meet stated needs and achieve desired goals is foundational in engaging an individual in care coordination. NWCCO via GOBHI also identifies members with SUD diagnoses and reaches out to engage these individuals that were in higher levels of care but have no documented follow-up.

Addressing engagement barriers with the ICC population: NWCCO through GOBHI is committed to outreach to members, especially those who have difficulty coming to a clinic. ACT outreach services at the local level provide a mechanism to engage individuals who might not otherwise seek services. Peer Support services provide a non-threatening connection with needed care coordination services. GOBHI's Complex Care Management Team on behalf of NWCCO reaches out to contact individuals telephonically to engage them in needed care coordination services. Care coordinators make use of techniques, such as Motivational Interviewing, to encourage an individual to engage more fully in their care. In addition telehealth allows members to receive mental health services and access care coordination services from their home. If transportation is needed, NWCCO provides Non-Emergent Medical Transportation (NEMT) services.

MAT Services: MAT team care coordinators engage with outreach and engagement specialists, drug court staff, law enforcement, physical health providers, housing providers, behavioral health providers and social service providers in order to identify and connect with members who may have SUDs and ICC needs.

i. Please describe Applicant's process of notifying a Member if they are discharged from Care Coordination/ICC services. Please include additional processes in place for Members who are being discharged due to lack of engagement.

Children and Adolescents: If a youth is enrolled in ICC and/or wraparound, they and their caregivers have full participation in their plan of care. Youth and their caregivers are the drivers of when discharge plans are implemented, and are part of the team decision making process that would determine discharge of care coordination.

SPMI population: For those Members who are graduating from ICC services, a conversation between the care coordinator and member is held to ensure that the member is in agreement that goals are met, then a congratulatory letter is mailed to the member as they are discharged from these services. If a member requests discharge from ICC services before achieving collaboratively developed goals, the care coordinator holds a conversation encouraging the member to continue with services. If the member continues to state that they no longer wish to participate, the care coordinator informs the member that their desire to leave the service is being honored and they are being discharged at their request. If a member is not engaging after accepting ICC services, every effort is made to re-engage the member prior to discharge. The care coordinator makes two telephonic attempts, calling on different days and different times of the day; and one attempt by mail. If the member still does not re-engage, then they are discharged from the program.

MAT services: We assume that addiction is a chronic, relapsing brain disease, and that engagement with the member is long term with possible breaks in services if the member relapses. Teams are prepared for multiple instances of moving in and out of service. The expectation is that reengagement is part of the process. A treatment team conference will be held when it is clinically determined that a member is ready for discharge from MAT. If all agree, necessary long term supports will be put in place.

j. Describe Applicant's plans to ensure continuity of care for Members while in different levels of care and/or episodes of care, including those outside of Applicant's Service Area. How will Applicant coordinate with Providers across levels of care?

Children and Adolescents (and Family): NWCCO through GOBHI works to coordinate care when children are placed out of area or out of state, including addressing barriers related to access of physical, dental, and mental health care. Existing care coordination, ICC, and Wraparound supports continue to engage with the child and family team, incorporating any new team members necessary when a child is placed in a different level of care. If this is an initial identification of SED, Wraparound services are offered and ICC services initiated. In addition, the Wraparound Transfer Protocol ensures that Wraparound will transfer with them if they transfer counties or outside of NWCCO service area. We use Pre-manage to track acute episodes of care. This allows for quick follow up with Providers and engagement of child and family teams after discharge from a hospitalization stay. NWCCO works to notify our provider network of these episodes and to ensure the member is seen with seven-day post-acute hospitalization stay.

SPMI population: NWCCO through GOBHI oversees care coordination of members throughout the system at all levels of care and over multiple episodes of care, including outside the service area. Each member involved in different levels of care is assigned to a CMHP ICC as determined by County of Record (COR). The ICC coordinates the care of the member, including outside the COR. The ICC works with the member's providers across the health spectrum to ensure the member receives needed services including medical, behavioral and dental care. NWCCO monitors these members through Choice Model reports. Staff are available daily to assist ICCs in care coordination. We achieve continuity of care because each member has one care coordinator throughout episodes of care and at different levels of care.

MAT services: MAT provides care coordination to Members involved in the program with any other needed services. When necessary, the MAT care coordinator can coordinate with the CCM team or the ICC's at the local CMHP.

Other services: NWCCO coordinates with the local CMHP in Clatsop County to provide doctor to doctor psychiatric consults for inmates in the Clatsop County Jail. Utilizing tele-behavioral health technology inmates are seen by a psychiatrist who then works with the jail physician to develop an appropriate treatment plan. This pilot program allows inmates with mental illness to be treated and stabilize while incarcerated, avoiding need for transfer to the Oregon State Hospital. The psychiatrist also coordinates with the local CMHP to assure that discharge planning is in place when inmates are released. This continuity of care is designed to decrease jail time and assure supports are in place as the Member transitions back into the community.

k. How will Applicant manage discharge planning, knowing that good discharge planning begins from the moment a Member enters services?

Children and Adolescents: Members in ICC and Wraparound participate in the development of the team mission at the initial development of the plan of care. This plan of care developed at intake addresses the planned discharge when the team mission is met and is evaluated at each child and family team meeting. As progress is made, more specifics related to discharge planning are developed by the child and family team to ensure successful transition to a lower level of Care Coordination. This transition phase is also addressed in the parent's Wraparound Guidebook, which is given to each youth and family at entrance to the program.

SPMI: Because NWCCO through GOBHI monitors PreManage software daily for Members, immediately upon identification of a member as being admitted to an acute care facility, we can notify the local CMHP staff. Discharge planning begins as soon as a member is known to be admitted to a facility. NWCCO monitors discharge planning progress and provides support for challenging discharge planning situations. Cases are reviewed weekly in NWCCO UM/CM rounds to ensure that discharge planning is progressing as needed. Once an individual is discharged the CMHP staff ensure that a 7-day visit follow-up occurs. NWCCO monitors 7-day follow-up visits and, when necessary, provides CMHP staff support in successfully making the 7-day follow-up visit. (In 2018 94.48% of NWCCO Members received a Follow-up with 7-days of Hospitalization for a Mental Illness, surpassing the goal of 66%.)

MAT Services: Discharge discussion begins at the first team meeting and in the first conversation with the member. Identification of and planning for needed long term recovery supports is a part of every session. Encouragement for involvement in local support groups, educational activities and housing that is supportive of recovery goals is a major focus of the program. At the point of discharge, the team works with the member to assure that needed follow-up is in place.

l. What steps will Applicant take to ensure Care Coordination involvement for ICC Members while they are in other systems (e.g., Hospital, subacute, criminal justice facility)?

NWCCO Utilization Management, Care Management and CMHP ICCs are notified through PreManage for all Members that enter the hospital, subacute, and PRTS. More detailed Member information (admissions, providers, diagnosis, medications, upcoming appointments, screening gaps, and clinical information) is also available near real time in the NWCCO HIE. Increasing access to PreManage and the HIE for NWCCO Providers not yet connected will be a priority focus area going into the new CCO contracting period.

Children and Adolescents: System of Care Manager and Director of Therapeutic Foster Care attend the UM meetings to ensure appropriate transition and care coordination is occurring. SOC Manager relays treatment information to the youth's local care coordinator and monitors coordination activities throughout the youth's stay.

As evidenced in GOBHI Policy #300.20.13 (3.3)-Intensive Treatment Services: Care Coordination During Treatment - While a child/adolescent is in a PRTS and/or Sub-Acute facility, the Care Coordinator, or the designated primary clinician for the child/adolescent and family, will be responsible for consistent collaboration with and support to the PRTS and/or Sub Acute facility.

- Ongoing CFT meetings will occur to support proactive preparation for the child/adolescent's transition to the community.
- A utilization review meeting (or teleconference), involving the PRTS facility, GOBHI's Utilization Management Team, the WCC, the child/adolescent's parent and/or legal guardian, and other involve parties, will occur every 30 days to ensure that the child/adolescent is receiving services at the most clinically appropriate and least restrictive environment possible.
- After the child/adolescent has resided in PRTS for 90 days, the Care Coordinator will contact GOBHI's Chief Medical Officer for a utilization review update.
- The transition of the child back to community will be coordinated by the Care Coordinator and Child & Family Team. Attention will be given to needed supports such as medication management, therapy, school and parent support to avoid gaps in care during the process. Attention to the family/caregiver's ability to successfully receive the child back into the home should be an ongoing process that began when the child entered the PRTS facility.

SPMI population: Each member involved in different levels of care is assigned to a CMHP ICC in their county of record. The ICC coordinates the care of the member across all levels of care, including outside the COR. The ICC conducts in-reach activities into

the hospital and subacute settings as needed. ACT staff may provide in-reach in a criminal justice facility as needed. The ICC takes primary responsibility for the care coordination of the individual across all levels of care.

m. Describe how Applicant will ensure ICC Care Coordinators will maintain the 15:1 caseload requirement.

NWCCO through GOBHI requires that all behavioral health care ICC Care Coordinators remain at a 15:1 caseload or lower. NWCCO enforces contract requirements by conducting annual reviews of all high capacity behavioral health providers.

n. Which outcome measure tool for Care Coordination services will Applicant use? What other general ways will Applicant use to measure for Care Coordination?

Children and Adolescents:
We are currently exploring evidence-based tools for use with our infant/child/adolescent populations. For consistency, we are first analyzing the PROMIS 10 pediatric version against our needs. In addition, we are consulting the AHRQ Care Coordination Measures Atlas and the National Quality Forum endorsed practices in care coordination and corresponding performance measures.

For Youth and Family: NWCCO through GOBHI plans to extend the two Wraparound measures that are currently approved by the State of Oregon to ICC clients. We plan to utilize the Wraparound Fidelity Index Short Version (WFI-EZ), administered 6 months after enrollment, and the Team Observation Measure (TOM), conducted on each care coordinator to ensure twelve facilitation components. Beginning in 2019, we will participate in a pilot program with OHA to purchase rights to the Team Observation Metric System (TOMS) so that is can be captured electronically. The Child & Adolescent Needs and Strengths Comprehensive Screening (CANS) will also be utilized as an outcome measure since it is required at enrollment and every 90- days following enrollment.

SPMI population:

- Members in the Complex Care Management program: the PROMIS 10 survey is conducted during initial assessment, every three months while engaged in CCM and at closure. Comparisons are made between baseline scores and scores overtime.
- Other general ways of measuring: An experience survey is conducted every three months while engaged in CCM and at closure. In addition, NWCCO analyzes complaints to identify opportunities to improve satisfaction with its ICC program. NWCCO measures ED incidents per 1000 Members and Inpatient incidents per 1000 Members for this population.

Note: All NWCCO CMHPs implemented the PROMIS Global Health Assessment (adult and pediatric) in 2018 to provide a standardized patient-reported outcome metric that can be utilized at an individual, organizational, and plan level to determine progress toward Member and Population health. Value-based payment incentives will be utilized during 2019 to assure that assessments are being completed.

(http://www.healthmeasures.net/administrator/components/com_instruments/uploads/Global%20Health%20Scale%20v1.2%2008.22.2016.pdf)

o. How will Applicant ensure that Member information is available to Primary Care Providers, specialists, Behavioral Health Providers, care managers and other appropriate parties (e.g., caregivers, Family) who need the information to ensure the Member is receiving needed services and Care Coordination?

The NWCCO HIE contains the following information to help facilitate care coordination for our Members. Expanding access to this information (Two CMHPs, an FQHC, and NWCCO staff already have access) will be a priority focus area for NWCCO.

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

Children and Adolescents: Our network providers secure consent for release of information from youth and families to facilitate sharing care plans with child and family team Members. If a child and family have excluded specific partners from their child and family team, NWCCO encourages the use of Motivational Interviewing when appropriate to encourage the benefit of sharing of information for the coordination of their care.

SED- 85% youth and family develop their care team.

MAT Services: The MAT team has, at minimum, a weekly huddle where client status is reviewed. Notes and summaries are required to be shared among involved clinicians on a regular basis.

SPMI population. All member information related to care coordination is recorded in a medical case management system. In accordance with HIPAA law, this information is shared with appropriate providers/parties that need access in order to provide services and assist with care coordination. In addition, NWCCO through GOBHI maintains an HIE with member information that is shared as appropriate with other providers based on current HIPAA regulations. NWCCO will also implement PreManage in all NWCCO CMHP's and with Primary Care practices. To coordinate care, CMHP staff enter PreManage care plans on Members meeting the ED Disparity metric in order to provide the ED physician of key information when the member visits the ED. (Note: As part of the NWCCO's through GOBHI, CMHP 2018 VBP program over 500 Members now have active behavioral health care plans in PreManage.)

4. Severe and Persistent Mental Illness (SPMI)

a. How will Applicant work with OHA, other state agencies, and other state funded or operated entities to identify areas where treatment and services for adult Members with SPMI can be improved?

Building relationships with a broad set of community providers and allied service networks is an area is strength and focus for us. On behalf of NWCCO, GOBHI will expand our partnerships with components justice system to improve access and services at all intercept points. Over the past two years, we have laid the groundwork by facilitating Sequential Intercept Mapping, Crisis Intervention Training and other specialized technical assistance through the efforts of the Oregon Center on Behavioral Health and Justice Integration, housed at GOBHI and funded by OHA through a separate agreement. The Center provides specialized training and technical assistance for behavioral health and justice partners to enhance knowledge and improve practices aimed at a treating people who, primarily due to symptoms of serious behavioral health conditions, are at risk of becoming incarcerated or are already within the criminal justice system.

NWCCO, equity partner, GOBHI has contracted directly with the OHA for the Choice Model Contract (previously AMHI) for the Counties of Northwest Oregon since 2009 http://www.gobhi.org/programs-for-ohp-members/choice-model/.The program is designed to promote the availability and quality of individualized community-based services and supports so that adults with severe and persistent mental illnesses are served in the most independent environment possible and use of long term institutional care is minimized. This is achieved, in part, through effective utilization of current capacity in facility-based treatment settings, increased care coordination and increased accountability at a local and state level.

Over the past two years, we have laid the groundwork for collaboration between behavioral health care and the justice system by facilitating Sequential Intercept Mapping, Crisis Intervention Training and other specialized technical assistance through

the efforts of the Oregon Center on Behavioral Health and Justice Integration, housed at GOBHI and funded by OHA through a separate agreement. The Center provides specialized training and technical assistance for behavioral health and justice partners to enhance knowledge and improve practices aimed at a treating people who, primarily due to symptoms of serious behavioral health conditions, are at risk of becoming incarcerated or are already within the criminal justice system.

We have a very strong partnership with Northwest Oregon Housing Authority, covering Clatsop, Columbia and Tillamook Counties and have been working with them on a Clatsop supportive housing project for the past two years. We helped forge a partnership between NOHA and Tillamook Family Services, CMHP in Tillamook, where there is now a housing development project for adults with SPMI. We have the commitment from NOHA to work with us on future housing development projects for individuals with behavioral health needs. We have been building relationships with the community action agencies in Clatsop related to this project and will engage in partnership efforts with agencies covering Columbia and Tillamook in the coming year. We will work to ensure that housing needs for individuals with SPMI are known and understood by these partners and expand our network capacity to work with housing partners in developing options that promote independent living. Other areas of improvement for this population are highlighted below. NWCCO will continue to look for additional partnership opportunities to further improve the care provided for Members with SPMI.

b. How will Applicant provide oversight, Care Coordination, transition planning and management for Members receiving Behavioral Health services, including Mental Health Rehabilitative Services, Personal Care Services and Habilitation Services, in licensed and non-licensed home and Community-based settings, to ensure individuals who no longer need placement in such settings are transitioned to a Community placement in the most integrated Community setting appropriate for that person?

The cognitive and functional deficits caused by mental illness may result in the need for housing and treatment in all manner of facilities funded by the State of Oregon. Some of these conditions are severe but temporary, while others can experience lifelong disabilities. SPMI is by definition prone to cycles of improvement and relapse and there is no set level of care an individual requires for life. We are fully cognizant of the need to allow people to get better and to move out of highly structured care settings. We will work within a continuum of residential treatment capacity that serves residents from the entire state, allowing for transitions from higher level to lower levels of care in a thoughtful and carefully coordinated manner. Strategically placed resources have helped eliminate travel barriers between the different levels of care often needed for Members with SPMI.

In addition to the Choice Model and in concert with IHN, NWCCO partner GOBHI was an "Early Adopter" for the transition of the long term care benefit to managed care in 2015-16. These efforts were effective in meeting the needs of individuals being served by the delivery system while assuring that they were receiving the correct level of care and were not stuck at a level higher than medically necessary.

NWCCO through GOBHI continues to look for opportunities to invest in and partner with the development of both large and small, specialized residential treatment and adult foster home capacity that can work with certain subsets of the population who are extremely difficult to place. Knowledgeable and experienced Residential Care Management staff continue to promote flexible clinical programs, designed to adapt to the specific needs of individuals at risk for higher levels of care.

We will continue managing the residential service array for mentally ill people whose needs are immediate and who may require residential services with a focus on crisis resolution, intensive short-term interventions and the preservation of existing connections to systems of support. Delay in residential placement because of waiting lists and complicated authorization procedures should not be the reason for hospitalization that is otherwise unnecessary. Some people need services requiring immediate decisions and intensive intervention. GOBHI's Utilization Management program is available to work rapidly on these situations, day and night, every day. *Note: NWCCO would like to work with OHA on accepting risk for managing residential care.*

We approach the care of persons with an established residential treatment history through a focus on transition issues and by building long-term connections to natural systems of support. Coordination between Care Management, Utilization Authorization, clinical staff and community partners is critical as Members are move through various level of care. We provide Choice Model and Care Coordination staff with a variety of skills to work with CMHPs and community partners to assure these transitions are successful.

c. How will Applicant ensure Members with SPMI receive ICC support in finding appropriate housing and receive coordination in addressing Member's housing needs?

In addition to including language in each of the agreements with CMHPs in this region requiring ICC and care coordination, we will work collaboratively with each of the CMHPs and their ICC teams to understand the unique strengths, resources, needs and gaps that impact Members with SPMI who are also in need of permanent housing. The region has a rental assistance program, "Together we House" supported housing program, that provides peer services and rent subsidies, but there are wait lists to access these resources in each county. We will ensure OHP covered services are effectively coordinated with other non-Medicaid resources available in each county that provide ICCC and housing supports, such as Choice Model and other flexible funding. Opportunities to expand capacity for care coordination and home-based services, such as through Oregon's 1915i Home and Community Based Services Waiver, will be explored. ACT teams are present in each of the counties – for Members involved with ACT teams, intensive care coordination occurs as part of their care. We will continue to support each CMHP in implementing fidelity ACT services. Further, this coordination will be specified in the Memorandum of Agreement with each CMHP and addressed through the Local Behavioral Health Plan.

d. How will Applicant assist Members with SPMI to obtain housing, Supported Housing to the extent possible, consistent with the individual's treatment goals, clinical needs, and the individual's informed choice?

Lack of affordable, safe housing units is a significant obstacle for people living with severe and persistent mental illness in all three counties comprising the NWCCO service area. We estimate at least 50 additional housing units are needed for the SPMI population in this region based on the Oregon Performance Plan model for calculating estimated need. The capacity for transitional, low barrier housing is very limited. Increasing options for transitional and permanent housing for people with SPMI will be a primary focus in the NWCCO region. Housing options need to be available for individuals with varying needs and choices.

We will assist Members with SPMI in obtaining housing and supported housing by investing additional resources in short, medium and long-term solutions in partnership with the CMHPs.

- Short-Term: Use health related services funding for hotel vouchers and other transitional housing options for Members with SPMI participating in ACT or other intensive case management and who are homeless or who have more immediate housing needs.
- Medium-Term: Provide Master Lease templates and technical assistance to build confidence among care coordinators in working with landlords to implement these agreements for Members with SPMI who have adequate clinical supports to live independently. Through GOBHI, We have been working on a toolkit to help providers effectively address resistance among landlords in renting units to people with SPMI and other serious behavioral health concerns. We will finalize this toolkit and share it with the provider network in the NWCCO region along with providing technical assistance in using the toolkit.
- Long-Term: Partner with CMHPs, NOHA, CAP agencies, consumers, and other stakeholders to develop additional housing units for people with SPMI. One development is currently underway in Tillamook for individuals with SPMI and one is scheduled to open in Clatsop for individuals in SUD recovery. Combined, these projects provide a template for developing housing for people with serious behavioral health needs in the region. NWCCO will convene partners across the region, providing opportunities for sharing lessons learned from both of these developments. This is discussed further below under j.

e. How will Applicant ensure ACT services are provided for all adult Members with SPMI who are referred to and eligible for ACT services in accordance with OAR 309-019-0105 and 309-019-0225 through 309-019-0255?

We will continue to address infrastructure needs for each CMHP so that ACT services are available in each county. There are currently three fidelity ACT teams in the NWCCO region (see oceact.org). We will make sure that for each ACT referral from OSH, the CMHP covering that region is aware. ICCs are the single point of contact for all ACT referrals. Referrals to ACT who meet eligibility are comprehensive assessed for

enrollment in ACT. We will comply with OAR 309-019-0248. Our ultimate aim is that there be fidelity ACT services in all counties through CMHPs.

f. How will Applicant determine (and report) whether ACT team denials are appropriate and responsible for inappropriate denials. If denial is appropriate for that particular team, but Member is still eligible for ACT, how will Applicant find or create another team to serve Member?

We will set up a process to receive information from all ACT teams regarding admission and denials. A licensed clinician (QMHP or higher) will review every denial for ACT services against the admission criteria established by the team. We will determine whether the denial is appropriate or inappropriate. This will include review of the explanation for denial and recommendations for alternative intensive services to be provided. We will work with OHA and the Oregon Center of Excellence on ACT to develop more capacity/teams. Individuals will be served through alternative evidence-based services while we wait for placements to be opened up or developed. We will amend contract language with ACT providers to ensure compliance with information sharing and member admission into ACT.

g. How will Applicant engage all eligible Members who decline to participate in ACT in an attempt to identify and overcome barriers to the Member's participation as required by the Contract?

We will explore engagement strategies with OCEACT, our consumer caucus and ACT teams to identify best practices associate with engaging this population. We will require ACT teams to conduct outreach in an attempt to engage people who have declined to participate in ACT.

h. How will Applicant provide alternative evidence-based intensive services if Member continues to decline participation in ACT, which must include Care Coordination?

We will ensure that providers develop a person-centered plan for each individual who declines ACT participation. The plan will include care coordination and appropriate level of community-based services and supports. We will ensure that providers engage Members in the following service alternatives: IPS Supported Employment, peer delivered services and other community resources including supportive housing. We will work with OCEACT and OHA to develop a set of evidence-based service alternatives to ACT.

i. How will Applicant work with Secure Residential Treatment Facilities (SRTFs) to expeditiously move a civilly committed Member with SPMI, who no longer needs placement in an SRTF, to a placement in the most integrated Community setting appropriate for that person?

NWCCO hopes to work together with the OHA to expand our existing capacity to use SRTF beds for short term placements. We will work with regional and then state wide systems of care to develop SRTF beds for patients who cannot be directly discharged to the community after commitment hearings and for whom hospital placement is either unavailable in the short term or unnecessary. These people often end up going back to emergency rooms or jails while awaiting hospital placement which is often traumatizing

and clinically inappropriate. To accomplish this NWCCO will work with secure residential providers on creating the clinical capacity to admit and discharge people more rapidly than current practices. This would mean an expansion of the secure respite bed capacities NWCCO currently operates in compliance with Level I statutes and rules. The clinical program for short stay SRTF beds would be different from that typically associated with longer term residential treatment programs. Short stay clinical models and rates would first need to be designed in collaboration with NWCCO's SRTF providers and the OHA. NWCCO proposes to require our providers to adapt their treatments to the short terms clinical needs of newly committed people, rather than building new beds for this purpose.

In order to free up beds for this capacity, long term SRTF residents who no longer need that level of care will have to be transitioned to unlocked programs. Many care providers and their residents have come to regard SRTF placement as indefinite, typically because past attempts to transition some people failed. These residents and their providers cannot suddenly be told there is no longer eligibility because of a rigid new UM system, or another round of destabilization and hospitalization will result.

The clinical method by which NWCCO approaches the population with an established residential treatment history will focus on identifying transitional issues, critically examining past attempts at discharge and then mitigating risk factors while adding protective factors. Again the most important protective factor, the key to resiliency in recovery is the construction of durable relationships outside the SRTF and that means using our robust organizational connections to community based systems of support.

j. How will Applicant work with housing providers and housing authorities to assure sufficient supportive and Supported Housing and housing support services are available to Members with SPMI?

As mentioned above in 4.d., we will partner with CMHPs, NOHA, CAP agencies, housing development experts, consumers, and other stakeholders to develop additional housing units for people with SPMI. One development is currently underway in Tillamook for individuals with SPMI and one is scheduled to open in Clatsop for individuals in SUD recovery. Combined, these projects provide a template for developing housing for people with serious behavioral health needs in the region. NWCCO will convene partners across the region, providing opportunities for sharing lessons learned from both of these developments.

NWCCO equity partner, GOBHI, conducted interviews with representatives from the behavioral health service delivery network in every county throughout the NWCCO region in the Spring of 2017. 100% of the respondents said that there is inadequate affordable housing capacity in their areas to serve people with SPMI and serious substance use disorders. Many providers are using short-term hotel stays as a way to provide shelter and transitional housing for people. This strategy is costly and not sustainable in the long run. Additionally, the housing market is so tight providers are having difficulty recruiting employees because there is inadequate housing stock making it difficult for them to find permanent housing.

As stated earlier, we have a strong partnership with NOHA. NOHA is aware of the shortage of housing units in the region and for individuals with SPMI. One entity alone

cannot meet the challenge of increasing the availability of affordable, safe housing and supported housing. Further, capacity to develop and partner in the development of housing is needed among the behavior health provider network. NWCCO will work to increase capacity among the provider community on the components of affordable housing development and how to effectively partner with housing development experts. We will also provide access to housing development experts to partner with providers, the housing authority and other stakeholders with an interest in development projects for the region. We currently have a contract with Kate Allen (a woman-owned small business), Community Development Consultant who resides in Astoria, to assist us and partners in the region with grant applications, project management, and development projects.

k. Provide details on how Applicant will ensure appropriate coverage of and service delivery for Members with SPMI in acute psychiatric care, an emergency department, and peer-directed services, in alignment with requirements in the Contract.

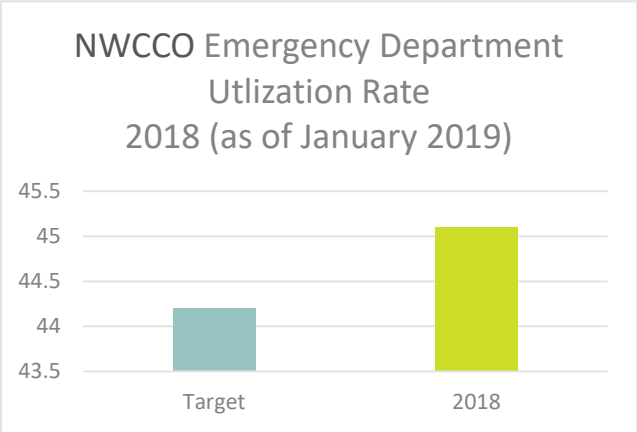
NWCCO, through its Utilization Management and Care Management teams closely works with acute psychiatric care providers to assure that Members with SPMI are receiving appropriate care in the least restrictive environment possible. They also work closely with local CMHPs on discharge planning and smooth transitions between levels of care. NWCCO, also requires local CMHPs to submit copies of their MOUs with local Emergency Departments that outline how post-stabilization and post-emergency department care will be coordinated. In addition, NWCCO is continuing to look for innovative and effective ways to utilize peer services, especially as part of the transitions between levels of care. As a baseline, 2018 claims showed that behavioral health peer services reached .74% (240) Members and SUD focused peer services reached 0.16% (51) Members. The work involves training peer specialist, and the creation of a Consumer Caucus. This nine-member group provides insight on how to engage people in the peer process, as well as acts as a sounding board for any proposed improvement projects.

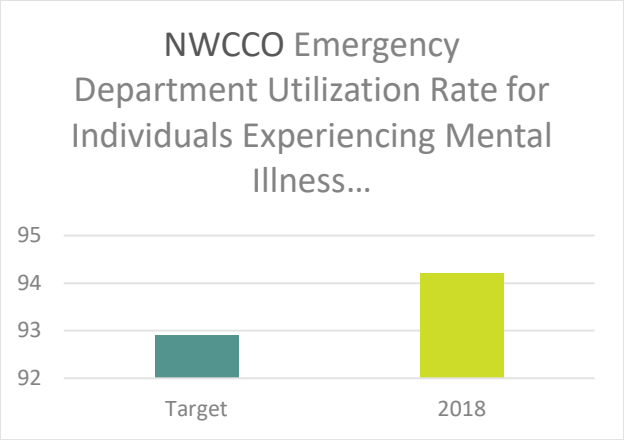
NWCCO's Network Management process continually evaluates the delivery network to assure contracts are in place for all needed services at all levels of care. Quality of care is reviewed and monitored through documentation reviews as part of the authorization process, as well as through complaints and grievances.

5. Emergency Department

a. How will Applicant establish a policy and procedure for developing a management plan for contacting and offering services to each Member who has two or more readmissions to an Emergency Department in a six-month period? The management plan must show how the Contractor plans to reduce admissions to Emergency Departments, reduce readmissions to Emergency Departments, reduce the length of time Members spend in Emergency Departments, and ensure adults with SPMI have appropriate connection to Community-based services after leaving an Emergency Department and will have a follow-up visit within three days.

NWCCO has a multi-pronged approach to reducing ED utilization.





- NWCCO CMHPs are required to have mobile crisis services that can respond to Members in crisis out in the community, without requiring a trip to the local Emergency Department. Pilot projects will be developed to "medically clear" a Member if necessary through alternative arrangements outside of the ED.
- Pilot programs are underway with Crisis workers "riding along" with local law enforcement to help facilitate getting Members to the appropriate care immediately.
- NWCCO along with Community Mental Health Programs (CMHPs) and Primary Care Clinics (PCPs) are notified each time a member is admitted to an Emergency Department. Along with these notifications monthly reports will be reviewed to determine Members with more than 2 or more ED visits who need to be contacted and assisted in connecting to appropriate services.
- Alternates to Emergency Department services are being developed to provide Members suffering from mental illness with easily accessible options for care. Utilization of direct to Member tele-behavioral health services allow Members to utilize technology to connection to psychiatrists, therapists, care managers and peer support without the Member needing to leave their home or any other location. NWCCO is working to extend these services so that they are available 24-hours per day, utilizing shared services across the NWCCO region. This work is being supported by a three year HRSA grant that provides funding for the direct to patient tele-behavioral software platform. Funds are also available to provide Members with cell phones, Ipads, cellular data or internet access as needed.
- NWCCO CMHPs have worked to extend office hours to provide easier access to their Members. Many CMHPs now have evening or weekend hours. NWCCO will continue to provide incentives to expand these services.
- NWCCO CMHPs, as part of the 2019 CMHP VBP program are required to enter a care recommendation into PreManage for every member with an SPMI. This program will expand in 2020 to ensure that every member with 2 or more ED visits in a 6 month period has a care recommendation (including contact information for the local CMHP) entered into PreManage. Outreach to the NWCCO ED and primary care clinics will occur in 2019 to help facilitate the use of these care recommendations throughout the care continuum.

- NWCCO partners including PCPs and CMHP will continue weekly sharing meetings (HUBs) to discuss care plans for Members. This weekly meeting will identify barrier(s), determine main point of contact for Members and discuss potential solutions. Care plans will be monitored monthly by NWCCO clinicians and support staff to ensure care plan in appropriate and make recommended changes as necessary. NWCCO will provide resources as needed to support this collaboration activity.
- NWCCO works with CMHPs to assure that follow-up post inpatient stays have occurred. This same process will be expanded to include Members seen in the ED. We are piloting data collection on the ED metric utilizing our HIE, so this process will be in place prior to 2020.
- For Members who continue to utilize the ED despite the above mentioned efforts, NWCCO psychiatrists will be assigned to work with local providers to brainstorm alternative care recommendations and treatment options.

NWCCO has implemented processes to reduce Members length of stay in the Emergency Department. These include:

- Planned and Crisis respite through TFC program to coordinate efforts to deliberately transition kids to Respite from ED.
- Two NWCCO partners have formed the Caring for Clatsop Coalition, LLC (with Providence Seaside Hospital and Clatsop County) which operates the North Coast Crisis Respite Center (NCCRC). Future goals include a pilot program to move Members directly from the Emergency Department, or ideally, prior to being taken to the Emergency Department, to the NCCRC as appropriate.
- NWCCO regularly monitors to assure timely assessments and care planning with local CMHPs is occurring.
- For children and adolescents, NWCCO uses our established policy and procedure to contact and offer services to individuals within seven dates of being admitted into an Emergency Department. This procedure is implemented after an initial visit, and would be followed in the event of a second episode of care. PreManage health information system is used to alert NWCCO staff of the need to complete follow up with the youth who are seen at an emergency department.
- Our partnership with GOBHI Therapeutic Foster Care (TFC) to establish a Planned and Crisis Respite program across the NWCCO service area has been implemented to reduce the number of youth entering ED services. Community Mental Health Program staff are able to refer to and access Crisis Respite services from highly trained foster parents, with 24/7 on call crisis support from the GOBHI TFC team. This service is designed to prevent admission into Emergency Departments, reduce readmission, and shorten the length of time Members spend in Emergency Departments. GOBHI is also working with a community partner to develop a Regional Crisis Center(RCC) to reduce the number of youth accessing emergency departments and shorten length of stay for those who do access the ED.
- Additionally NWCCO supports Early Assessment and Support Alliance (EASA) programs, and Mobile Crisis units in each county served. These services provide support for a reduction of ER visits through intervention in the community.

- NWCCO will implement telehealth through the MEND software program to provide services to clients in their home in the Fall of 2019. MEND utilizes low bandwidth service to allow for use in rural areas, and incorporates the ability to use phones and tablets. This ability allows for clients to connect directly from their home to prevent crisis, reduce trips to emergency rooms, and reduce additional visits to EDs. (This service is currently being provided for EOCCO Members and will be expanded to NWCCO as part of Year 2 of a HRSA grant.)
- The Wraparound program is also operated in each NWCCO county, and provides youth and family an opportunity to lead their plan of care. This allows for services to be provided, and natural supports to be strengthened and developed for individuals and their families. By building natural supports and developing resiliency through this process, Wraparound is able to stabilize youth and families and reduce their need for emergency services through a supportive process.

6. Oregon State Hospital

NWCCO has fully committed itself to the State's goal of reducing the use of the Oregon State Hospital (OSH) for all but those with no other treatment option. We have been reducing the overall number of persons going to the OSH under civil commitment as well as reducing their lengths of stay. The new CCO will continue this work with its positive outcomes as evidenced by partners' historic performance in the NW region as well as EOCCO.

a. How will Applicant coordinate with system partners as needed regarding Oregon State Hospital discharges for all adult Members with SPMI?

Prior to OSH admission, a GOBHI psychiatrist reviews all LTC referrals to ensure they meet criteria for OSH admission. Once an individual is accepted for OSH admission, the ICC completes a 72hr face-to-face diversion visit. Thus, individuals who do not meet the criterion are effectively diverted from admission. However, once a member is admitted, NWCCO through GOBHI monitors the Members closely. The CMHP ICC is responsible for making an in-person visit with a member within 7 days of admission to OSH. At that time, the ICC provides additional historical information regarding the member to the OSH team and begins coordinating care toward an effective discharge plan. A clinician, administrative staff, and the ICC attend all IDTs held for a Member. The ICC provides an updated discharge plan at each Intra-disciplinary team meeting (IDT). In accordance with the Oregon Performance Plan (OPP), we focus predominately on civilly committed Members ensuring that they are discharged in a timely fashion. Through GOBHI, NWCCO supports the ICCs in working with system partners such as OSH SW, Kepro, residential facilities and housing supports. GOBHI facilities on behalf of NWCCO discharge to the most integrated setting appropriate to meet the member's needs with the ultimate goal of providing ACT services, with integrated community placement.

b. How will Applicant coordinate care for Members receiving Behavioral Health treatment while admitted to the State Hospital during discharge planning for the return to Applicant's Service Area when the Member has been deemed ready to transition?

The ICC begins developing discharge plans within seven days of OSH admission. The discharge plan evolves and is discussed during IDT meetings with OSH. If an individual is not returning to their original service area, the ICC will work closely with the county of placement to coordinate with out-of-area providers and ensure that all out-of-service exception agreements are in place. If the member is returning to their service area, efforts are made to ensure housing is available. This may involve maintaining an individual's housing during their OSH stay. If it is determined that the individual needs placement in a residential facility, facilities that are deemed to match the needs of the member are sent Mental Health referral packets in preparation for when the member is made Ready to Transition(RTT). The ICC schedules screenings at residential facilities as appropriate working closely with the OSH clinical team. NWCCO through GOBHI oversees this care coordination and assists the ICC when needed.

Because of GOBHI's relationships with Community Mental Health Programs, hospitals, residential Care Providers, and ownership in CCO's, NWCCO is uniquely positioned to work closely with the OHA to meet the requirements of the Oregon Performance Plan as well as to act as pilots for the transition of risk for the cost of long term mental health care to CCOs and sharing of risk for cost of state hospital level of care between CCO's and Counties. These efforts are essential not only to meeting the requirements of EXHIBIT M of the CCO Contract but also meeting the needs of some of our most vulnerable members.

7. Supported Employment Services

a. How will Applicant ensure access to Supported Employment Services for all adult Members eligible for these services, in accordance with OAR 309-019-0275 through 309- 019-0295?

GOBHI's supported employment services, provided by the local CMHPs, utilize an evidence- based approach model called the Individual Placement and Support Supported Employment (IPS). We have a strong partnership with Oregon Supported Employment Center for Excellence (OSECE) and actively supports the coordination between the ACT (Assertive Community Treatment) and IPS to meet the needs of Members with severe mental illness. We also actively supports the eight core principles of the IPS program throughout the NWCCO region. At intake and throughout the process of engagement in mental health treatment, Members are encouraged to consider if they want to engage in the IPS program. Members engaged in the ACT program are also encouraged to consider employment opportunities. SE staff are often part of ACT service delivery teams and continually coordinate and assist Members in meeting their treatment and employment objectives.

In addition, GOBHI has been leading the effort for Members to utilize their lived experiences by becoming community health peer support specialists. We utilize a network of ten peer support specialists and were one of the first organizations to establish a rate of reimbursement to support the utilization of these workers at a competitive salary.

The access and provision of IPS services in rural communities is monitored and reviewed on a regular basis by NWCCO. NWCCO collects and reviews fidelity reports annually for all IPS programs in their network. NWCCO coordinates with OSECE to provide

technical assistance for programs to ensure that IPS programs meet minimum fidelity standards. IPS programs must score at least 100 out of 125 to receive Medicaid or GF reimbursement for services. If the IPS program fails meet minimum fidelity standards, the IPS program will work with both OSECE and NWCCO over a 90-day period to address deficiencies in services to improve overall performance. OSECE conducts a re-review of the deficiencies after the 90-day period. If the program has not sufficiently addressed the deficiencies identified in the initial fidelity review are subject to additional monitoring, oversight, technical assistance, and potential Corrective Action Plan (CAP) in order to restore care to the highest level possible. NWCCO reviews a copy of any amended fidelity review in response to a non-passing score and follow-up review from the Division approved reviewer (OSECE). Referral forms, assessment, service plans, and service notes are reviewed to ensure that Members are not restricted from receiving SE services, and they are receiving appropriate outreach and follow-up by service delivery providers. NWCCO collects a copy of SE outcome reports sent to the Division as required by OAR 309-019-0295 as part of contractually required reporting process. If NWCCO does not receive evidence of submission to the Division, programs are subject to sanctions.

8. Children's System of Care

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

Juvenile Department, Oregon Youth Authority, DHS Child Welfare and Self Sufficiency, CASA, County Judges, Local and State-Wide Child Serving partners such as Youth Era, Clatsop Parks and Recreation, Lower Columbia Hispanic Council, OFSN, Community Mental Health, SUD Programs, Primary Care, I/DD services, Vocational Rehab, Local Lawyers and District Attorneys, SSI, Child Support Enforcement Division, Police, Parole and Probation, NW Regional Education Service District, NW Early Learning Hub, Help Me Grow, Oregon Infant Mental Health Association (ORIMHA), Local School Districts, local child and family representatives, Tribal reservations and culturally responsive programs of the area, domestic violence shelter/programs, faith based communities and local businesses.

b. Please provide detail on how Applicant will utilize the practice level work group, advisory council, and executive council.

NWCCO will work to meet the intention of these three different groups, while understanding that in rural Oregon, some communities are small enough that the individuals on the Practice Level may also be appropriate for the Advisory Council, or that there will be some overlap on the Advisory and Executive Council. The function of the Advisory Committee is absorbed in the Executive Steering Committee within each county due the rural region committee Members being the same individuals.

The Practice Level Workgroup will gather and review System Barriers that are identified by Wraparound Teams and other System of Care partners throughout the community. This group will work actively to address any System Barriers that are brought to the group through a collaborative effort. NWCCO works consistently to increase youth and family participation in this Workgroup to be over 50%.

The Advisory Council will be utilized as a support to the Practice Level Workgroup, reviewing system barriers brought to them if the Practice Level Workgroup was unsuccessful in resolving the Barrier. This group should also be able to identify and plan to resolve policy and financial barriers in recommendations to the Executive Council.

The Executive Steering Committee is made up of Director level staff that have budget and policy decision making authority locally. This group is intended to change policy and make budgetary decisions to resolve barriers that could not be addressed at the other levels previously mentioned. This Council, if not able to address the barrier, should have the knowledge and ability to identify where the barrier exists and provide that information to the System of Care Statewide Steering Committee.

c. How does Applicant plan to track submitted, resolved, and unresolved barriers to a SOC?

The Systems of Care (SOC) Manager works with chair of each committee in Columbia, Clatsop, and Tillamook counties. This individual continues to use a Barrier Tracking spreadsheet to monitor all Barriers identified across the region. Each Local Practice Level Workgroup (PLW) completes a Barrier Submission form and emails this to the SOC Manager who adds it to the Barrier Tracking Spreadsheet as a submitted barrier. After the next Practice Level Workgroup is completed, the SOC Manager updates the Spreadsheet, indicating it is resolved, or unresolved, which is then escalated to the Advisory Council. A clear benefit of NWCCO tracking these centrally is it allows our CCO to monitor trends across rural Oregon, identifying patterns of concern as targets for strategic initiatives and allows for neighboring SOC groups to be connected to work creatively to resolve regional barriers as well. In order to track these barriers across all Eastern Oregon Counties, GOBHI has created a SOC Tracking Spreadsheet that will be managed and monitored by the System of Care Manager. Local communities SOC groups will send to SOC manager who tracks and monitors status of all barrier submissions.
Examples of SOC barriers that have been addressed and mitigated are:

- Finalized SOC Executive Committee Vision, Mission, Charter, Cross Sector Membership and hold monthly Executive Committee Meetings.
- At least one unpaid volunteer family and youth representative on each county's SOC Executive Committee. Established equity voting standards- 1 vote per agency and one vote per individual youth and family representative.
- Completed Executive Barrier Referral to CSAC (Children's System Advisory Council) regarding the conflict to provide quality care to each youth and family accepted into Wraparound, Oregon Best Practices Standards outline Wraparound Care Coordinator cannot exceed serving 15 youth, while under the Medicaid rule one cannot deny services and supports, 4/25/17.
- Completed Executive Barrier Referral to SOCWI Steering Committee, Governor Kate Brown as well as additional legislators and State Department Directors regarding the effects of the extended duration of background checks.
- Identified cross system partner liaisons to be part of a sub-workgroup to ensure a strong TIC Practice ACROSS agencies and formed Columbia County Trauma Informed Care Task Force 9/16/16. Goal-gather TIC champions to collaborate and coordinate efforts to blend resources, reduce redundancy, increase efficiency and minimize costs.

    - Identify Columbia County resource groups with Point-of-Contact to maintain communication
    - Partnered to Host Paper Tigers film showing and panel discussion in each school district
    - Shared information to created and continuously revise Columbia County Youth Suicide Communication, Postvention Plan and Response Protocol for Columbia County 8/3/2017.
- SOC Responsive Plan to INS & ICE Action Steps: 1. Listening sessions with local families 2. Cross-System receptionist training (NWREDS script) interacting with ICE agents 3. “Everyone is welcome here” poster dissemination 4. Education Forum: How to respond to bullying, harassment, discrimination and xenophobia-Subcommittee 5. Each School District attempt to revise policy to protect students from ICE/INS. 1) Limited the amount of identifying student information in the public record 2) Revised policy from state agents having access to students in the classroom “at any time” to within 24 hours (model Scappoose).
- Braided funding to support startup of a Columbia County youth drop-in center & Braided funding to create a Day Treatment accessed by all 5 school districts in partnership with GOBHI and CCMH.
- Prioritized TFCC in hiring a local part-time youth partner in funding and community recruitment.
- Outline similarities, differences, strengths and gaps for needs in foster care (DHS-BRS and TFC) regarding recruitment, training and support to collaborate and increase local number of homes.
- Collaboration across systems to enact Family Finding Project, Lead SOC

d. What strategies will Applicant employ to ensure that the above governance groups are comprised of youth, families, DHS (Child Welfare, I/DD), special education, juvenile justice, Oregon Youth Authority, Behavioral Health, and youth and Family voice representation at a level of at least 51 percent?

Through GOBHI, NWCCO continues to conduct Systems of Care and Wraparound 101 trainings in each community at least annually, continuing to encourage community awareness of elements of the System of Care by educating community partners. The SOC Manager continues to engage local community leaders with the support of the NWCCO provider network and other SOC champions. To support efforts of maintaining youth and family voice as a majority of the Members on the Practice Level Workgroup, NWCCO provides a stipend for Youth & Family representation at the Systems of Care governance boards. Included in the stipend is reimbursement for the individual’s time, mileage and child care. In an effort to remove barriers for youth and family attendance, there is an Orientation packet for youth and family representation which includes approaches to communication, description of other Members of the committee, previous meeting minutes, and other supportive documents. Utilizing our Wraparound funding, we cover tuition and travel expenses for youth and family support partners who attend the 4-day Wraparound training. In addition, our Youth and Family Support Coordinator offers individual and group coaching to all youth and family support partners and provides orientation packets, which include the charter, previous minutes, person first language, advocacy hints, strategic sharing protocol, and positive approaches to improved

communication. Strategies utilized to accommodate youth and family voice representation have included changing date, time and locations of meetings; providing food/snacks as well as utilizing electronic modalities such as conference call line as well as secure video.

In addition, NWCCO via GOBHI is currently collaborating with Portland State University, Regional Research Institute, School of Social Work study which will determine whether the Assessment of Youth/Young Adult Voice on Committees and Councils (Y-VOC) is an accurate assessment tool for committees and councils to use if they wish to measure their support for youth and young adult voice.

Currently, NWCCO region supports 3 Review Committees and Practice Level Workgroups, and 3 Executive Steering Committees

9. Wraparound Services

a. Provide details on how Applicant plans to ensure administration of the Wraparound Fidelity Index Short Form (WFI-EZ)?

NWCCO is appropriately administering and collecting the WFI-EZ at the six-month mark of each Child and Family team meeting. During NWCCO quarterly technical assistance meetings, Wraparound Care Coordinators across the NWCCO service are updated on results from the WFI-EZ, and use the opportunity to collaborate on improving administration and collection efforts. Further, NWCCO provider network Members use the Wraparound Monitoring Tool, which includes formatting to notify the provider when the WFI-EZ is due for each child and family. Additionally, the NWCCO Children's System Support Coordinator contacts the Wraparound Care Coordinators when the WFI-EZ due date is approaching and monitors until it is completed. This is monitored through Wraptrack for data collection at a state level.

b. How will Applicant communicate WFI-EZ and other applicable data to the System of Care Advisory Council?

NWCCO works in close collaboration with our provider network, distributing WFI-EZ and other data as quickly as it is available and engaging in supportive conversations that focus on system improvements. NWCCO utilizes a Children's System Support Coordinator to compile all reports, which is then provided to the chairperson of each local System of Care Advisory Council. The local chairperson then distributes this data to the local SOC Advisory Council.

NWCCO includes data that is specific to the local SOC Council which is then compared to CCO wide data. The NWCCO Systems of Care Manager reviews these reports across the CCO service area, identifying opportunities for continuous improvement. The SOC Manager and Director of Foster Care also attend System of Care Council meetings across NWCCO communities to support data review and community engagement.

A unique aspect of NWCCO, via GOBHI, is our cross system involvement with Child Welfare, which has been a major focus of many SOC Advisory Councils. The need for additional foster homes being a frequent expressed barrier to success. We are also a Licensed Child Caring Agency that provides Therapeutic Foster Care for children in the custody of Child Welfare. This allows us to track data trends of placement needs in local

communities based on referrals for placement from Child Welfare. This data, combined with data related to higher levels of care, Wraparound, etc. helps our System of Care Manager provide a more complete picture of the need, root causes of the barrier, and possible solutions to local community SOC Councils. Data requests from System of Care Councils helped identify the need for a Planned and Crisis Respite program in local communities, which partners with providers to implement across the NWCCO service area.

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

NWCCO through GOBHI has an established procedure to ensure all Wraparound programs are appropriately administering and collecting the WFI-EZ at the six month mark of each Child and Family team meeting. We train all Wraparound Care Coordinators to conduct the WFI-EZ's during the Child and Family Team Meetings to ensure they are completed in a timely manner. Further, our provider network members use the Wraparound Monitoring Tool, which includes formatting to notify the provider when the WFI-EZ is due for each child and family. Additionally, the NWCCO Children's System Support Coordinator contacts Wraparound Care Coordinators when the WFI-EZ due date is approaching and monitors until it is completed. With these steps implemented response rate of 35% for youth is attainable with multiple checks in place to ensure completion. Currently our youth response rate averages 37% with our highest county reaching 69%.

d. How will Applicant's Wraparound policy address:

(1) How Wraparound services are implemented and monitored by Providers?

As a newly forming CCO, NWCCO embraces the philosophy of proactive intervention that strives to facilitate the ability of a child and family to access services at lower levels of care that are youth driven and family guided. GOBHI Providers will ensure that children and families will have timely access to the System of Care Wraparound Process.

Admission into Wraparound is a referral based process. Referrals can come from any involved source, provided appropriate releases are signed when referrals come from non-legal guardian sources. The Wraparound Care Coordinator (WCC) or Children's Program Supervisor will assist the referrer with the collection of information for the referral packet and serve as point of contact for the submission of information.

A request for approval in Wraparound will be considered authorized when: A Wraparound referral form has been filled out and submitted to the WCC; A consent to participate in Wraparound has been signed by a legal guardian; A HIPAA authorization for the disclosure of protected health information has been signed by an individual authorized with lawful authority to sign on the youth's behalf; and The family and youth have received the National Wraparound Initiative Document: The Wraparound Process User's Guide: A Handbook for Families.

Upon receipt of the Wraparound referral packet, the WCC will present the packet to the local Wraparound Review Committee for approval. The local Wraparound Review

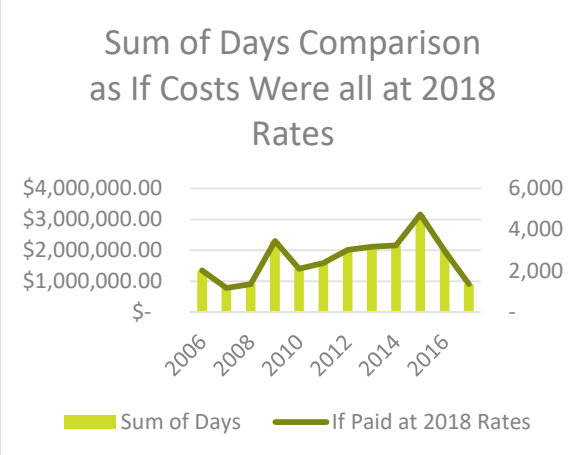
Committee has established criteria based on wraparound model designed for children & youth who have complex emotional, behavioral and social issues who typically require care coordination across two or more child-serving systems. The remaining criteria will be site specific.

If approved, the WCC will contact the youth and family within 5 business days to schedule a meeting and develop, with the Child & Family Team, a Wraparound Plan of Care, which will guide the delivery of community based supports and services. The Wraparound Process for Families User's Guide: A Handbook for Families, a Product of the National Wraparound Initiative is given to all families enrolled and can be easily accessed at the following website: http://www.nwi.pdx.edu/pdf/Wraparound_Family_Guide09-2010.pdf .

System of Care Wraparound Manager will conduct random reviews of referral and approval process every 6 months for youth in Wraparound.

NWCCO through GOBHI utilizes the Wraparound Fidelity Index Short Version (WFI-EZ) and the Team Observation Measure (TOM) are two measures approved by the State of Oregon Wraparound Team. The Wraparound Care Coordinator, Project Site Lead, or other identified persons may be responsible for the submission, completion and collection of these measures. Additionally, a Child & Adolescent Needs and Strengths Comprehensive Screening (CANS) may also be used to support decision making. The CANS will be administered at enrollment and every 90 days following admission. NWCCO does not use the CANS to exclude participation in Wraparound; however, the CANS Oregon will serve as a multi-purpose tool to support decision making including level of care and service planning, to facilitate improvement initiatives, and to allow for the monitoring of outcomes of services.

Beginning in 2019, GOBHI agreed to participate in a pilot program with OHA to purchase rights to the Team Observation Metric System (TOMS) so that is can be captured electronically through Wraptrack (mentioned above) Team Observations Measures are conducted on each Wraparound Care Coordinator to ensure twelve facilitation components and ten principles of Wraparound are being implemented in practice.



NWCCO, through its equity partner GOBHI, provides Wraparound care in Columbia County. This program has drastically reduced the cost of inpatient admission

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

This is accomplished through each county's review committee, all Members who reach a higher level of need or who are involved in at least two child serving agencies will have the option of being referred to Wraparound. In addition, any youth that is in Psychiatric Residential Treatment and/or Long Term Placement automatically qualify

for Wraparound. If the youth and/or caregiver refuse to be enrolled in Wraparound, the youth will still have access to Intensive Care Coordination, which entails the full array of intensive services and supports. On staff, we have a System of Care Manager who provides systematic site visits to offer support and monitors whether a program is meeting fidelity. In addition, Wraparound Care Coordinators are required to submit monthly progress reports to System of Care Manager.

e. Describe Applicant's plan for serving all eligible youth in Wraparound services so that no youth is placed on a waitlist. Describe Applicant's strategy to ensure there is no waitlist for youth who meet criteria.

NWCCO is committed to ensuring high quality fidelity Wraparound are immediately available to all who are eligible. All CCO Members that qualify for Wraparound in NWCCO will receive ICC services if the child and family declines to participate in the Wraparound process. NWCCO Systems of Care Manager continuously monitors local Review Committees to confirm youth eligible for Wraparound are not placed on a waitlist. NWCCO does not allow providers to place youth on a waitlist for Wraparound; instead, they are provided with and Intensive Care Coordinator and have access to Intensive Outpatient Services and Supports (IOSS).

f. Describe Applicant's strategy to ensure that Applicant has the ability to implement Wraparound services to fidelity. This includes ensuring access to Family and youth Peer support and that designated roles are held by separate professionals as indicated (for example: Wraparound coaches and Wraparound supervisors are filled by two different individuals).

Each Youth and Family accepted into Wraparound is provided with an introduction to a Youth Partner (if age 12 and above) and a Family Partner during the first engagement session facilitated by the Wraparound Care Coordinator. The Youth Partner and Family partner each explain their role and offer the member the choice as to whether they would like to have a Support Partner on their Child & Family Team.

Existing Memorandum of Understanding (MOU) with the NWCCO provider network ensure access to Family and Youth Peer Support. NWCCO employs a Youth and Family Support Coordinator who also operates as a Peer Coach, conducting one on one coaching with Family and Youth Peer Supports across the NWCCO service area. Additional group peer coaching sessions are held twice monthly to provide support, collaboration, and feedback from Family and Youth Peer Supports. Finally, NWCCO provides co-supervision with Family and Youth Peer Supports and Children's Clinical Supervisors within the provider network.

In addition, NWCCO participates in coaching and supervision with Portland State University Wraparound Department. We also hold a contract with Oregon Family Support Network and Youth ERA, both peer support organization, to provide training, consultation, staffing, and support to our support partners.

Attachment 12 — Cost and Financial Questionnaire

A. Evaluate CCO performance to inform CCO-specific profit margin beginning in CY 2022

OHA will implement a provision of its current waiver that requires the state to vary the profit load in CCO capitation rates based on an evaluation of CCO performance. The goal of the policy is to encourage CCOs to provide financial incentives for CCOs to improve the delivery of benefits to CCO Members. This includes more efficient use of Medical Services, increased delivery of high-value services, and an increased use of Health-Related Services when appropriate. The ability to increase the profit load for high-performing CCOs is designed to alleviate concerns that CCO investments that reduce costs and use of Medical Services will lead to capitation rate reductions that threaten CCO ability to maintain access to Health-Related Services and other programs that improve value and efficiency.

1. **Does Applicant have internal measures of clinical value and efficiency that will inform delivery of services to Members? If so, please describe.**

NWCCO will build off of the experience of its equity partners with EOCCO, and use numerous ways to track and report on clinical value and efficiency of services delivered to its members. These include retrospective risk-adjusted cost analysis; analysis of avoidable costs; analysis of delivery channels such as ED vs. primary care, inpatient vs. outpatient, hospital-based vs. clinic based; high-cost/risk member management, and others. In addition, our future value based payment models focus providers on controlling wasteful spending and improving efficiency, both through financial incentives and by sharing data on opportunities to address these areas. Some examples of these are discussed below.

For a provider-level view of resource use, we will employ risk-adjusted cost analysis to identify areas of opportunity for efficiency improvement. A retrospective risk score will be used to provide a treatment-agnostic view of the conditions present in the population. In this way, population morbidity can be normalized and providers can be measured and compared on their efficiency of resource use in an apples-to-apples way. This is in addition to our prospective risk modeling, which is used to forecast future costs.

We will track avoidable costs in several ways. For example, we will prepare reports on emergency department utilization, inpatient readmissions, utilization of ‘preference sensitive’ treatments (those treatments for which utilization is often guided by member or provider preference as opposed to clinical indication); and other categories. Emergency department utilization will be further broken down into ‘potentially avoidable’ vs. ‘not avoidable’ events, and frequent ED utilizers will be tracked. In evaluating readmissions, we will calculate all-cause readmissions and same-facility-only readmissions, over 30/60/90 day time periods, and also take into account transfer admissions. Examples of

preference sensitive treatments include some imaging, certain orthopedic procedures, and C-sections.

Delivery channels are an important influencer of costs, and warrant tracking and reporting. To help care delivery migrate from reactive to proactive, we will regularly monitor rates of primary care utilization, with the intent that investment there will reduce downstream ED, hospital, and specialist costs. We will identify members with chronic conditions but without primary care utilization on rosters sent to providers, and also summarized in reports to the CCO leadership. Some procedures can be done in clinical settings with very high quality and low cost, compared to hospital settings; therefore we will regularly produce reports and analysis on opportunities to shift sites of care.

High-cost/high-risk members are a big contributor of overall spending, and it is important to evaluate and manage this population. NWCCO will use predictive modeling, in combination with aggregate member-level cost reports, to identify and track these members. Output will then be fed into both provider reports as well as internal reports for the purpose of connecting members to case management, member advocate, care coordination, disease management, or other services.

NWCCO will also review drivers of trend on a regular basis, to identify services that might be contributing to cost growth. DRGs, procedure codes, and diagnosis codes that account for a higher-than-average amount of trend increase will be identified and discussed. For example, we plan to look into billing intensity of office visits and ED visits, to address the creep of RVUs over time.

We will share a comprehensive package of reporting with all of the providers in our VBP arrangements, to ensure that they have the most complete information possible on opportunities to improve quality and efficiency. For example, our member roster will include a count of ED visits in the prior year to help clinics manage high utilizers; the same report will also include a comparison of risk score to primary care utilization, to help identify mismatches (i.e. many chronic conditions but few/no primary care visits). Our pharmacy reports will identify members taking a brand name medication for which a generic is available. In the coming year we expect to roll out reports on the downstream costs of provider referral patterns. All of these activities are geared toward identifying opportunities to improve efficiency.

2. What tools does the Applicant plan to deploy to identify areas of opportunity to eliminate Waste and inefficiency, improve quality and outcomes, and lower costs?

As described above, NWCCO will have a robust infrastructure for analyzing and reporting on cost and utilization. This allows us to identify members, services, providers, or geographic areas needing focus from a cost or quality control perspective. This reporting will feed into NWCCO, GOBHI and provider staff collaborative work groups focused on improving quality and reducing costs.

NWCCO intends to implement an HIE tool, Arcadia Analytics, which has been extremely helpful in improving quality and coordinating care for members, by making available to providers a complete dashboard of cost and quality performance, with links to scheduling data so that providers can plan interventions. We believe Arcadia will strongly tie to our

efforts to control cost, quality, and outcomes. Similarly, PreManage gives providers the ability to coordinate and manage care for members utilizing ED and inpatient services.

Through Moda's long experience managing health plans, NWCCO will have access to a highly developed infrastructure for managing utilization of services that are high cost and/or have potential for overutilization. We will regularly review the results of prior authorization and other medical management activities to ensure that these programs are evidence based, efficient, and effective while minimizing the compliance burden on providers. For example, new high-cost technologies or procedures will be investigated for the purpose of determining whether prior authorization is warranted. In some cases, prior authorization requirements will be removed if it is determined that most procedures that are requested are appropriate, in order to minimize administrative costs. As an additional way to control hospital spending on low-value ED utilization, we intend to limit reimbursement for certain kinds of ED visits that are determined to be non-emergent based on predefined criteria.

In addition to the above, our Fraud, Waste, and Abuse team will work with internal data analytics teams to run queries on a regular basis that may trigger a focused review. The team will also initiate inquires based upon employee or external tips, as well as knowledge gained form participation in local and national Anti-Fraud groups. NWCCO's partner Moda is in the process of implementing new FWA detection software, HealthCare Fraud Shield, which will be in place by the end of 2019 and available to NWCCO. This software will monitor claims and suspicious activities through advanced post payment detection as well as provide reporting, tracking and case management tools.

Our embedded clinical editing tool will identify incorrect coding and recommends corrections or denials prior to payment. In addition to pre-payment editing, we will utilize our embedded clinical editing to 'profile' providers who may be utilizing abusive billing practices. We will use these reports to identify potential outliers and request medical records in order to document correct or incorrect billing. As a further control, a daily claim batch file will be sent post-adjudication and pre-payment to Change Healthcare, where additional provider integrity payment recommendations are returned. Medical records may be requested as well as part of this review.

3. Does the Applicant have a strategy to use Health-Related Services to reduce avoidable health care services utilization and cost? If so, please describe.

NWCCO believes that Health-Related Services are a key lever for health system transformation. Our strategy to use Health-Related Services to reduce avoidable health care services utilization and costs include:

- Evaluate and approve flex services, as part of a member's overall integrated care planning and management within or in conjunction with, their primary care team, including behavioral and oral health.

- Utilize flex services within the care coordination and case management functions within ICC and ENCC.

- Distribute Community Benefit Initiative Reinvestments (CBIRs) through the local CACs and through Grant funds that focus on reducing avoidable healthcare services utilization and costs.

- Work with our providers and communities to identify specific local community needs to improve the care delivery and overall health and well-being of the members, as improved health outcomes reduces cost and utilization.

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

NWCCO's strategy to use Health-Related Services to improve quality and efficiency in service delivery include the same strategies as reducing avoidable health care services and utilization. NWCCO believes that when Health Related Services are deployed, there is a vast impact to a member and/or community. The strategy is listed again below:

- Evaluate and approve flex services, as part of a member's overall integrated care planning and management within or in conjunction with, their primary care team, including behavioral and oral health.

- Utilize flex services within the care coordination and case management functions within ICC and ENCC.

- Distribute Community Benefit Initiative Reinvestments (CBIRs) through the local CACs and through Grant funds that focus on reducing avoidable healthcare services utilization and costs.

- Work with our providers and communities to identify specific local community needs to improve the care delivery and overall health and well-being of the members, as improved health outcomes reduces cost and utilization.

5. What process and analysis will the Applicant use to evaluate investments in Health-Related Services and initiatives to address the Social Determinants of Health & Health Equity (SDOH- HE) in order to improve the health of Members?

NWCCO plans to fund SDOH-HE initiatives in two ways:

1) NWCCO will distribute Community Benefit Initiative Reinvestments (CBIRs) to the three local CACs (LCACs) to utilize for SDOH-HE and transformation projects that connect to their Community Health Improvement Plans (CHIPs). LCACs will be required to select appropriate interventions, evaluation metrics, and methods to measure impact which will then be reported to NWCCO on a quarterly basis.

2) NWCCO will fund SDOH-HE initiatives through the use of Health Related Services for needs that are unique to each community. Primary care clinics and other community partners within our service area will have the opportunity to submit requests for health related service initiatives that they need funding for.

This will then be approved and administered accordingly. NWCCO will track which members these services are provided to in order to evaluate the success of these investments. Many of the funded initiatives could be associated with an incentive measure which provides an additional evaluation metric.

B. Qualified Directed Payments to Providers

Beginning in 2020, OHA will develop a program of qualified directed payments (QDP) for the repayment of most provider taxes paid by Hospitals in Oregon. The specific parameters and methodology of the QDPs for fiscal year 2020 will be determined following completion of the 2019-21 Legislatively Adopted Budget and will rely on input from a variety of stakeholders. OHA will promulgate administrative rules to include a Quality and Access pool for Hospitals reimbursed by Medicare based on diagnostic-related groups (aka, DRG Hospitals).

1. **Does Applicant currently measure, track, or evaluate quality or value of Hospital services provided to its enrollees? If so, please describe.**

   NWCCO will produce a variety of analysis on hospital utilization (inpatient, outpatient, ED use, site of service, readmits, C-section rates, etc.), as described above in section A. From this we will be able to identify areas of relative efficiency or inefficiency between hospitals. As a further example, we will calculate normalized average cost per admit using DRG weights, to understand the relative price and value for hospital inpatient services. We will introduce hospital quality metrics into our shared savings model, some of which will be based on claims data (e.g. C-section rate), and others will be based on clinical data provided by the hospitals (e.g. infection ratio).

C. Quality Pool Operation and Reporting

OHA will adjust the funding mechanism of the quality incentive pool from a bonus to a withhold of a portion of CCO capitation rates. This allows CCO expenditures of Quality Pool funds to be considered in capitation rate development and be included in the Medical Loss Ratio (MLR) requirements that apply to the CCOs. This change is intended to motivate CCOs to make timely investments in their communities and the providers and partners that enable their achievement of metrics associated with the incentive program. Including CCO spending of incentive pool earnings in capitation rate development increases the transparency of the program while retaining significant flexibility for CCOs in how they utilize their Global Budget.

1. **Does the Applicant plan to distribute Quality Pool earnings to any public health partners or non- clinical providers, such as SDOH-HE partners or other Health-Related Services Providers? If so, please specify the types of organizations and providers that will be considered.**

   NWOCCO plans to reinvest 100% of its quality pool dollars back into providers and communities. We plan to provide quality pool funding to our 3 local community advisory councils to fund Community Health Improvement Plan (CHIP) activities to address the

social determines of health and dedicate quality pool funds for community benefit initiative reinvestment projects that any partner in the service area can apply for. NWCCO will distribute quality pool earnings to other non-clinical partners to address local and statewide SDOH-HE priority areas as part of CCO 2.0. These partners will include but will not be limited to organizations and providers outlined in the community engagement plan tables for Attachment 10.

2. **How much of the Quality Pool earnings does the Applicant plan on distributing to clinical Providers, versus non-clinical providers? Please discuss the approach as it relates to SDOH-HE partners, public health partners, or other Health-Related Services Providers.**

   NWCCO plans to reinvest 100% of its available quality pool funds back into providers and communities. As we transition to CCO 2.0 NWCCO will make investments using quality pool and other global budget funds and surpluses to address local and statewide SDOH-HE priority areas such as housing related services and supports with partners identified in the community engagement plan tables. NWCCO will engage its Regional and Local Community Advisory Councils, our Clinical Advisory Council, the NWCCO Board and newly identified SDOH-HE partners to determine the amount of funding to distribute each year to non-clinical providers.

3. **How much of the Quality Pool earnings does the Applicant plan on investing outside its own organization? On what would Applicant make such investments?**

   NWCCO plans to reinvest 100% of its available quality pool funding back into providers and communities. Planned investments include quality bonus payments to primary care providers, enhanced Patient Centered Primary Care Home funding, quality bonus payments to Dental Care Organizations, payments to Local Community Advisory Councils to invest in projects to meet quality measure targets and identified CHIP activities, Community Benefit Initiatives Reinvestments (CBIR's), technology and other initiatives such as newly identified SDOH-HE activities as identified and approved by the NWCCO Board.

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

   In collaboration with its Clinical Advisory Panel (CAP), Local Community Advisory Councils (LCACs), and Regional Community Advisory Council (RCAC), NWCCO's relevant subcommittees will recommend the quality pool funding projects, initiatives and the annual allocation of funds. These recommendations will be discussed and approved by the NWCCO board annually.

5. **When will Applicant invest its Quality Pool earnings, compared with when these earning are received?**

   We expect to distribute quality pool earnings immediately after they are received. This is to ensure we know what dollars are available to reinvest. For initiatives that we intend to fund on an ongoing basis we will replenish the funds annually with quality pool funds once they are received. This ensures that there is no break in funding with respect to our various ongoing investments. As a new entity we will modify our strategy with respect to when quality pool earnings will be invested at the direction of the board.

6. **Does the Applicant have sufficient cash resources to be able to manage a withhold of a portion of its Capitation Payments?**

   Yes, we will have sufficient reserves and cash resources to be able to manage a withhold of a portion of capitation payments for the quality pool.

D. Transparency in Pharmacy Benefit Management Contracts

OHA seeks to address increasing pharmacy costs by increasing the transparency of CCO relationships with Pharmacy Benefit Managers (PBMs) and requiring no-spread contracts between CCOs and PBMs. CCOs will be required to ensure they are receiving competitive pricing from their PBMs by obtaining 3rd party market checks audits.

1. **Please describe the PBM arrangements Applicant will use for its CCO Members.**

   NWCCO will use the Oregon Prescription Drug Program (OPDP) as the pharmacy benefit management solution for members. OPDP is an Oregon Health Authority (OHA)-backed innovative pharmacy program designed to meet the broad and unique pharmacy benefit needs for both public and private entities in Oregon. OPDP services are provided consistent with the objectives of the Oregon Health Policy Review Board, are delivered transparently using 100% pass-through pricing of pharmacy claims and manufacturer rebates (i.e., no spread), and are backed with robust annual market check and audit provisions to ensure market competitiveness. NWCCO's equity partner, Moda, has administered OPDP for OHA since 2007.

   In addition to Moda's responsibility for managing all clinical support, including formulary and utilization management, as well as providing PBM operational oversight and customer service, our pharmacy program is backed by a long-standing partnership with MedImpact, the largest privately-held PBM in the U.S. MedImpact provides Moda's back-end claims processing system; contracts the OPDP pharmacy network; and serves as our primary aggregator for manufacturer rebates. This PBM platform offers tremendous flexibility to configure and manage pharmacy programs to meet the program management objectives for NWCCO.

2. **Does Applicant currently have a "no-spread" arrangement with its PBM? If not, please describe the steps the Applicant will take to ensure its contracts are compliant with these requirements and the intended timing of these changes. If changes cannot be made by January 1, 2020, please explain why and what interim steps Applicant will take to increase PBM transparency in CY 2020. (In order for an extension in the timeline to be considered, Applicant must show it is contractually obligated to use non-compliant PBM and shall provide OHA a copy of PBM agreement as justification along with a plan to ensure compliance with transparency requirements at the earliest date possible)**

   Yes, NWCCO's PBM relationship using OPDP requires that all pharmacy claims and manufacturer rebates administered through its PBM are 100% pass-through. NWCCO will validate the pass-through and transparency requirements of its PBM agreement with quarterly and annual tracking of reimbursed pharmacy claims (Basis of Reimbursement Reports) and quarterly tracking and reconciliation of manufacturer rebate billing and payment.

3. **Does the Applicant obtain 3rd party market checks or audits of its PBM arrangement to ensure competitive pricing? If not, does the Applicant have a plan to receive this analysis? If so, how often are these analyses performed, what is done with this third party data and what terms inside of your PBM contract allow this analysis to have power for the CCO to ensure its pharmacy contract remains competitive?**

   Yes, the OPDP program includes mandatory market checks to ensure the competitiveness of financial guarantees for all groups that participate in this program, including NWCCO. Surveys are conducted annually, with results published by July 1st each year. If survey results fall outside a predetermined point, OPDP contractually requires that Moda, as the Administrator for the OPDP program, propose updated network guarantees within 90 days of the report. Updated network rates become effective immediately upon review and acceptance.

4. **Does the Applicant plan to use the Oregon Prescription Drug Program to meet the PBM transparency requirements?**

   Yes, the OPDP program is fully transparent and includes extensive reporting and robust audit rights.

E. Alignment Preferred Drug Lists (PDLs) and Prior Authorization Criteria

OHA seeks to address increasing pharmacy costs by increasing the alignment of CCO preferred drug lists (PDLs) with the PDL used by OHA for the fee-for-service program with a particular focus on high- cost drugs and on alignment strategies that reduce overall program costs and/or improve the pharmacy benefit for OHP Members. OHA will work in conjunction with Successful Applicants to establish

initial PDL alignment criteria and will take additional steps to modify alignment criteria over time. As part of this requirement, CCOs will be expected to make public and accessible their PDLs as well as the coverage and Prior Authorization criteria for all pharmaceutical products.

1. **Does Applicant currently publish its PDL? If not, please describe the steps the Applicant will take to ensure its PDL is publicly accessible concurrent or in advance of the Year 1 Effective Date for prescribers, patients, dispensing pharmacies, and OHA.**

   NWCCO will be utilizing a custom Medicaid PDL, which is the same PDL utilized by EOCCO, and it will be published online no later than January 1, 2020. Today, this PDL can be found at:

   https://www.eocco.com/eocco/-/media/eocco/pdfs/rx/rx_formulary_ohp.pdf

2. **Does Applicant currently publish its pharmacy coverage and Prior Authorization criteria concurrently with or in advance of changes made? If not, please describe the steps the Applicant will take to ensure its pharmacy coverage and PA criteria are both publicly accessible for prescribers, patients, dispensing pharmacies, and OHA and updated in a timely manner.**

   NWCCO's coverage criteria are not currently published online; however, they will be available to providers at the point of prescribing through our electronic prior authorization platform. Through this platform, member and drug-specific criteria are presented to the prescriber upon drug selection in the tool. Additionally, we publish a list of medications that require prior authorization and/or have other utilization management edits such as step therapy or quantity limits. That list will be the same as what is in use today for EOCCO and can be found at:
   https://www.eocco.com/eocco/-/media/eocco/pdfs/rx/rx_priorauth_ohp.pdf

   NWCCO is committed to publishing our coverage criteria in an easily accessible location and format for prescribers, patients, pharmacies, and OHA. We have already started the process of converting our coverage criteria question algorithms into our easily readable and interpretable policy format. This process is about 10% complete, but is on track to be completed by January 1, 2020. These policies will be updated concurrently as changes to coverage criteria are made.

3. **To what extent is Applicant's PDL aligned with OHA's fee-for-service PDL? Please explain whether and how supplemental rebates or other financial incentives drive differences in the Applicant's PDL as compared to the fee-for-services PDL**

   While there are many areas in which NWCCO's PDL will align with OHA's fee-for-service PDL, there is a key area where the PDLs differ. NWCCO's PDL does not embrace brand-over-generic strategies, so when an AB-rated generic becomes available it is added to formulary and the brand is removed.

OBRA '90 rebates are available to OHA through its Medicaid program but are not available to CCOs. Those rebates are often large enough to make the net cost of a brand medication less than its AB-rated or therapeutic alternative generics. Supplemental rebates, which are available to CCOs, are essentially commercial rebates that some manufacturers may extend into the Managed Medicaid market. Supplemental rebates tend to be significantly smaller than OBRA '90 rebates and rarely yield a lower net cost brand compared to generic alternatives. Additionally, not all manufacturers offer supplemental Medicaid rebates on commercially rebated products.

In therapeutic categories that are not clinically differentiated, such as TNF-alpha inhibitors for autoimmune conditions, supplemental rebates may drive selection of a preferred, lowest net-cost product. These preferred products may differ from preferred products on OHA's fee-for-service PDL.

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

   If required, NWCCO will fully align its PDL with OHA's fee-for-service PDL. However, in doing so, NWCCO may realize higher cost claims experience that would require consideration. We would welcome discussion with OHA on methods that could be applied to offset the financial risk in doing so. For example, preferring brands over alternative generics may yield a larger OBRA '90 rebate for the state, but supplemental rebates on those brands are unlikely to offset the higher cost paid by the CCO for brands relative to lower cost therapeutic alternative generic products. We would need to better understand how this issue could be offset by OHA.

F. Financial Reporting Tools and Requirements

OHA will enhance financial reporting and solvency evaluation tools by moving to the financial reporting standards used by the National Association of Insurance Commissioners (NAIC) and the associated Risk Based Capital (RBC) tool to evaluate carrier solvency, along with supplemental schedules as requested by OHA (identified in Exhibit L of the Contract). CCOs will file required NAIC reports using Statutory Accounting Principles (SAP). A financial hardship exemption will be available for Year 1 for CCOs with a demonstrated financial hardship related to converting to SAP and filing reports through NAIC. Additional reporting through the Exhibit L Financial Reporting Template will be required. OHA will promulgate administrative rules describing regulatory interventions based on RBC level.

1. **Does Applicant or any Affiliate of Applicant currently report on NAIC health insurance forms? If so, please describe the reporting company or companies and its relationship with Applicant.**

   Yes, NWCCO is affiliated with entities that submit NAIC health filings in accordance with SAP (Oregon Dental Service and Moda Health Plan, Inc are affiliates of ODS Community Health which is an equity partner and administrator of NWCCO).

2. **Does the Applicant currently participate and file financial statements with the NAIC?**

   No, NWCCO does not file financial statements with the NAIC. As mentioned above, NWCCO has affiliates who prepare and submit all filings and statements as required by NAIC.

3. **Has Applicant prepared a financial statement which includes a RBC calculation? If so, please submit.**

   No, NWCCO has not prepared a RBC calculation. As mentioned above, NWCCO has affiliates who prepare and submit all filings and statements as required by NAIC.

4. **Does the Applicant currently have experience reporting in SAP either directly or through any Affiliate of Applicant?**

   Yes, NWCCO is affiliated with entities that submit NAIC health filings in accordance with SAP (Oregon Dental Service and Moda Health Plan, Inc. are affiliates of ODS Community Health which is an equity partner and administrator of NWCCO).

5. **Does the Applicant seek an exemption from SAP and NAIC reporting for 2020? If yes, please explain in detail (a) the financial hardship related to converting to SAP for the filing, and (b) Applicant's plan to be ready to use SAP in 2021.**

   Yes, NWCCO seeks an exemption from SAP and NAIC reporting for 2020 in order to allow sufficient time for hiring and training personnel. NWCCO's affiliates currently have expertise in SAP and NAIC reporting but do not have adequate coverage to complete filings without additional resources.

6. **Please submit pro forma financial statements of Applicant's financial condition for three years starting in 2020, using Enrollment, rates and cost projections that presume Applicant is awarded a Contract under this RFA. If OHA expects there may be more than two CCOs in Applicant's Service Area, OHA may require Applicant to submit additional pro forma financials based on the expected number of CCOs. OHA will evaluate Applicant's pro forma financials to assure that they provide a realistic plan of solvency. See the RFA Pro Forma Reference Document and UCAA Supplemental Financial Analysis workbook template for a complete description of the requirements and deliverables. The pro forma workbook templates and required supporting documents are excluded from the page limit.**

Required Documentation

- **Completed Pro Forma Workbook Templates (NAIC Form 13H)**
- **Completed NAIC Biographical Affidavit (NAIC Form 11)**
- **Completed UCAA Supplemental Financial Analysis Workbook Template**
- **Three years of Audited Financial Reports**

We have included the required documentation above with our response with the exception of three years of audited financial reports. NWCCO is a newly formed entity in 2019.

G. Accountability to Oregon's Sustainable Growth Targets

OHA seeks to improve the connection between CCO Contracts and the sustainable growth targets established in Oregon's Medicaid waiver and the legislatively enacted budget.

1. **What strategies will the Applicant employ to achieve a sustainable expenditure growth year over year?**

   We believe that our health plan/provider LLC equity model is a key strategy for engaging providers in the financial success of our CCO. When the entities that deliver care to CCO members are at ultimate financial risk which includes risk for achieving a sustainable expenditure growth rate we have their full buy in and engagement. From there they are part of the design of strategies and initiatives along with other community partners to meet financial goals.

   We also believe that significant financial investments in primary care, the implementation of VBP's such as shared risk/shared savings models, capitation and payments for meeting quality metrics, reinvestments of savings back into providers and communities and the use of traditional health workers have a cumulative effect in achieving the quadruple aim and meeting a sustainable expenditure growth rate. We also utilize OPDP to help manage pharmacy expenses. We will implement these strategies and others as they are identified to meet the sustainable expenditure growth rate goals.

2. **How will the CCO allocate and monitor expenditures across all categories of services?**

   On an annual basis NWCCO's financial and actuarial teams will develop a global budget to be approved by the NWCCO Board. The global budget will be developed using a ground up approach to ensure adequate funding is available to cover all services we are required to provide to the NWCCO population. To ensure that expenditures are tracking with the budget, the NWCCO analytics team will produce a variety of reports and analysis that highlight areas for focus across service categories. This reporting infrastructure is already in place for EOCCO and Moda's other lines of business, and will be rolled out to NWCCO.

   For example, regular cost and utilization reports show spending and utilization patterns by member type, service category, diagnosis, provider, and geographic region, to name a few. We intend to monitor inpatient admissions and readmissions, ED visits, outpatient surgeries, infused and specialty drugs, primary and specialty care, and many other cost categories to ensure that any trend outliers are addressed. In addition, both fee-for-service and alternative payments (e.g. capitation) will be summarized by provider to spot trends

and outliers. Reports will be reviewed regularly by the NWCCO board, CAP, and Community Advisory Councils, as well as operational staff such as actuarial, finance, and health care services teams.

3. **What strategies will the Applicant utilize related to Value-Based Payment arrangements to achieve a sustainable expenditure growth?**

   We believe that the use of Value Based Payment (VBP) arrangements play an important role in achieving a sustainable expenditure growth rate. Building upon NWCCO affiliates experience implementing VBP arrangements with EOCCO providers we will implement foundational payments for PCPCH's, shared savings/shared risk models, payments for meeting quality targets and full risk capitation, NWCCO will work toward moving more providers and categories of service to the higher LAN category of 4A while achieving a 70% VBP target by 2024.

   These VBP efforts will be supported by a robust HIT and reporting infrastructure that gives providers timely and accurate data on their assigned member populations, including risk stratification, care gaps, utilization patterns, and other opportunities for intervention. Additionally, NWCCO will put significant resources into care coordination and quality improvement, to assist clinics with acting on the data and reporting we provide.

4. **What strategies will the Applicant utilize to contain costs, while ensuring quality care is provided to Members?**

   Strategies for containing costs will heavily involve implementation of VBP arrangements. We will have access to claims and clinical data and the ability and capacity to monitor the underlying utilization to make sure that all members continue to receive the appropriate level of services. We will run reports such as our cost and utilization reports to show how different sub-populations have performed from an overall utilization and quality measure perspective to ensure quality care is being provided to members.

   High cost members can be a significant driver of overall spending, and so we produce spending and risk stratification reports that identify members that either have high cost now, or that we predict might have high cost in the future. We regularly review these high cost member reports to make sure the members are being managed as needed, both to ensure that members are getting the appropriate care management services, but also to ensure that resources are being utilized appropriately. Frequent ED utilizers, opiate utilizers, and members with chronic conditions are other examples of members that are important cost drivers, which receive scrutiny in our reporting.

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

   NWCCO affiliates ODS Community Health, Inc. and GOBHI are equity partners and administrators of EOCCO. For calendar year 2017 (For 2019 rate setting) EOCCO met the growth target of 3.4%.

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

OHA seeks to establish a statewide reinsurance program to better control costs related to high-cost medical conditions, treatments, and patients.

1. **What type of reinsurance policy does the Applicant plan on holding for 2020? Please include the specifics. (e.g. attachment points, coinsurance, etc.)**

   NWCCO anticipates it will have reinsurance coverage with RGA where NWCCO receives 90% coinsurance for eligible claims paid on members in excess of $350,000 for:

   - Inpatient Hospital Services
   - Outpatient Health Services
   - Inpatient Rehabilitation Services
   - Physician Services
   - Skilled Nursing Facility Services
   - Drug Related Services

This coverage is consistent with the EOCCO.

2. **What is the Applicant's reasoning for selecting the reinsurance policy described above?**

   NWCCO will select reinsurance policy based on competitive price, coverage, risk and claims mitigation, and long term standing relationship.

3. **What aspects of its reinsurance policy are the most important to the Applicant?**

   Level of coverage and risk and claims mitigation are most important to NWCCO when assessing reinsurance policies.

4. **Does existing or previous reinsurance contract allow specific conditions or patients to be excluded, exempted, or lasered out from being covered?**

   Yes

5. **Is Applicant able to leave or modify existing reinsurance arrangements at any time or is Applicant committed to existing arrangements for a set period of time? If so, for how long is Applicant committed to existing arrangements? Are there early cancelation penalties?**

   Not applicable. NWCCO does not have any current reinsurance arrangement. NWCCO would obtain coverage if selected as a CCO through the RFA process.

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

OHA seeks to ensure continued financial viability of the CCO program as a whole so as to ensure OHP Members are protected from potential access barriers that could come with a CCO insolvency event. In addition, OHA may implement new solvency regulation tools that are similar to those utilized by DCBS in its regulation of commercial carriers that would allow OHA to prevent or meliorate insolvency events.

1. **Please describe Applicant's past sources of capital.**

   NWCCO affiliate ODS Community Health, as an equity partner/administrator of EOCCO, has demonstrated experience and capacity for generating positive cash flow and net income after initial sources of capital are contributed by equity partners.

2. **Please describe Applicant's possible future sources of capital.**

   It is anticipated that the initial funding of the organization will be determined based on capital level requirements based on membership and stress scenarios. Equity partners will fund their proportional share of the required capital.

3. **What strategies will the Applicant use to ensure solvency thresholds are maintained?**

   NWCCO affiliate ODS Community Health, as an equity partner/administrator of EOCCO, has demonstrated experience and capacity for reporting loss ratios in excess of minimum requirements as well as the capacity to maintain sufficient capital, primarily based on its low risk investment portfolio weighted in cash and cash equivalents, in the event claims experience is unfavorable. In addition, NWCCO affiliate ODS Community Health, as an equity partner/administrator of EOCCO, has demonstrated capacity to establish value based payment models including full risk models, risk sharing models, and works closely with provider partners and case managers to manage the overall claims experience.

4. **Does Applicant have a parent company, Affiliate, or capital partner from which Applicant may expect additional capital in the event Applicant becomes undercapitalized? If so, please describe.**

   In the event additional capital is needed, the partners/owners of the entities will provide additional capital to meet the required capital levels.

J. Encounter Data Validation Study

1. **Please describe Applicant's capacity to perform regular Provider audits and claims review to ensure the timeliness, correctness, and accuracy of Encounter Data.**

NWCCO will perform annual validation of encounter data audit, in compliance with OHA requirements established in 2016. Member chart notes will be collected and evaluated for accuracy of coding and documentation, against the submitted encounter. Additional areas of validation include:

- Documentation matches day, time duration and location submitted
- Documentation includes the credentials of the provider
- Provider is qualified to use the procedure code submitted
- Documentation is specific to the encounter
- Clinical record documentation matches the service code used

2. **Does Applicant currently perform any activities to validate Claims data at the chart level that the claims data accurately reflects the services provided? If yes, please describe those activities.**

   NWCCO has a robust claims processing and clinical editing system that is programmed to flag and stop encounter claims that may require additional review. When this occurs, NWCCO will require provider chart notes prior to claims payment approval. If the chart notes do not support the encounter submission, claims payment is denied. This is an ongoing process incorporated into our workflow.

   NWCCO also has policies and workflows for the detection, prevention and reporting of fraud, waste and abuse, which, depending on the circumstance, may result in a chart level review of the claims data submitted.

UCAA Proforma Financial Statements

Health

UNIFORM CERTIFICATE OF AUTHORITY APPLICATION

Instructions

1. Enter the Applicant Company Name below
2. Enter the first full year of the proformas (start with 1st full year of operation).
3. Select the states to be completed for proformas by clicking the check boxes on the right and then click on the "Create Selected State Worksheets" button below.
4. Complete all sections of the proforma statements contained on each tab below.
5. Note that several tabs contain worksheets for 3 years of data. Be sure to complete all years of data.
6. Do not "Cut" and "Paste" cells in the worksheets. Use "Copy" and "Paste" instead.

Enter the Applicant Company Name:

NorthWest CCO

Year 1: 2020

Year 2: 2021

Year 3: 2022

☐	AK	Alaska	☐	MT	Montana	
☐	AL	Alabama	☐	NC	North Carolina	
☐	AR	Arkansas	☐	ND	North Dakota	
☐	AS	American Samoa	☐	NE	Nebraska	
☐	AZ	Arizona	☐	NH	New Hampshire	
☐	CA	California	☐	NJ	New Jersey	
☐	CO	Colorado	☐	NM	New Mexico	
☐	CT	Connecticut	☐	NV	Nevada	
☐	DC	District Of Columbia	☐	NY	New York	
☐	DE	Delaware	☐	OH	Ohio	
☐	FL	Florida	☐	OK	Oklahoma	
☐	GA	Georgia	☑	OR	Oregon	Go to OR
☐	GU	Guam	☐	PA	Pennsylvania	
☐	HI	Hawaii	☐	PR	Puerto Rico	
☐	IA	Iowa	☐	RI	Rhode Island	
☐	ID	Idaho	☐	SC	South Carolina	
☐	IL	Illinois	☐	SD	South Dakota	
☐	IN	Indiana	☐	TN	Tennessee	
☐	KS	Kansas	☐	TX	Texas	
☐	KY	Kentucky	☐	UT	Utah	
☐	LA	Louisiana	☐	VA	Virginia	
☐	MA	Massachusetts	☐	VI	U.S. Virgin Islands	
☐	MD	Maryland	☐	VT	Vermont	
☐	ME	Maine	☐	WA	Washington	
☐	MI	Michigan	☐	WI	Wisconsin	
☐	MN	Minnesota	☐	WV	West Virginia	
☐	MO	Missouri	☐	WY	Wyoming	
☐	MS	Mississippi				

If states were added to this spreadsheet in error:

1. Select the states to be deleted by clicking the check boxes on the right.
2. Click on the "Delete Selected State Worksheets" button above.

Updated: 10/07/2016

NorthWest CCO
(Health Company)
Pro Forma Statutory Balance Sheet (Nationwide)
(In Thousands)

	2020	2021	2022
Admitted Assets			
1. Bonds	5,324	6,855	7,833
2. Stock	2,867	3,691	4,218
3. Real Estate/Mortgage Investments			
4. Affiliated Investments			
5. Affiliated Receivables			
6. Cash/Cash Equivalents	16,450	16,270	16,839
7. Aggregate write in for assets	1,120	1,157	1,195
8. Total Assets(1+2+3+4+5+6+7)	**25,759**	**27,973**	**30,084**
Liabilities			
9. Losses (Unpaid Claims for Accident and Health Policies)	10,789	11,144	11,512
10. Unpaid claims adjustment expenses	514	530	548
11. Reserve for Accident and Health Policies			
12. Ceded Reinsurance Payable	87	91	91
13. Payable to Parents, Subsidiaries & Affiliates			
14. MLR rebates			
15. Premiums received in advanced	1,472	1,521	1,571
16. All other Liabilites	2,352	2,637	2,745
17. Total Liabilities (9+10+11+12+13+14+15+16)	**15,213**	**15,923**	**16,467**
Capital and Surplus			
18. Capital Stock			
19. Gross Paid In and Contributed Surplus	9,100	9,100	9,100
20. Surplus Notes			
21. Unassigned Surplus	1,447	2,950	4,512
22. Other Items(elaborate)			
23. Total Capital and Surplus(18+19+20+21+22)	10,547	12,050	13,612
Risk-Based Capital Analysis			
24. Authorized Control Level Risk-Based Capital	$ 5,933	$ 5,965	$ 6,054
25. Calculated Risk-Based Capital (23/24)	177.8%	202.0%	224.9%

NorthWest CCO
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Thousands)

	2020	2021	2022
1. Member months	300,000	300,000	300,000
2. Net Premium Income	175,636	181,402	187,364
3. Fee for Service			
4. Risk Revenue			
5. Change in unearned premium reserves			
6. Aggregate write in for other health related revenue			
7. Aggregate write in for other non-health related revenue			
8. Total (L2+L3+L4+L5+L6+L7)	**175,636**	**181,402**	**187,364**
Hospital and Medical:			
9. Hospital/Medical Benenfits	111,774	115,455	119,261
10. Other professional Services	33,353	34,451	35,587
11. Prescription Drugs	13,880	14,337	14,810
12. Aggregate write ins for other hospital/medical	-		
13. Subtotal (L9+L10+L11+L12)	**159,007**	**164,243**	**169,658**
Less:			
14. Reinsurance recoveries	581	610	641
15. Total hospital and Medical (L13 -L14)	158,425	163,633	169,017
16. Non health claims			
17. Claims adjustment expenses	7,155	7,391	7,635
18. General admin expenses	8,745	9,033	9,331
19. Increase in reserves for accident and health contacts			
20. Total underwriting deductions (L15+L16+L17+L18+L19)	**174,326**	**180,057**	**185,983**
21. Net underwriting gain or loss (L8 -L20)	1,310	1,345	1,382
22. Net investment income earned	137	158	181
23. Aggregate write in for other income or expenses			
24. Federal Income Taxes	-	-	-
25. Net Realized Capital Gains (Losses)			
26. Less Capital Gains Tax			
27. Net Income (L21+L22+L23-L24+L25)	**1,447**	**1,504**	**1,562**
28. Prior YE Surplus	0	10,547	12,050
29. Net Income	1,447	1,504	1,562
30. Capital Increases	9100		
31. Other Increases (Decreases)			
32. Dividends to Stockholders			
33. YE Surplus (L28+L29+L30+L31-L32)	**10,547**	**12,050**	**13,612**

***Itemize in Assumptions**

NorthWest CCO
(Health Company)
Pro Forma Statutory Cash Flow Statement
(In Thousands)

	2020	2021	2022
Cash From Operations			
1. Premiums Collected Net of Reinsurance	175,989	181,414	187,376
2. Benefits Paid	147,123	163,261	168,632
3. Underwriting Expenses Paid	13,463	16,135	16,853
4. Total Cash From Underwriting (L1-L2-L3)	**15,403**	**2,019**	**1,892**
5. Net Investment Income	137	158	181
6. Other Income			
7. Dividends to Policyholders			
8. Federal and Foreign Income Taxes (Paid) Recovered	-	-	-
9. Net Cash From Operations (L4+L5+L6-L7+L8)	**15,540**	**2,177**	**2,072**
Cash From Investments			
10. Net Cash from Investments	(8,190)	(2,357)	(1,504)
Cash From Financing and Misc Sources			
11. Capital and paid in Surplus	9,100		
12. Surplus Notes			
13. Borrowed Funds			
14. Dividends			
15. Other Cash Provided (Applied)			
16. Net Cash from Financing and Misc Sources (L11+L12+L13-L14+L15)	**9,100**	**-**	**-**
17. Net Change in Cash, Cash Equivalents and Short -Term Investments (L9+L10+L16)	16,450	(180)	569

Nationwide
Year 1

NorthWest CCO
(Health Company)
Analysis of Operations by Line of Business
(In Thousands)

	Total	Comprehensive	Medicare Supplement	Dental	Vision	Federal Employees plan	Medicare	Medicaid	Other health	Other non-health	Aggregate of All Other Lines Business
1. Net Premiums (All Business)	175,636							175,636			
2. Change in unearned premium reserve	-										
3. Fee for service	-										XXX
4. Risk revenue	-										XXX
5. Aggregate write ins for other health related revenues	-										XXX
6. Aggregate write ins for other non-health related revenues	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX
7. Total Revenue (1+2+3+4+5+6)	**175,636**	**-**	**-**	**-**	**-**	**-**	**-**	**175,636**	**-**	**-**	**-**
8. Hospital/medical benefits	111,774							111,774			
9. Other professional services	33,353							33,353			
10. Prescription Drugs	13,880							13,880			
11. Aggregatae writes for other hospital/ medical/health	-										XXX
12. Subtotal (8+9+10+11)	**159,007**	**-**	**-**	**-**	**-**	**-**	**-**	**159,007**	**-**	**-**	**-**
	-										
13. Net reinsurance recoveries								581.28			
14. Total hospital and medical (12-13)	**158,425**	**-**	**-**	**-**	**-**	**-**	**-**	**158,425**	**-**	**-**	**-**
15. Non health claims	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
16. Claims adjustment expenses	7,155							7155.297			
17. General admin expenses	8,745							8745.363			
18. Increase in reserves for accident and health contracts	-										
19. Aggregate write in for Other Expenses	-										
20. Total underwriting deductions (14 to19)	**174,326**	**-**	**-**	**-**	**-**	**-**	**-**	**174,326**	**-**	**-**	**-**
21. Net underwriting Gain (Loss) (7-20)	**1,310**	**-**	**-**	**-**	**-**	**-**	**-**	**1,310**	**-**	**-**	**-**

Nationwide
Year 2

NorthWest CCO
(Health Company)
Analysis of Operations by Line of Business
(In Thousands)

	Total	Comprehensive	Medicare Supplement	Dental	Vision	Federal Employees plan	Medicare	Medicaid	Other health	Other non-health	Aggregate of All Other Lines
1. Net Premiums (All Business)	181,402							181,402			
2. Change in unearned premium reserve	-										
3. Fee for service	-										XXX
4. Risk revenue	-										XXX
5. Aggregate write ins for other health related revenues	-										XXX
6. Aggregate write ins for other non-health related revenues	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX
7. Total Revenue (1+2+3+4+5+6)	**181,402**	**-**	**-**	**-**	**-**	**-**	**-**	**181,402**	**-**	**-**	**-**
	-										
8. Hospital/medical benefits	115,455							115,455			
9. Other professional services	34,451							34,451			
10. Prescription Drugs	14,337							14,337			
11. Aggregate write ins for other hospital/ medical/health	-										XXX
12. Subtotal (8+9+10+11)	**164,243**	**-**	**-**	**-**	**-**	**-**	**-**	**164,243**	**-**	**-**	**-**
	-										
13. Net reinsurance recoveries								610.344			
14. Total hospital and medical (12-13)	163,633	-	-	-	-	-	-	163,633	-	-	-
15. Non health claims	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
16. Claims adjustment expenses	7,391							7390.942			
17. General admin expenses	9,033							9033.373			
18. Increase in reserves for accident and health contracts	-										
19. Aggregate write in for Other Expenses	-										
20. Total underwriting deductions (14 to19)	**180,057**	**-**	**-**	**-**	**-**	**-**	**-**	**180,057**	**-**	**-**	**-**
21. Net underwriting Gain (Loss) (7-20)	**1,345**	**-**	**-**	**-**	**-**	**-**	**-**	**1,345**	**-**	**-**	**-**

Nationwide
Year 3

NorthWest CCO
(Health Company)
Analysis of Operations by Line of Business
(In Thousands)

	Total	Comprehensive	Medicare Supplement	Dental	Vision	Federal Employees plan	Medicare	Medicaid	Other health	Other non-health	Aggregate of All Other Lines
1. Net Premiums (All Business)	187,364							187364.2			
2. Change in unearned premium reserve	-										
3. Fee for service	-										XXX
4. Risk revenue	-										XXX
5. Aggregate write ins for other health related revenues	-										XXX
6. Aggregate write ins for other non-health related revenues	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX
7. Total Revenue (L1+L2+L3+L4+L5+L6)	**187,364**	**-**	**-**	**-**	**-**	**-**	**-**	**187,364**	**-**	**-**	**-**
	-										
8. Hospital/medical benefits	119,261							119,261			XXX
9. Other professional services	35,587							35,587			XXX
10. Prescription Drugs	14,810							14,810			XXX
11. Aggregatae writes for other hospital/ medical/health	-										XXX
12. Subtotal (L8+L9+L10+L11)	**169,658**	**-**	**-**	**-**	**-**	**-**	**-**	**169,658**	**-**	**-**	
13. Net reinsurance recoveries	641							640.8612			
14. Total hospital and medical (L12-L13)	169,017	-	-	-	-	-	-	169,017	-	-	-
15. Non health claims	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX
16. Claims adjustment expenses	7,635							7634.599			
17. General admin expenses	9,331							9331.176			
18. Increase in reserves for accident and health contracts	-										XXX
19. Aggregate write in for Other Expenses	-										
20. Total underwriting deductions (L14 : L19)	**185,983**	**-**	**-**	**-**	**-**	**-**	**-**	**185,983**	**-**	**-**	**-**
21. Net underwriting Gain (Loss) (L7-L20)	**1,382**	**-**	**-**	**-**	**-**	**-**	**-**	**1,382**	**-**	**-**	**-**

Nationwide
Year 1

NorthWest CCO
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	176,673,990		1,038,000	175,635,990
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	176,673,990	-	1,038,000	175,635,990

Nationwide
Year 2

NorthWest CCO
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	182,492,388		1,089,900	181,402,488
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	182,492,388	-	1,089,900	181,402,488

Nationwide
Year 3

NorthWest CCO
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	188,508,612		1,144,395	187,364,217
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	188,508,612	-	1,144,395	187,364,217

Nationwide
Year 1

NorthWest CCO
(Health Company)
Preliminary MLR
(In Thousands)

	Individual Comprehensive	Small group comprehensive	Large Group comprehensive	Individual mini-med	Small group mini-med	Large Group mini-med	Total
1. Premiums earned							-
2. Federal taxes/Federal asessments							-
3. State insurance, premium, and other taxes							-
4. Regulatory authority license and fees							-
5. Adjusted premium earned (L1-L2-L3-L4)	**-**	**-**	**-**	**-**	**-**	**-**	**-**
6. Incurred claims excluding prescription drugs							-
7. Prescription drugs							-
8. Pharmaceutical rebates							-
9. State stop loss, market stabilization and claim/census based assessments							-
10. Incurred medical incentive pools and bonuses							-
11. Total incurred claims (L6+L7-L8-L9+L10)	**-**	**-**	**-**	**-**	**-**	**-**	**-**
12. Deductible abuse detection/recovery expenses							**-**
13. Improved health outcomes							-
14. Activities to prevent hospital readmissions							-
15. Improve patient safety and reduce medical errors							-
16. Wellness and health promotion activities							-
17. QI Health information technology expenses							-
18. Total expenses incurred for improving health quality (L13+L14+L15+L16+L17)	**-**	**-**	**-**	**-**	**-**	**-**	**-**
19 Prelimary MLR (L11+L12+L18/L5)	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**

Nationwide
Year 2

NorthWest CCO
(Health Company)
Preliminary MLR
(In Thousands)

	Individual Comprehensive	Small group comprehensive	Large Group comprehensive	Individual mini-med	Small group mini-med	Large Group mini-med	Total
1. Premiums earned							-
2. Federal taxes/Federal asessments							-
3. State insurance, premium, and other taxes							-
4. Regulatory authority license and fees							
5. Adjusted premium earned (L1-L2-L3-L4)	-	-	-	-	-	-	-
6. Incurred claims excluding prescription drugs							-
7. Prescription drugs							-
8. Pharmaceutical rebates							-
9. State stop loss, market stabilization and claim/census based assessments							-
10. Incurred medical incentive pools and bonuses							-
11. Total incurred claims (L6+L7-L8L-9+L10)	-	-	-	-	-	-	-
12. Deductible abuse detection/recovery expenses							-
13. Improved health outcomes							-
14. Activities to prevent hospital readmissions							-
15. Improve patient safety and reduce medical errors							-
16. Wellness and health promotion activities							-
17. QI Health information technology expenses							-
18. Total expenses incurred for improving health quality (L13+L14+L15+L16+L17)	-	-	-	-	-	-	-
19 Prelimary MLR (L11+L12+L18/L5)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Nationwide
Year 3

NorthWest CCO
(Health Company)
Preliminary MLR
(In Thousands)

	Individual Comprehensive	Small group comprehensive	Large Group comprehensive	Individual mini-med	Small group mini-med	Large Group mini-med	Total
1. Premiums earned							-
2. Federal taxes/Federal asessments							-
3. State insurance, premium, and other taxes							-
4. Regulatory authority license and fees							-
5. Adjusted premium earned (1-2-3-4)	**-**	**-**	**-**	**-**	**-**	**-**	**-**
6. Incurred claims excluding prescription drugs							-
7. Prescription drugs							-
8. Pharmaceutical rebates							-
9. State stop loss, market stabilization and claim/census based assessments							-
10. Incurred medical incentive pools and bonuses							-
11. Total incurred claims (6+7-8-9+10)	-	-	-	-	-	-	-
12. Deductible abuse detection/recovery expenses							**-**
13. Improved health outcomes							-
14. Activities to prevent hospital readmissions							-
15. Improve patient safety and reduce medical errors							-
16. Wellness and health promotion activities							-
17. QI Health information technology expenses							-
18. Total expenses incurred for improving health quality (L13+L14+L15+L16+L17)	**-**	**-**	**-**	**-**	**-**	**-**	**-**
19 Prelimary MLR (L11+L12+L18/L5)	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**

UCAA Proforma Financial Statements
Assumptions

List all of the relevant assumptions used to create the proformas.
Note, assumptions enclosed within the Plan of Operation need not be disclosed again here.

The purpose of this proforma is to demonstrate the how the NorthWest CCO (NWCCO) could potentially be formed as well as to provide a forecast of the expected results over the next three-year period. The underlying assumption is that a partnership will be formed with provider partners similar to the Eastern Oregon CCO (EOCCO).

The six partners intend to contribute capital to cover the estimated minimum net worth requirement which, based on the Company's projected Authorized Control Level, would also allow the Company to exceed 200% RBC by year 2.

For discussion purposes only we have assumed six partners (as documented below) would be responsible to contribute the intitial funding of the NWCCO. The funding would cover the Minimum Net Worth Requirement, which based on the NWCCO's projected Authorized Control Level (ACL), would allow NWCCO to exceed the 200% Risk Based Capital (RBC) level from inception. It should be noted that the Minimum Net Worth Requirements have been stricted from the draft contract and replaced with RBC language. We have included the estimated Minimum Net Worth Requirement on the Proforma for comparative purposes. It is the expectation that ODS Community Health (Moda) will take a 51% interest.

Partner	Interest %	$ Contributions	
ODS Community Health (Moda)	51%	$ 4,641,000	
Columbia Memorial Hospital	%	$	
Adventist - Tillamook	%	$	
Greater Oregon Behavioral Health, Inc.	%	$	
Yakima Valley Farm Workers	%	$	
Reinhart Clinic	%	$	
	100%	$ 9,100,000	reflects best estimate scenario

Region/Counties:
The geographic region that NorthWest CCO would operate in is Clatsop County, Columbia County and Tillamook County.

Enrollment Levels:
The total membership for this area is estimated to be approximately 25,000. The current best estimate is that NWCCO will capture 100% of this market. It is believed that the proposed strong provider partnerships will allow it to deliver high-quality care while staying within the 3.4% annual medical trend target. It is expected that the NWCCO would be able to sucessfully manage membership levels between 75% and 125% of the total estimated enrollment and be able to stay within the 3.4% annual medical trend target while effectively managing fixed and variable administrative costs and maintaining the appropriate service and network adequacy levels.

Revenue:
The Company estimated revenues using the provided PMPM revenue amount from Attachment 12 - CCO 2.0 Procurement Rate Methodology Appendix. The company assumed the average gross rate ($570.43) excluding tax for its rating area. The gross rate was chosen because the Company intends to achieve 100% of the bonus pool. While the Company acknowledges that the performance metrics are progressively more difficult to achieve, it also believes that its structure and strong provider-partnerships and success record with administering the EOCCO through its affiliates demonstrates that this is achievable.

Included in the revenue amount is the projected maternity payments based on the projected rate from Attachment 12 - CCO 2.0 Procurement Rate Methodology Appendix. The Company assumed the average gross rate ($13,913.24) excluding tax for its rating area and multiplied that with the projected births for the region based on the projected enrollment targets.

Underwriting Expenses:
The Company estimated medical expenses at 90% of total revenues, based on the rate setting methodology and the projected non-medical load amounts. Total Pay-for-Performance amounts were also projected at 90% of total revenues.

Administrative Expenses:
The adminstrative expenses have been estimated using the rating methodology for the non-medical load administration and case management services. The 1% profit contingency has been factored into the underwriting results.

Other:
Reinsurance: Reinsurance premiums are based on the current market per member per month rate and increases 5% each year.
Reinsurance recoveries are based on a conservative 56% of premium.

Investment Income: Investment income is assumed at 1.5% of invested balances

Oregon
Year 1

NorthWest CCO
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	176,673,990		1,038,000	175,635,990
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	**176,673,990**	**-**	**1,038,000**	**175,635,990**

Oregon
Year 2

NorthWest CCO
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	182,492,388		1,089,900	181,402,488
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	**182,492,388**	**-**	**1,089,900**	**181,402,488**

Oregon
Year 3

NorthWest CCO
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	188,508,612		1,144,395	187,364,217
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	**188,508,612**	**-**	**1,144,395**	**187,364,217**

UCAA Proforma Financial Statements

Health

UNIFORM CERTIFICATE OF AUTHORITY APPLICATION

Instructions

1. Enter the Applicant Company Name below
2. Enter the first full year of the proformas (start with 1st full year of operation).
3. Select the states to be completed for proformas by clicking the check boxes on the right and then click on the "Create Selected State Worksheets" button below.
4. Complete all sections of the proforma statements contained on each tab below.
5. Note that several tabs contain worksheets for 3 years of data. Be sure to complete all years of data.
6. Do not "Cut" and "Paste" cells in the worksheets. Use "Copy" and "Paste" instead.

Enter the Applicant Company Name:

NorthWest CCO

Year 1: 2020

Year 2: 2021

Year 3: 2022

☐	AK	Alaska	☐	MT	Montana	
☐	AL	Alabama	☐	NC	North Carolina	
☐	AR	Arkansas	☐	ND	North Dakota	
☐	AS	American Samoa	☐	NE	Nebraska	
☐	AZ	Arizona	☐	NH	New Hampshire	
☐	CA	California	☐	NJ	New Jersey	
☐	CO	Colorado	☐	NM	New Mexico	
☐	CT	Connecticut	☐	NV	Nevada	
☐	DC	District Of Columbia	☐	NY	New York	
☐	DE	Delaware	☐	OH	Ohio	
☐	FL	Florida	☐	OK	Oklahoma	
☐	GA	Georgia	☑	OR	Oregon	Go to OR
☐	GU	Guam	☐	PA	Pennsylvania	
☐	HI	Hawaii	☐	PR	Puerto Rico	
☐	IA	Iowa	☐	RI	Rhode Island	
☐	ID	Idaho	☐	SC	South Carolina	
☐	IL	Illinois	☐	SD	South Dakota	
☐	IN	Indiana	☐	TN	Tennessee	
☐	KS	Kansas	☐	TX	Texas	
☐	KY	Kentucky	☐	UT	Utah	
☐	LA	Louisiana	☐	VA	Virginia	
☐	MA	Massachusetts	☐	VI	U.S. Virgin Islands	
☐	MD	Maryland	☐	VT	Vermont	
☐	ME	Maine	☐	WA	Washington	
☐	MI	Michigan	☐	WI	Wisconsin	
☐	MN	Minnesota	☐	WV	West Virginia	
☐	MO	Missouri	☐	WY	Wyoming	
☐	MS	Mississippi				

If states were added to this spreadsheet in error:

1. Select the states to be deleted by clicking the check boxes on the right.
2. Click on the "Delete Selected State Worksheets" button above.

Updated: 10/07/2016

NorthWest CCO
(Health Company)
Pro Forma Statutory Balance Sheet (Nationwide)
(In Thousands)

	2020	2021	2022
Admitted Assets			
1. Bonds	6,640	8,912	10,511
2. Stock	3,575	4,799	5,660
3. Real Estate/Mortgage Investments			
4. Affiliated Investments			
5. Affiliated Receivables			
6. Cash/Cash Equivalents	20,772	20,553	21,278
7. Aggregate write in for assets	1,379	1,425	1,472
8. Total Assets(1+2+3+4+5+6+7)	**32,366**	**35,689**	**38,920**
Liabilities			
9. Losses (Unpaid Claims for Accident and Health Policies)	13,290	13,728	14,180
10. Unpaid claims adjustment expenses	633	653	675
11. Reserve for Accident and Health Policies			
12. Ceded Reinsurance Payable	108	114	114
13. Payable to Parents, Subsidiaries & Affiliates			
14. MLR rebates			
15. Premiums received in advanced	1,814	1,873	1,935
16. All other Liabilites	2,810	3,151	3,281
17. Total Liabilities (9+10+11+12+13+14+15+16)	**18,655**	**19,519**	**20,184**
Capital and Surplus			
18. Capital Stock			
19. Gross Paid In and Contributed Surplus	11,350	11,350	11,350
20. Surplus Notes			
21. Unassigned Surplus	2,361	4,820	7,380
22. Other Items(elaborate)			
23. Total Capital and Surplus(18+19+20+21+22)	13,711	16,170	18,730
Risk-Based Capital Analysis			
24. Authorized Control Level Risk-Based Capital	$ 7,264	$ 7,326	$ 7,411
25. Calculated Risk-Based Capital (23/24)	188.7%	220.7%	252.7%

NorthWest CCO
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Thousands)

	2020	2021	2022
1. Member months	375,000	375,000	375,000
2. Net Premium Income	216,336	223,435	230,775
3. Fee for Service			
4. Risk Revenue			
5. Change in unearned premium reserves			
6. Aggregate write in for other health related revenue			
7. Aggregate write in for other non-health related revenue			
8. Total (L2+L3+L4+L5+L6+L7)	**216,336**	**223,435**	**230,775**
Hospital and Medical:			
9. Hospital/Medical Benenfits	137,687	142,220	146,906
10. Other professional Services	41,085	42,438	43,836
11. Prescription Drugs	17,098	17,661	18,243
12. Aggregate write ins for other hospital/medical	-		
13. Subtotal (L9+L10+L11+L12)	**195,870**	**202,318**	**208,985**
Less:			
14. Reinsurance recoveries	727	763	801
15. Total hospital and Medical (L13 -L14)	195,144	201,555	208,184
16. Non health claims			
17. Claims adjustment expenses	8,551	8,832	9,123
18. General admin expenses	10,451	10,795	11,151
19. Increase in reserves for accident and health contacts			
20. Total underwriting deductions (L15+L16+L17+L18+L19)	**214,145**	**221,182**	**228,458**
21. Net underwriting gain or loss (L8 -L20)	2,191	2,253	2,317
22. Net investment income earned	170	206	243
23. Aggregate write in for other income or expenses			
24. Federal Income Taxes	-	-	-
25. Net Realized Capital Gains (Losses)			
26. Less Capital Gains Tax			
27. Net Income (L21+L22+L23-L24+L25)	**2,361**	**2,459**	**2,560**
28. Prior YE Surplus	0	13,711	16,170
29. Net Income	2,361	2,459	2,560
30. Capital Increases	11350		
31. Other Increases (Decreases)			
32. Dividends to Stockholders			
33. YE Surplus (L28+L29+L30+L31-L32)	**13,711**	**16,170**	**18,730**

***Itemize in Assumptions**

NorthWest CCO
(Health Company)
Pro Forma Statutory Cash Flow Statement
(In Thousands)

	2020	2021	2022
Cash From Operations			
1. Premiums Collected Net of Reinsurance	216,771	223,450	230,789
2. Benefits Paid	181,221	201,097	207,710
3. Underwriting Expenses Paid	16,083	19,281	20,139
4. Total Cash From Underwriting (L1-L2-L3)	**19,467**	**3,072**	**2,941**
5. Net Investment Income	170	206	243
6. Other Income			
7. Dividends to Policyholders			
8. Federal and Foreign Income Taxes (Paid) Recovered	-	-	-
9. Net Cash From Operations (L4+L5+L6-L7+L8)	**19,637**	**3,278**	**3,184**
Cash From Investments			
10. Net Cash from Investments	(10,215)	(3,496)	(2,459)
Cash From Financing and Misc Sources			
11. Capital and paid in Surplus	11,350		
12. Surplus Notes			
13. Borrowed Funds			
14. Dividends			
15. Other Cash Provided (Applied)			
16. Net Cash from Financing and Misc Sources (L11+L12+L13-L14+L15)	**11,350**	**-**	**-**
17. Net Change in Cash, Cash Equivalents and Short -Term Investments (L9+L10+L16)	20,772	(219)	725

Nationwide
Year 1

NorthWest CCO
(Health Company)
Analysis of Operations by Line of Business
(In Thousands)

	Total	Comprehensive	Medicare Supplement	Dental	Vision	Federal Employees plan	Medicare	Medicaid	Other health	Other non-health	Aggregate of All Other Lines Business
1. Net Premiums (All Business)	216,336							216,336			
2. Change in unearned premium reserve	-										
3. Fee for service	-										XXX
4. Risk revenue	-										XXX
5. Aggregate write ins for other health related revenues	-										XXX
6. Aggregate write ins for other non-health related revenues	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX
7. Total Revenue (1+2+3+4+5+6)	**216,336**	**-**	**-**	**-**	**-**	**-**	**-**	**216,336**	**-**	**-**	**-**
8. Hospital/medical benefits	137,687							137,687			
9. Other professional services	41,085							41,085			
10. Prescription Drugs	17,098							17,098			
11. Aggregatae writes for other hospital/ medical/health	-										XXX
12. Subtotal (8+9+10+11)	**195,870**	**-**	**-**	**-**	**-**	**-**	**-**	**195,870**	**-**	**-**	**-**
	-										
13. Net reinsurance recoveries								726.6			
14. Total hospital and medical (12-13)	**195,144**	**-**	**-**	**-**	**-**	**-**	**-**	**195,144**	**-**	**-**	**-**
15. Non health claims	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
16. Claims adjustment expenses	8,551							8550.579			
17. General admin expenses	10,451							10450.71			
18. Increase in reserves for accident and health contracts	-										
19. Aggregate write in for Other Expenses	-										
20. Total underwriting deductions (14 to19)	**214,145**	**-**	**-**	**-**	**-**	**-**	**-**	**214,145**	**-**	**-**	**-**
21. Net underwriting Gain (Loss) (7-20)	**2,191**	**-**	**-**	**-**	**-**	**-**	**-**	**2,191**	**-**	**-**	**-**

Nationwide
Year 2

NorthWest CCO
(Health Company)
Analysis of Operations by Line of Business
(In Thousands)

	Total	Comprehensive	Medicare Supplement	Dental	Vision	Federal Employees plan	Medicare	Medicaid	Other health	Other non-health	Aggregate of All Other Lines
1. Net Premiums (All Business)	223,435							223,435			
2. Change in unearned premium reserve	-										
3. Fee for service	-										XXX
4. Risk revenue	-										XXX
5. Aggregate write ins for other health related revenues	-										XXX
6. Aggregate write ins for other non-health related revenues	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX
7. Total Revenue (1+2+3+4+5+6)	**223,435**	**-**	**-**	**-**	**-**	**-**	**-**	**223,435**	**-**	**-**	**-**
	-										
8. Hospital/medical benefits	142,220							142,220			
9. Other professional services	42,438							42,438			
10. Prescription Drugs	17,661							17,661			
11. Aggregate write ins for other hospital/ medical/health	-										XXX
12. Subtotal (8+9+10+11)	**202,318**	**-**	**-**	**-**	**-**	**-**	**-**	**202,318**	**-**	**-**	**-**
	-										
13. Net reinsurance recoveries								762.93			
14. Total hospital and medical (12-13)	201,555	-	-	-	-	-	-	201,555	-	-	-
15. Non health claims	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
16. Claims adjustment expenses	8,832							8832.175			
17. General admin expenses	10,795							10794.88			
18. Increase in reserves for accident and health contracts	-										
19. Aggregate write in for Other Expenses	-										
20. Total underwriting deductions (14 to19)	**221,182**	**-**	**-**	**-**	**-**	**-**	**-**	**221,182**	**-**	**-**	**-**
21. Net underwriting Gain (Loss) (7-20)	**2,253**	**-**	**-**	**-**	**-**	**-**	**-**	**2,253**	**-**	**-**	**-**

Nationwide
Year 3

NorthWest CCO
(Health Company)
Analysis of Operations by Line of Business
(In Thousands)

	Total	Comprehensive	Medicare Supplement	Dental	Vision	Federal Employees plan	Medicare	Medicaid	Other health	Other non-health	Aggregate of All Other Lines
1. Net Premiums (All Business)	230,775							230774.7			
2. Change in unearned premium reserve	-										
3. Fee for service	-										XXX
4. Risk revenue	-										XXX
5. Aggregate write ins for other health related revenues	-										XXX
6. Aggregate write ins for other non-health related revenues	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX
7. Total Revenue (L1+L2+L3+L4+L5+L6)	**230,775**	**-**	**-**	**-**	**-**	**-**	**-**	**230,775**	**-**	**-**	**-**
	-										
8. Hospital/medical benefits	146,906							146,906			XXX
9. Other professional services	43,836							43,836			XXX
10. Prescription Drugs	18,243							18,243			XXX
11. Aggregatae writes for other hospital/ medical/health	-										XXX
12. Subtotal (L8+L9+L10+L11)	**208,985**	**-**	**-**	**-**	**-**	**-**	**-**	**208,985**	**-**	**-**	
13. Net reinsurance recoveries	801							801.0765			
14. Total hospital and medical (L12-L13)	208,184	-	-	-	-	-	-	208,184	-	-	-
15. Non health claims	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX
16. Claims adjustment expenses	9,123							9123.346			
17. General admin expenses	11,151							11150.76			
18. Increase in reserves for accident and health contracts	-										XXX
19. Aggregate write in for Other Expenses	-										
20. Total underwriting deductions (L14 : L19)	**228,458**	**-**	**-**	**-**	**-**	**-**	**-**	**228,458**	**-**	**-**	**-**
21. Net underwriting Gain (Loss) (L7-L20)	**2,317**	**-**	**-**	**-**	**-**	**-**	**-**	**2,317**	**-**	**-**	**-**

Nationwide
Year 1

NorthWest CCO
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	217,633,812		1,297,500	216,336,312
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	217,633,812	-	1,297,500	216,336,312

Nationwide
Year 2

NorthWest CCO
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	224,797,715		1,362,375	223,435,340
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	224,797,715	-	1,362,375	223,435,340

Nationwide
Year 3

NorthWest CCO
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	232,205,190		1,430,494	230,774,696
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	232,205,190	-	1,430,494	230,774,696

Nationwide
Year 1

NorthWest CCO
(Health Company)
Preliminary MLR
(In Thousands)

	Individual Comprehensive	Small group comprehensive	Large Group comprehensive	Individual mini-med	Small group mini-med	Large Group mini-med	Total
1. Premiums earned							-
2. Federal taxes/Federal asessments							-
3. State insurance, premium, and other taxes							-
4. Regulatory authority license and fees							-
5. Adjusted premium earned (L1-L2-L3-L4)	**-**	**-**	**-**	**-**	**-**	**-**	**-**
6. Incurred claims excluding prescription drugs							-
7. Prescription drugs							-
8. Pharmaceutical rebates							-
9. State stop loss, market stabilization and claim/census based assessments							-
10. Incurred medical incentive pools and bonuses							-
11. Total incurred claims (L6+L7-L8-L9+L10)	**-**	**-**	**-**	**-**	**-**	**-**	**-**
12. Deductible abuse detection/recovery expenses							**-**
13. Improved health outcomes							-
14. Activities to prevent hospital readmissions							-
15. Improve patient safety and reduce medical errors							-
16. Wellness and health promotion activities							-
17. QI Health information technology expenses							-
18. Total expenses incurred for improving health quality (L13+L14+L15+L16+L17)	**-**	**-**	**-**	**-**	**-**	**-**	**-**
19 Prelimary MLR (L11+L12+L18/L5)	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**

Nationwide
Year 2

NorthWest CCO
(Health Company)
Preliminary MLR
(In Thousands)

	Individual Comprehensive	Small group comprehensive	Large Group comprehensive	Individual mini-med	Small group mini-med	Large Group mini-med	Total
1. Premiums earned							-
2. Federal taxes/Federal asessments							-
3. State insurance, premium, and other taxes							-
4. Regulatory authority license and fees							
5. Adjusted premium earned (L1-L2-L3-L4)	-	-	-	-	-	-	-
6. Incurred claims excluding prescription drugs							-
7. Prescription drugs							-
8. Pharmaceutical rebates							-
9. State stop loss, market stabilization and claim/census based assessments							-
10. Incurred medical incentive pools and bonuses							-
11. Total incurred claims (L6+L7-L8L-9+L10)	-	-	-	-	-	-	-
12. Deductible abuse detection/recovery expenses							-
13. Improved health outcomes							-
14. Activities to prevent hospital readmissions							-
15. Improve patient safety and reduce medical errors							-
16. Wellness and health promotion activities							-
17. QI Health information technology expenses							-
18. Total expenses incurred for improving health quality (L13+L14+L15+L16+L17)	-	-	-	-	-	-	-
19 Prelimary MLR (L11+L12+L18/L5)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Nationwide
Year 3

NorthWest CCO
(Health Company)
Preliminary MLR
(In Thousands)

	Individual Comprehensive	Small group comprehensive	Large Group comprehensive	Individual mini-med	Small group mini-med	Large Group mini-med	Total
1. Premiums earned							-
2. Federal taxes/Federal asessments							-
3. State insurance, premium, and other taxes							-
4. Regulatory authority license and fees							-
5. Adjusted premium earned (1-2-3-4)	**-**	**-**	**-**	**-**	**-**	**-**	**-**
6. Incurred claims excluding prescription drugs							-
7. Prescription drugs							-
8. Pharmaceutical rebates							-
9. State stop loss, market stabilization and claim/census based assessments							-
10. Incurred medical incentive pools and bonuses							-
11. Total incurred claims (6+7-8-9+10)	-	-	-	-	-	-	-
12. Deductible abuse detection/recovery expenses							**-**
13. Improved health outcomes							-
14. Activities to prevent hospital readmissions							-
15. Improve patient safety and reduce medical errors							-
16. Wellness and health promotion activities							-
17. QI Health information technology expenses							-
18. Total expenses incurred for improving health quality (L13+L14+L15+L16+L17)	**-**	**-**	**-**	**-**	**-**	**-**	**-**
19 Prelimary MLR (L11+L12+L18/L5)	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**

UCAA Proforma Financial Statements
Assumptions

List all of the relevant assumptions used to create the proformas.
Note, assumptions enclosed within the Plan of Operation need not be disclosed again here.

The purpose of this proforma is to demonstrate the how the NorthWest CCO (NWCCO) could potentially be formed as well as to provide a forecast of the expected results over the next three-year period. The underlying assumption is that a partnership will be formed with provider partners similar to the Eastern Oregon CCO (EOCCO).

The six partners intend to contribute capital to cover the estimated minimum net worth requirement which, based on the Company's projected Authorized Control Level, would also allow the Company to exceed 200% RBC by year 2.

For discussion purposes only we have assumed six partners (as documented below) would be responsible to contribute the intitial funding of the NWCCO. The funding would cover the Minimum Net Worth Requirement, which based on the NWCCO's projected Authorized Control Level (ACL), would allow NWCCO to exceed the 200% Risk Based Capital (RBC) level from inception. It should be noted that the Minimum Net Worth Requirements have been stricted from the draft contract and replaced with RBC language. We have included the estimated Minimum Net Worth Requirement on the Proforma for comparative purposes. It is the expectation that ODS Community Health (Moda) will take a 51% interest.

Partner	Interest %	$ Contributions	
ODS Community Health (Moda)	51%	$ 5,788,500	
Columbia Memorial Hospital	%	$	
Adventist - Tillamook	%	$	
Greater Oregon Behavioral Health, Inc.	%	$	
Yakima Valley Farm Workers	%	$	
Reinhart Clinic	%	$	
	100%	$ 11,350,000	reflects Max scenario

Region/Counties:
The geographic region that NorthWest CCO would operate in is Clatsop County, Columbia County and Tillamook County.

Enrollment Levels:
The total membership for this area is estimated to be approximately 25,000. The current best estimate is that NWCCO will capture 100% of this market. It is believed that the proposed strong provider partnerships will allow it to deliver high-quality care while staying within the 3.4% annual medical trend target. It is expected that the NWCCO would be able to sucessfully manage membership levels between 75% and 125% of the total estimated enrollment and be able to stay within the 3.4% annual medical trend target while effectively managing fixed and variable administrative costs and maintaining the appropriate service and network adequacy levels.

Revenue:
The Company estimated revenues using the provided PMPM revenue amount from Attachment 12 - CCO 2.0 Procurement Rate Methodology Appendix. The company assumed the average gross rate ($570.43) excluding tax for its rating area. The gross rate was chosen because the Company intends to achieve 100% of the bonus pool. While the Company acknowledges that the performance metrics are progressively more difficult to achieve, it also believes that its structure and strong provider-partnerships and success record with administering the EOCCO through its affiliates demonstrates that this is achievable.

Included in the revenue amount is the projected maternity payments based on the projected rate from Attachment 12 - CCO 2.0 Procurement Rate Methodology Appendix. The Company assumed the average gross rate ($13,913.24) excluding tax for its rating area and multiplied that with the projected births for the region based on the projected enrollment targets.

Underwriting Expenses:
The Company estimated medical expenses at 90% of total revenues, based on the rate setting methodology and the projected non-medical load amounts. Total Pay-for-Performance amounts were also projected at 90% of total revenues.

Administrative Expenses:
The adminstrative expenses have been estimated using the rating methodology for the non-medical load administration and case management services. The 1% profit contingency has been factored into the underwriting results.

Other:
Reinsurance: Reinsurance premiums are based on the current market per member per month rate and increases 5% each year.
Reinsurance recoveries are based on a conservative 56% of premium.

Investment Income: Investment income is assumed at 1.5% of invested balances

Oregon
Year 1

NorthWest CCO
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	217,633,812		1,297,500	216,336,312
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	**217,633,812**	**-**	**1,297,500**	**216,336,312**

Oregon
Year 2

NorthWest CCO
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	224,797,715		1,362,375	223,435,340
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	**224,797,715**	**-**	**1,362,375**	**223,435,340**

Oregon
Year 3

NorthWest CCO
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	232,205,190		1,430,494	230,774,696
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	**232,205,190**	**-**	**1,430,494**	**230,774,696**

APPLICANT NAME: **NorthWest CCO**

INTRODUCTION: This supplemental report is to be completed in conjunction with the NAIC UCAA Form 13H.

CALENDAR YEAR:	**2020**
CALENDAR YEAR START DATE:	**1/1/2020**
CALENDAR YEAR ENDING DATE:	**12/31/2020**

INSTRUCTIONS:

1 Prior to completing the UCAA Form 13H, first complete the "Company Assumptions" tab of this template. Identify the geographic area (Desired Locations) and the corresponding Member Months to be used in developing the Pro Formas.

2 The UCAA Balance Sheet and P and L input data comes directly from Form 13H. Three separate Form 13H templates will need to be created and submitted with the applicaion for each of the three scenarios described in the Reference Document. Copy and paste the values from Form 13H to the tabs in this template for each of the three scenarios.

3 Calculate and input the Authorized Control Level (ACL) into "UCAA Balance Sheet" Line 25 for each of the three years and each of the three scenarios (9 ACLs in total) as instructed in the Reference Document.

4 Enter your information in the yellow cells only. All other cells are calculated.

NorthWest CCO
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Whole Numbers)

			2020	2021	2022
1.	Desired Service Area (List Counties): Clatsop, Columbia, Tillamook				
2.	Membership totals for Desired Service Area:		25,000	25,000	25,000
3.	Best Estimate Membership Percentage:		100%	100%	100%
4.	Best Estimate Member Months	(BE MM)	300,000	300,000	300,000
5.	Estimated Minimum viable Membership Percentage:		75%	75%	75%
6.	Minimum Member Months	(MIN MM)	225,000	225,000	225,000
7.	Estimated Maximum viable Membership Percentage:		125%	125%	125%
8.	Maximum Member Months	(MAX MM)	375,000	375,000	375,000
	Administrative Costs:				
9.	What is the total "fixed" administrative costs for CCO Operations?		3,498,145	3,613,349	3,732,471
10.	What is the variable administrative costs for CCO Operations on a Per Member Per Month basis:		41	43	44

NorthWest CCO
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Whole Numbers)

Scenario Summary

	2020	2021	2022
Best Estimate MM:	300,000	300,000	300,000
Net Income	1,446,520	1,503,566	1,562,304
Net Income Claims +2%	(1,721,986)	(1,769,090)	(1,818,034)
MLR Claims +2%	92%	92%	92%
RBC Claims +2%	1.244	1.471	1.690
Net Income Claims +4%	(4,890,493)	(5,041,747)	(5,198,372)
MLR Claims +4%	94%	94%	94%
RBC Claims +4%	0.709	0.923	1.132
Minimum MM:	225,000	225,000	225,000
Net Income	51,958	43,902	35,150
Net Income Claims +2%	(2,289,768)	(2,374,758)	(2,463,053)
MLR Claims +2%	92%	92%	92%
RBC Claims +2%	1.518	1.490	1.460
Net Income Claims +4%	(4,631,494)	(4,793,419)	(4,961,256)
MLR Claims +4%	94%	94%	94%
RBC Claims +4%	0.996	0.958	0.919
Maximum MM:	375,000	375,000	375,000
Net Income	2,361,444	2,458,942	2,559,556
Net Income Claims +2%	(1,541,433)	(1,572,158)	(1,604,116)
MLR Claims +2%	92%	92%	92%
RBC Claims +2%	1.350	1.657	1.966
Net Income Claims +4%	(5,444,310)	(5,603,259)	(5,767,787)
MLR Claims +4%	94%	94%	94%
RBC Claims +4%	0.813	1.107	1.404

NorthWest CCO
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Whole Numbers)

Administrative Costs Summary

	Pro Forma Ref	2020	2021	2022
Best Estimate MM:		300,000	300,000	300,000
Fixed Administrative Costs	Assumptions Line 9	3,498,145	3,613,349	3,732,471
Variable Administrative Costs	Assumptions Line 10	12,402,514	12,810,966	13,233,305
Total Administrative Costs	calculated	15,900,659	16,424,315	16,965,775
Reported Administrative Costs	P and L Lines 17, 18	15,900,659	16,424,315	16,965,775
Difference (should be 0)	calculated	-	-	-
Minimum MM:		225,000	225,000	225,000
Fixed Administrative Costs	Assumptions Line 9	3,498,145	3,613,349	3,732,471
Variable Administrative Costs	Assumptions Line 10	9,301,886	9,608,224	9,924,978
Total Administrative Costs	calculated	12,800,031	13,221,574	13,657,449
Reported Administrative Costs	P and L Lines 17, 18	12,800,031	13,221,574	13,657,449
Difference (should be 0)	calculated	-	-	-
Maximum MM:		375,000	375,000	375,000
Fixed Administrative Costs	Assumptions Line 9	3,498,145	3,613,349	3,732,471
Variable Administrative Costs	Assumptions Line 10	15,503,143	16,013,707	16,541,631
Total Administrative Costs	calculated	19,001,288	19,627,056	20,274,101
Reported Administrative Costs	P and L Lines 17, 18	19,001,288	19,627,056	20,274,101
Difference (should be 0)	calculated	-	-	-

NorthWest CCO
(Health Company)
Pro Forma Statutory Balance Sheet (Nationwide)
(In Whole Numbers)

BASED ON BE MM IDENTIFIED IN ASSUMPTIONS

COPY VALUES OVER FROM FORM 13H (BE MM)

		12/31/2020	12/31/2021	12/31/2022
	Admitted Assets			
1.	Bonds	5,323,500	6,855,238	7,832,556
2.	Stocks (Preferred & Common)	2,866,500	3,691,282	4,217,530
3.	Real Estate/Mortgage Loans on Real Estate			
4.	Cash/Cash Equivalents/Short-Term Investments	16,449,659	16,269,963	16,838,815
5.	Other Invested Assets			
6.	Aggregate Write-Ins For Invested Assets	1,119,682	1,156,556	1,194,684
7.	All Other Assets			
8.	Total Admitted Assets (Lines 1+2+3+4+5+6+7)	**25,759,341**	**27,973,040**	**30,083,584**
	Liabilities			
9.	Losses (Unpaid Claims for Accident and Health Policies)	10,788,833	11,144,141	11,511,530
10.	Unpaid Claims Adjustment Expenses	513,548	530,461	547,949
11.	Aggregate Health Policy Reserves	-	-	-
12.	Ceded Reinsurance Premiums Payable	86,500	90,825	90,825
13.	Amounts Due To Parents, Subsidiaries & Affiliates	-	-	-
14.	MLR Rebates	-	-	-
15.	Premiums Received In Advance	1,472,283	1,520,770	1,570,905
16.	All Other Liabilites	2,351,656	2,636,757	2,745,445
17.	Total Liabilities (Lines 9+10+11+12+13+14+15+16)	**15,212,821**	**15,922,954**	**16,466,654**
	Capital and Surplus			
18.	Capital Stock			
19.	Gross Paid In And Contributed Surplus	9,100,000	9,100,000	9,100,000
20.	Surplus Notes			
21.	Unassigned Funds (Surplus)	1,446,520	2,950,086	4,512,389
22.	Aggregate Write-ins for Other-Than-Special Surplus Funds			
23.	Less Treasury Stock (Common and Preferred)			
24.	Total Capital and Surplus (Lines 18+19+20+21+22-23)	10,546,520	12,050,086	13,612,389
25.	Liabilities and Surplus (Lines 17+24)	25,759,341	27,973,040	30,079,043

	Risk-Based Capital Analysis			
25.	Authorized Control Level Risk-Based Capital	5,933,079	5,965,278	6,053,642
26.	Calculated Risk-Based Capital (Line 24 / Line 25)	177.8%	202.0%	224.9%

NorthWest CCO
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Whole Numbers)

BASED ON BE MM IDENTIFIED IN ASSUMPTIONS

COPY VALUES OVER FROM FORM 13H (BE MM)

	2020	2021	2022
1. Member Months	300,000	300,000	300,000
2. Net Premium Income	175,635,990	181,402,488	187,364,217
3. Fee For Service			
4. Risk Revenue			
5. Change In Unearned Premium Reserves and Reserve for Rate Credits			
6. Aggregate Write-Ins For Other Health Care Related Revenue			
7. Aggregate Write-Ins For Other Non-Health Revenue			
8. Total (Lines 2+3+4+5+6+7)	**175,635,990**	**181,402,488**	**187,364,217**
Hospital and Medical:			
9. Hospital/Medical Benefits	111,773,843	115,454,887	119,261,087
10. Other Professional Services	33,352,765	34,451,170	35,586,921
11. Prescription Drugs	13,879,983	14,337,092	14,809,743
12. Aggregate Write-Ins For Other Hospital and Medical			
13. Subtotal (Lines 9+10+11+12)	**159,006,591**	**164,243,149**	**169,657,750**
Less:			
14. Net Reinsurance Recoveries	581,280	610,344	640,861
15. Total Hospital and Medical (Lines 13 - 14)	158,425,311	163,632,805	169,016,889
16. Non-Health Claims (net)			
17. Claims Adjustment Expenses	7,155,297	7,390,942	7,634,599
18. General Administrative Expenses	8,745,363	9,033,373	9,331,176
19. Increase In Reserves For Life & Accident And Health Contacts			
20. Total underwriting deductions (Lines 15+16+17+18+19)	**174,325,970**	**180,057,120**	**185,982,664**
21. Net underwriting gain or loss (Lines 8 - 20)	1,310,020	1,345,368	1,381,552
22. Net investment income earned	136,500	158,198	180,751
23. Net investment gains (losses) (Lines 22 + 26)	136,500	158,198	180,751
24. Aggregate write in for other income or expenses			
25. Federal and Foreign Income Taxes Incurred	-	-	-
26. Net Realized Capital Gains (Losses)			
27. Less Capital Gains Tax			
28. Net Income (Lines 21 + 23 + 24 - 25)	**1,446,520**	**1,503,566**	**1,562,304**
29. Capital and Surplus Prior Reporting Year		10,546,520	12,050,086
30. Net Income or (Loss)	1,446,520	1,503,566	1,562,304
31. Capital Changes	9,100,000		
32. Other Increases (Decreases)			
33. Dividends to Stockholders			
34. Capital and Surplus End of Reporting Year (Lines 29 + 30 + 31 + 32 - 33)	**10,546,520**	**12,050,086**	**13,612,389**
Ratio Analysis			
35 Medical Loss Ratio (as calculated for insurers) (Line 15 / Line 2)	90%	90%	90%
36 Claim Expense Ratio (Line 17 / Line 2)	4%	4%	4%
37 Administrative Expense Ratio (Line 18 / Line 2)	5%	5%	5%
38 Combined Medical Loss and Expense Ratio (Line 35 + Line 37)	95%	95%	95%
39 Ratio of Total Revenue to Capital and Surplus (Line 8 / Line 34)	1665%	1505%	1376%
44 Authorized Control Level Risk-Based Capital	5,933,079	5,965,278	6,053,642
45 Risk Based Capital Calculation	1.778	2.020	2.249

NorthWest CCO
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Whole Numbers)

BASED ON BE MM IDENTIFIED IN ASSUMPTIONS

	Pro Forma Ref	2020	2021	2022
Financial Statement Data				
Total Admitted Assets	Bal Sht Line 8	25,759,341	27,973,040	30,083,584
Real Estate/Mortgage Loans on Real Estate	Bal Sht Line 3	-	-	-
Stocks (Preferred & Common)	Bal Sht Line 2	-	-	-
Restricted Reserve	calculated	6,726,055	6,943,034	7,167,370
Liquid assets	calculated	25,759,341	27,973,040	30,083,584
Aggregate Health Policy Reserves	Bal Sht Line 11	10,788,833	11,144,141	11,511,530
Ceded Reinsurance Premiums Payable	Bal Sht Line 12	513,548	530,461	547,949
Total claims reserves	calculated	11,302,382	11,674,602	12,059,479
Total liabilities	Bal Sht Line 17	15,212,821	15,922,954	16,466,654
Total capital and surplus	Bal Sht Line 24	10,546,520	12,050,086	13,612,389
Capitol stock	Bal Sht Line 18	-	-	-
Surplus	calculated	10,546,520	12,050,086	13,612,389
Net Premium Income	P and L Line 2	175,635,990	181,402,488	187,364,217
Total Hospital and Medical (net)	P and L Line 15	158,425,311	163,632,805	169,016,889
Divided by months in year	given	12	12	12
Avg claims expense	calculated	13,202,109	13,636,067	14,084,741
Ratio/Financial Analysis				
Primary Restricted Reserve	calculated	250,000	250,000	250,000
Secondary Restricted Reserve	calculated	6,476,055	6,693,034	6,917,370
Total Restricted Reserve Requirement	calculated	6,726,055	6,943,034	7,167,370
Minimum Net Worth Required	calculated	8,781,799	9,070,124	9,368,211
Working capital	given	500,000	500,000	500,000
Total Initial Required Net Worth	calculated	9,281,799	9,570,124	9,868,211
Liabilities to Liquid Assets	calculated	59%	57%	55%
Capital & Surplus/Liabilities	calculated	69%	76%	83%
Avg Mo Unpd Clms to Res & Surpl	calculated	2	2	2
Avg Mo Unpd Clms to Res & Surpl (excl minimum C&S)	calculated	1	1	1
Stress Test Results				
Combined Medical Loss and Expense Ratio	P and L Line 38	95%	95%	95%
Net underwriting gain or loss	P and L Line 21	1,310,020	1,345,368	1,381,552
Test #1 Combined Ratio plus 2 pts	calculated	97%	97%	97%
Additional underwriting expense	calculated	3,512,720	3,628,050	3,747,284
Test #2 Combined Ratio plus 4 pts	calculated	99%	99%	99%
Additional underwriting expense	calculated	7,025,440	7,256,100	7,494,569
Test #3 Combined Ratio plus 6 pts	calculated	101%	101%	101%
Additional underwriting expense	calculated	10,538,159	10,884,149	11,241,853
C&S after test #1	calculated	7,033,800	8,422,036	9,865,105
C&S after test #2	calculated	3,521,080	4,793,986	6,117,821
C&S after test #3	calculated	8,361	1,165,936	2,370,536

NorthWest CCO
(Health Company)
Pro Forma Statutory Balance Sheet (Nationwide)
(In Whole Numbers)

BASED ON MIN MM IDENTIFIED IN ASSUMPTIONS

COPY VALUES OVER FROM FORM 13H (MIN MM)

		12/31/2020	12/31/2021	12/31/2022
	Admitted Assets			
1.	Bonds	5,323,500	5,948,773	5,977,309
2.	Stocks (Preferred & Common)	2,866,500	3,203,185	3,218,551
3.	Real Estate/Mortgage Loans on Real Estate			
4.	Cash/Cash Equivalents/Short-Term Investments	11,534,150	11,132,400	11,507,746
5.	Other Invested Assets			
6.	Aggregate Write-Ins For Invested Assets	827,560	854,801	882,968
7.	All Other Assets			
8.	Total Admitted Assets (Lines 1+2+3+4+5+6+7)	**20,551,710**	**21,139,159**	**21,586,574**
	Liabilities			
9.	Losses (Unpaid Claims for Accident and Health Policies)	7,974,060	8,236,544	8,507,952
10.	Unpaid Claims Adjustment Expenses	379,565	392,059	404,979
11.	Aggregate Health Policy Reserves	-	-	-
12.	Ceded Reinsurance Premiums Payable	64,875	68,119	68,119
13.	Amounts Due To Parents, Subsidiaries & Affiliates	-	-	-
14.	MLR Rebates	-	-	-
15.	Premiums Received In Advance	1,088,169	1,123,989	1,161,026
16.	All Other Liabilites	1,893,083	2,122,589	2,210,083
17.	Total Liabilities (Lines 9+10+11+12+13+14+15+16)	**11,399,752**	**11,943,299**	**12,352,158**
	Capital and Surplus			
18.	Capital Stock			
19.	Gross Paid In And Contributed Surplus	9,100,000	9,100,000	9,100,000
20.	Surplus Notes			
21.	Unassigned Funds (Surplus)	51,958	95,860	131,010
22.	Aggregate Write-ins for Other-Than-Special Surplus Funds			
23.	Less Treasury Stock (Common and Preferred)			
24.	Total Capital and Surplus (Lines 18+19+20+21+22-23)	9,151,958	9,195,860	9,231,010
25.	Liabilities and Surplus (Lines 17+24)	20,551,710	21,139,159	21,583,168

	Risk-Based Capital Analysis			
25.	Authorized Control Level Risk-Based Capital	4,486,043	4,548,397	4,610,141
26.	Calculated Risk-Based Capital (Line 24 / Line 25)	204.0%	202.2%	200.2%

NorthWest CCO
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Whole Numbers)

BASED ON MIN MM IDENTIFIED IN ASSUMPTIONS

COPY VALUES OVER FROM FORM 13H (MIN MM)

	2020	2021	2022
1. Member Months	225,000	225,000	225,000
2. Net Premium Income	129,801,787	134,061,204	138,464,818
3. Fee For Service			
4. Risk Revenue			
5. Change In Unearned Premium Reserves and Reserve for Rate Credits			
6. Aggregate Write-Ins For Other Health Care Related Revenue			
7. Aggregate Write-Ins For Other Non-Health Revenue			
8. Total (Lines 2+3+4+5+6+7)	**129,801,787**	**134,061,204**	**138,464,818**
Hospital and Medical:			
9. Hospital/Medical Benefits	82,612,390	85,331,761	88,143,591
10. Other Professional Services	24,651,130	25,462,577	26,301,614
11. Prescription Drugs	10,258,738	10,596,427	10,945,598
12. Aggregate Write-Ins For Other Hospital and Medical			
13. Subtotal (Lines 9+10+11+12)	**117,522,258**	**121,390,766**	**125,390,803**
Less:			
14. Net Reinsurance Recoveries	435,960	457,758	480,646
15. Total Hospital and Medical (Lines 13 - 14)	117,086,298	120,933,008	124,910,157
16. Non-Health Claims (net)			
17. Claims Adjustment Expenses	5,760,014	5,949,708	6,145,852
18. General Administrative Expenses	7,040,017	7,271,865	7,511,597
19. Increase In Reserves For Life & Accident And Health Contacts			
20. Total underwriting deductions (Lines 15+16+17+18+19)	**129,886,329**	**134,154,581**	**138,567,606**
21. Net underwriting gain or loss (Lines 8 - 20)	(84,542)	(93,378)	(102,788)
22. Net investment income earned	136,500	137,279	137,938
23. Net investment gains (losses) (Lines 22 + 26)	136,500	137,279	137,938
24. Aggregate write in for other income or expenses			
25. Federal and Foreign Income Taxes Incurred	-	-	-
26. Net Realized Capital Gains (Losses)			
27. Less Capital Gains Tax			
28. Net Income (Lines 21 + 23 + 24 - 25)	**51,958**	**43,902**	**35,150**
29. Capital and Surplus Prior Reporting Year	-	9,151,958	9,195,860
30. Net Income or (Loss)	51,958	43,902	35,150
31. Capital Changes	9,100,000		
32. Other Increases (Decreases)			
33. Dividends to Stockholders			
34. Capital and Surplus End of Reporting Year (Lines 29 + 30 + 31 + 32 - 33)	**9,151,958**	**9,195,860**	**9,231,010**
Ratio Analysis			
35 Medical Loss Ratio (as calculated for insurers) (Line 15 / Line 2)	90%	90%	90%
36 Claim Expense Ratio (Line 17 / Line 2)	4%	4%	4%
37 Administrative Expense Ratio (Line 18 / Line 2)	5%	5%	5%
38 Combined Medical Loss and Expense Ratio (Line 35 + Line 37)	96%	96%	96%
39 Ratio of Total Revenue to Capital and Surplus (Line 8 / Line 34)	1418%	1458%	1500%
44 Authorized Control Level Risk-Based Capital	4,486,043	4,548,397	4,610,141
45 Risk Based Capital Calculation	2.040	2.022	2.002

NorthWest CCO
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Whole Numbers)

BASED ON MIN MM IDENTIFIED IN ASSUMPTIONS

	Pro Forma Ref	2020	2021	2022
Financial Statement Data				
Total Admitted Assets	Bal Sht Line 8	20,551,710	21,139,159	21,586,574
Real Estate/Mortgage Loans on Real Estate	Bal Sht Line 3	-	-	-
Stocks (Preferred & Common)	Bal Sht Line 2	-	-	-
Restricted Reserve	calculated	5,003,596	5,163,875	5,329,590
Liquid assets	calculated	20,551,710	21,139,159	21,586,574
Aggregate Health Policy Reserves	Bal Sht Line 11	7,974,060	8,236,544	8,507,952
Ceded Reinsurance Premiums Payable	Bal Sht Line 12	379,565	392,059	404,979
Total claims reserves	calculated	8,353,625	8,628,603	8,912,931
Total liabilities	Bal Sht Line 17	11,399,752	11,943,299	12,352,158
Total capital and surplus	Bal Sht Line 24	9,151,958	9,195,860	9,231,010
Capitol stock	Bal Sht Line 18	-	-	-
Surplus	calculated	9,151,958	9,195,860	9,231,010
Net Premium Income	P and L Line 2	129,801,787	134,061,204	138,464,818
Total Hospital and Medical (net)	P and L Line 15	117,086,298	120,933,008	124,910,157
Divided by months in year	given	12	12	12
Avg claims expense	calculated	9,757,192	10,077,751	10,409,180
Ratio/Financial Analysis				
Primary Restricted Reserve	calculated	250,000	250,000	250,000
Secondary Restricted Reserve	calculated	4,753,596	4,913,875	5,079,590
Total Restricted Reserve Requirement	calculated	5,003,596	5,163,875	5,329,590
Minimum Net Worth Required	calculated	6,490,089	6,703,060	6,923,241
Working capital	given	500,000	500,000	500,000
Total Initial Required Net Worth	calculated	6,990,089	7,203,060	7,423,241
Liabilities to Liquid Assets	calculated	55%	56%	57%
Capital & Surplus/Liabilities	calculated	80%	77%	75%
Avg Mo Unpd Clms to Res & Surpl	calculated	2	2	2
Avg Mo Unpd Clms to Res & Surpl (excl minimum C&S)	calculated	1	1	1
Stress Test Results				
Combined Medical Loss and Expense Ratio	P and L Line 38	96%	96%	96%
Net underwriting gain or loss	P and L Line 21	(84,542)	(93,378)	(102,788)
Test #1 Combined Ratio plus 2 pts	calculated	98%	98%	98%
Additional underwriting expense	calculated	2,596,036	2,681,224	2,769,296
Test #2 Combined Ratio plus 4 pts	calculated	100%	100%	100%
Additional underwriting expense	calculated	5,192,071	5,362,448	5,538,593
Test #3 Combined Ratio plus 6 pts	calculated	102%	102%	102%
Additional underwriting expense	calculated	7,788,107	8,043,672	8,307,889
C&S after test #1	calculated	6,555,922	6,514,636	6,461,714
C&S after test #2	calculated	3,959,887	3,833,412	3,692,417
C&S after test #3	calculated	1,363,851	1,152,188	923,121

NorthWest CCO
(Health Company)
Pro Forma Statutory Balance Sheet (Nationwide)
(In Whole Numbers)

BASED ON MAX MM IDENTIFIED IN ASSUMPTIONS

COPY VALUES OVER FROM FORM 13H (MAX MM)

		12/31/2020	12/31/2021	12/31/2022
	Admitted Assets			
1.	Bonds	6,639,750	8,912,438	10,510,750
2.	Stocks (Preferred & Common)	3,575,250	4,799,005	5,659,635
3.	Real Estate/Mortgage Loans on Real Estate	-	-	-
4.	Cash/Cash Equivalents/Short-Term Investments	-	-	-
5.	Other Invested Assets	-	-	-
6.	Aggregate Write-Ins For Invested Assets	20,771,854	20,553,048	21,277,884
7.	All Other Assets	1,379,267	1,424,669	1,471,614
8.	Total Admitted Assets (Lines 1+2+3+4+5+6+7)	**32,366,121**	**35,689,160**	**38,919,884**
	Liabilities			
9.	Losses (Unpaid Claims for Accident and Health Policies)	13,290,099	13,727,573	14,179,920
10.	Unpaid Claims Adjustment Expenses	632,609	653,432	674,964
11.	Aggregate Health Policy Reserves	-	-	-
12.	Ceded Reinsurance Premiums Payable	108,125	113,531	113,531
13.	Amounts Due To Parents, Subsidiaries & Affiliates	-	-	-
14.	MLR Rebates	-	-	-
15.	Premiums Received In Advance	1,813,615	1,873,314	1,935,043
16.	All Other Liabilites	2,810,229	3,150,924	3,280,807
17.	Total Liabilities (Lines 9+10+11+12+13+14+15+16)	**18,654,677**	**19,518,775**	**20,184,265**
	Capital and Surplus			
18.	Capital Stock			
19.	Gross Paid In And Contributed Surplus	11,350,000	11,350,000	11,350,000
20.	Surplus Notes	-	-	-
21.	Unassigned Funds (Surplus)	2,361,444	4,820,385	7,379,942
22.	Aggregate Write-ins for Other-Than-Special Surplus Funds	-	-	-
23.	Less Treasury Stock (Common and Preferred)			
24.	Total Capital and Surplus (Lines 18+19+20+21+22-23)	13,711,444	16,170,385	18,729,942
25.	Liabilities and Surplus (Lines 17+24)	32,366,121	35,689,160	38,914,207

	Risk-Based Capital Analysis			
25.	Authorized Control Level Risk-Based Capital	7,264,483	7,325,749	7,410,877
26.	Calculated Risk-Based Capital (Line 24 / Line 25)	188.7%	220.7%	252.7%

NorthWest CCO
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Whole Numbers)

BASED ON MAX MM IDENTIFIED IN ASSUMPTIONS

COPY VALUES OVER FROM FORM 13H (MAX MM)

	2020	2021	2022
1. Member Months	375,000	375,000	375,000
2. Net Premium Income	216,336,312	223,435,340	230,774,696
3. Fee For Service	-	-	-
4. Risk Revenue	-	-	-
5. Change In Unearned Premium Reserves and Reserve for Rate Credits	-	-	-
6. Aggregate Write-Ins For Other Health Care Related Revenue	-	-	-
7. Aggregate Write-Ins For Other Non-Health Revenue	-	-	-
8. Total (Lines 2+3+4+5+6+7)	**216,336,312**	**223,435,340**	**230,774,696**
Hospital and Medical:			
9. Hospital/Medical Benefits	137,687,317	142,219,602	146,905,985
10. Other Professional Services	41,085,217	42,437,629	43,836,023
11. Prescription Drugs	17,097,897	17,660,712	18,242,663
12. Aggregate Write-Ins For Other Hospital and Medical	-		
13. Subtotal (Lines 9+10+11+12)	**195,870,431**	**202,317,943**	**208,984,671**
Less:			
14. Net Reinsurance Recoveries	726,600	762,930	801,077
15. Total Hospital and Medical (Lines 13 - 14)	195,143,831	201,555,013	208,183,594
16. Non-Health Claims (net)			
17. Claims Adjustment Expenses	8,550,579	8,832,175	9,123,346
18. General Administrative Expenses	10,450,708	10,794,881	11,150,756
19. Increase In Reserves For Life & Accident And Health Contacts			
20. Total underwriting deductions (Lines 15+16+17+18+19)	**214,145,118**	**221,182,069**	**228,457,696**
21. Net underwriting gain or loss (Lines 8 - 20)	2,191,194	2,253,270	2,317,001
22. Net investment income earned	170,250	205,672	242,556
23. Net investment gains (losses) (Lines 22 + 26)	170,250	205,672	242,556
24. Aggregate write in for other income or expenses			
25. Federal and Foreign Income Taxes Incurred	-	-	-
26. Net Realized Capital Gains (Losses)			
27. Less Capital Gains Tax			
28. Net Income (Lines 21 + 23 + 24 - 25)	**2,361,444**	**2,458,942**	**2,559,556**
29. Capital and Surplus Prior Reporting Year	-	13,711,444	16,170,385
30. Net Income or (Loss)	2,361,444	2,458,942	2,559,556
31. Capital Changes	11,350,000		
32. Other Increases (Decreases)			
33. Dividends to Stockholders			
34. Capital and Surplus End of Reporting Year (Lines 29 + 30 + 31 + 32 - 33)	**13,711,444**	**16,170,385**	**18,729,942**
Ratio Analysis			
35 Medical Loss Ratio (as calculated for insurers) (Line 15 / Line 2)	90%	90%	90%
36 Claim Expense Ratio (Line 17 / Line 2)	4%	4%	4%
37 Administrative Expense Ratio (Line 18 / Line 2)	5%	5%	5%
38 Combined Medical Loss and Expense Ratio (Line 35 + Line 37)	95%	95%	95%
39 Ratio of Total Revenue to Capital and Surplus (Line 8 / Line 34)	1578%	1382%	1232%
44 Authorized Control Level Risk-Based Capital	7,264,483	7,325,749	7,410,877
45 Risk Based Capital Calculation	1.887	2.207	2.527

NorthWest CCO
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Whole Numbers)

BASED ON MAX MM IDENTIFIED IN ASSUMPTIONS

	Pro Forma Ref	2020	2021	2022
Financial Statement Data				
Total Admitted Assets	Bal Sht Line 8	32,366,121	35,689,160	38,919,884
Real Estate/Mortgage Loans on Real Estate	Bal Sht Line 3	-	-	-
Stocks (Preferred & Common)	Bal Sht Line 2	-	-	-
Restricted Reserve	calculated	8,255,993	8,523,126	8,799,316
Liquid assets	calculated	32,366,121	35,689,160	38,919,884
Aggregate Health Policy Reserves	Bal Sht Line 11	13,290,099	13,727,573	14,179,920
Ceded Reinsurance Premiums Payable	Bal Sht Line 12	632,609	653,432	674,964
Total claims reserves	calculated	13,922,708	14,381,005	14,854,884
Total liabilities	Bal Sht Line 17	18,654,677	19,518,775	20,184,265
Total capital and surplus	Bal Sht Line 24	13,711,444	16,170,385	18,729,942
Capitol stock	Bal Sht Line 18	-	-	-
Surplus	calculated	13,711,444	16,170,385	18,729,942
Net Premium Income	P and L Line 2	216,336,312	223,435,340	230,774,696
Total Hospital and Medical (net)	P and L Line 15	195,143,831	201,555,013	208,183,594
Divided by months in year	given	12	12	12
Avg claims expense	calculated	16,261,986	16,796,251	17,348,633
Ratio/Financial Analysis				
Primary Restricted Reserve	calculated	250,000	250,000	250,000
Secondary Restricted Reserve	calculated	8,005,993	8,273,126	8,549,316
Total Restricted Reserve Requirement	calculated	8,255,993	8,523,126	8,799,316
Minimum Net Worth Required	calculated	10,816,816	11,171,767	11,538,735
Working capital	given	500,000	500,000	500,000
Total Initial Required Net Worth	calculated	11,316,816	11,671,767	12,038,735
Liabilities to Liquid Assets	calculated	58%	55%	52%
Capital & Surplus/Liabilities	calculated	74%	83%	93%
Avg Mo Unpd Clms to Res & Surpl	calculated	2	2	2
Avg Mo Unpd Clms to Res & Surpl (excl minimum C&S)	calculated	1	1	1
Stress Test Results				
Combined Medical Loss and Expense Ratio	P and L Line 38	95%	95%	95%
Net underwriting gain or loss	P and L Line 21	2,191,194	2,253,270	2,317,001
Test #1 Combined Ratio plus 2 pts	calculated	97%	97%	97%
Additional underwriting expense	calculated	4,326,726	4,468,707	4,615,494
Test #2 Combined Ratio plus 4 pts	calculated	99%	99%	99%
Additional underwriting expense	calculated	8,653,452	8,937,414	9,230,988
Test #3 Combined Ratio plus 6 pts	calculated	101%	101%	101%
Additional underwriting expense	calculated	12,980,179	13,406,120	13,846,482
C&S after test #1	calculated	9,384,717	11,701,679	14,114,448
C&S after test #2	calculated	5,057,991	7,232,972	9,498,954
C&S after test #3	calculated	731,265	2,764,265	4,883,460

Please provide any text, tables, numbers, etc. that you would like to communicate but were not able to include within the

The purpose of this proforma is to demonstrate how the NorthWest CCO (NWCCO) could potentially be formed as well a
assumption is that a partnership will be formed with provider partners similar to the Eastern Oregon CCO (EOCCO).

The six partners intend to contribute capital to cover the estimated minimum net worth requirement which, based on the
RBC by year 2.

For discussion purposes only we have assumed six partners (as documented below) would be responsible to contribute t
Requirement, which based on the NWCCO's projected Authorized Control Level (ACL), would allow NWCCO to exceed t
Net Worth Requirements have been stricted from the draft contract and replaced with RBC language. We have included
It is the expectation that ODS Community Health (Moda) will take a 51% interest.

Partner	Interest %
ODS Community Health (Moda)	51%
Columbia Memorial Hospital	%
Adventist - Tillamook	%
Greater Oregon Behavioral Health, Inc.	%
Yakima Valley Farm Workers	%
Reinhart Clinic	%
	100%

Region/Counties:
The geographic region that NorthWest CCO would operate in is Clatsop County, Columbia County and Tillamook County

Enrollment Levels:
The total membership for this area is estimated to be approximately 25,000. The current best estimate is that NWCCO v
will allow it to deliver high-quality care while staying within the 3.4% annual medical trend target. It is expected that the N
the total estimated enrollment and be able to stay within the 3.4% annual medical trend target while effectively managing
adequacy levels.

Revenue:
The Company estimated revenues using the provided PMPM revenue amount from Attachment 12 - CCO 2.0 Procureme
excluding tax for its rating area. The gross rate was chosen because the Company intends to achieve 100% of the bonus
difficult to achieve, it also believes that its structure and strong provider-partnerships and success record with administeri

Included in the revenue amount is the projected maternity payments based on the projected rate from Attachment 12 - C
rate ($13,913.24) excluding tax for its rating area and multiplied that with the projected births for the region based on the

Total revenue for years 2021 and 2022 were increased by a growth rate of 3.4% to account for the overall global budget t

Underwriting Expenses:
The Company estimated medical expenses at 90% of total revenues, based on the rate setting methodology and the proj
90% of total revenues.

Administrative Expenses:
The adminstrative expenses have been estimated using the rating methodology for the non-medical load administration a
underwriting results.

Other:
Reinsurance: Reinsurance premiums are based on the current market per member per month rate and increases 5% ea
Reinsurance recoveries are based on a conservative 56% of premium.

Investment Income: Investment income is assumed at 1.5% of invested balances

preceding reports.

as to provide a forecast of the expected results over the next three-year period. The underlying

Company's projected Authorized Control Level, would also allow the Company to exceed 200%

the intitial funding of the NWCCO. The funding would cover the Minimum Net Worth
the 200% Risk Based Capital (RBC) level from inception. It should be noted that the Minimum
the estimated Minimum Net Worth Requirement on the Proforma for comparative purposes.

$ Contributions
$ Contributions
$
$
$
$
$
$ 9,100,000 reflects best estimate scenario

'.

will capture 100% of this market. It is believed that the proposed strong provider partnerships
NWCCO would be able to sucessfully manage membership levels between 75% and 125% of
fixed and variable administrative costs and maintaining the appropriate service and network

ent Rate Methodology Appendix. The company assumed the average gross rate ($570.43)
s pool. While the Company acknowledges that the performance metrics are progressively more
ng the EOCCO through its affiliates demonstrates that this is achievable.

CO 2.0 Procurement Rate Methodology Appendix. The Company assumed the average gross
projected enrollment targets.

target.

jected non-medical load amounts. Total Pay-for-Performance amounts were also projected at

and case management services. The 1% profit contingency has been factored into the

ach year.

UCAA Proforma Financial Statements

Health

UNIFORM CERTIFICATE OF AUTHORITY APPLICATION

Instructions

1. Enter the Applicant Company Name below
2. Enter the first full year of the proformas (start with 1st full year of operation).
3. Select the states to be completed for proformas by clicking the check boxes on the right and then click on the "Create Selected State Worksheets" button below.
4. Complete all sections of the proforma statements contained on each tab below.
5. Note that several tabs contain worksheets for 3 years of data. Be sure to complete all years of data.
6. Do not "Cut" and "Paste" cells in the worksheets. Use "Copy" and "Paste" instead.

Enter the Applicant Company Name:

NorthWest CCO

Year 1: 2020

Year 2: 2021

Year 3: 2022

☐	AK	Alaska	☐	MT	Montana	
☐	AL	Alabama	☐	NC	North Carolina	
☐	AR	Arkansas	☐	ND	North Dakota	
☐	AS	American Samoa	☐	NE	Nebraska	
☐	AZ	Arizona	☐	NH	New Hampshire	
☐	CA	California	☐	NJ	New Jersey	
☐	CO	Colorado	☐	NM	New Mexico	
☐	CT	Connecticut	☐	NV	Nevada	
☐	DC	District Of Columbia	☐	NY	New York	
☐	DE	Delaware	☐	OH	Ohio	
☐	FL	Florida	☐	OK	Oklahoma	
☐	GA	Georgia	☑	OR	Oregon	Go to OR
☐	GU	Guam	☐	PA	Pennsylvania	
☐	HI	Hawaii	☐	PR	Puerto Rico	
☐	IA	Iowa	☐	RI	Rhode Island	
☐	ID	Idaho	☐	SC	South Carolina	
☐	IL	Illinois	☐	SD	South Dakota	
☐	IN	Indiana	☐	TN	Tennessee	
☐	KS	Kansas	☐	TX	Texas	
☐	KY	Kentucky	☐	UT	Utah	
☐	LA	Louisiana	☐	VA	Virginia	
☐	MA	Massachusetts	☐	VI	U.S. Virgin Islands	
☐	MD	Maryland	☐	VT	Vermont	
☐	ME	Maine	☐	WA	Washington	
☐	MI	Michigan	☐	WI	Wisconsin	
☐	MN	Minnesota	☐	WV	West Virginia	
☐	MO	Missouri	☐	WY	Wyoming	
☐	MS	Mississippi				

If states were added to this spreadsheet in error:

1. Select the states to be deleted by clicking the check boxes on the right.
2. Click on the "Delete Selected State Worksheets" button above.

Updated: 10/07/2016

NorthWest CCO
(Health Company)
Pro Forma Statutory Balance Sheet (Nationwide)
(In Thousands)

	2020	2021	2022
Admitted Assets			
1. Bonds	5,324	5,949	5,977
2. Stock	2,867	3,203	3,219
3. Real Estate/Mortgage Investments			
4. Affiliated Investments			
5. Affiliated Receivables			
6. Cash/Cash Equivalents	11,534	11,132	11,508
7. Aggregate write in for assets	828	855	883
8. Total Assets(1+2+3+4+5+6+7)	**20,552**	**21,139**	**21,587**
Liabilities			
9. Losses (Unpaid Claims for Accident and Health Policies)	7,974	8,237	8,508
10. Unpaid claims adjustment expenses	380	392	405
11. Reserve for Accident and Health Policies			
12. Ceded Reinsurance Payable	65	68	68
13. Payable to Parents, Subsidiaries & Affiliates			
14. MLR rebates			
15. Premiums received in advanced	1,088	1,124	1,161
16. All other Liabilites	1,893	2,123	2,210
17. Total Liabilities (9+10+11+12+13+14+15+16)	**11,400**	**11,943**	**12,352**
Capital and Surplus			
18. Capital Stock			
19. Gross Paid In and Contributed Surplus	9,100	9,100	9,100
20. Surplus Notes			
21. Unassigned Surplus	52	96	131
22. Other Items(elaborate)			
23. Total Capital and Surplus(18+19+20+21+22)	9,152	9,196	9,231

	Risk-Based Capital Analysis		
24. Authorized Control Level Risk-Based Capital	$ 4,486	$ 4,548	$ 4,610
25. Calculated Risk-Based Capital (23/24)	204.0%	202.2%	200.2%

NorthWest CCO
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Thousands)

	2020	2021	2022
1. Member months	225,000	225,000	225,000
2. Net Premium Income	129,802	134,061	138,465
3. Fee for Service			
4. Risk Revenue			
5. Change in unearned premium reserves			
6. Aggregate write in for other health related revenue			
7. Aggregate write in for other non-health related revenue			
8. Total (L2+L3+L4+L5+L6+L7)	**129,802**	**134,061**	**138,465**
Hospital and Medical:			
9. Hospital/Medical Benenfits	82,612	85,332	88,144
10. Other professional Services	24,651	25,463	26,302
11. Prescription Drugs	10,259	10,596	10,946
12. Aggregate write ins for other hospital/medical	-		
13. Subtotal (L9+L10+L11+L12)	**117,522**	**121,391**	**125,391**
Less:			
14. Reinsurance recoveries	436	458	481
15. Total hospital and Medical (L13 -L14)	117,086	120,933	124,910
16. Non health claims			
17. Claims adjustment expenses	5,760	5,950	6,146
18. General admin expenses	7,040	7,272	7,512
19. Increase in reserves for accident and health contacts			
20. Total underwriting deductions (L15+L16+L17+L18+L19)	**129,886**	**134,155**	**138,568**
21. Net underwriting gain or loss (L8 -L20)	(85)	(93)	(103)
22. Net investment income earned	137	137	138
23. Aggregate write in for other income or expenses			
24. Federal Income Taxes	-	-	-
25. Net Realized Capital Gains (Losses)			
26. Less Capital Gains Tax			
27. Net Income (L21+L22+L23-L24+L25)	**52**	**44**	**35**
28. Prior YE Surplus	0	9,152	9,196
29. Net Income	52	44	35
30. Capital Increases	9100		
31. Other Increases (Decreases)			
32. Dividends to Stockholders			
33. YE Surplus (L28+L29+L30+L31-L32)	**9,152**	**9,196**	**9,231**

***Itemize in Assumptions**

NorthWest CCO
(Health Company)
Pro Forma Statutory Cash Flow Statement
(In Thousands)

	2020	2021	2022
Cash From Operations			
1. Premiums Collected Net of Reinsurance	130,062	134,070	138,474
2. Benefits Paid	108,733	120,658	124,626
3. Underwriting Expenses Paid	10,842	12,989	13,567
4. Total Cash From Underwriting (L1-L2-L3)	**10,488**	**423**	**281**
5. Net Investment Income	137	137	138
6. Other Income			
7. Dividends to Policyholders			
8. Federal and Foreign Income Taxes (Paid) Recovered	-	-	-
9. Net Cash From Operations (L4+L5+L6-L7+L8)	**10,624**	**560**	**419**
Cash From Investments			
10. Net Cash from Investments	(8,190)	(962)	(44)
Cash From Financing and Misc Sources			
11. Capital and paid in Surplus	9,100		
12. Surplus Notes			
13. Borrowed Funds			
14. Dividends			
15. Other Cash Provided (Applied)			
16. Net Cash from Financing and Misc Sources (L11+L12+L13-L14+L15)	**9,100**	**-**	**-**
17. Net Change in Cash, Cash Equivalents and Short -Term Investments (L9+L10+L16)	11,534	(402)	375

Nationwide
Year 1

NorthWest CCO
(Health Company)
Analysis of Operations by Line of Business
(In Thousands)

	Total	Comprehensive	Medicare Supplement	Dental	Vision	Federal Employees plan	Medicare	Medicaid	Other health	Other non-health	Aggregate of All Other Lines Business
1. Net Premiums (All Business)	129,802							129,802			
2. Change in unearned premium reserve	-										
3. Fee for service	-										XXX
4. Risk revenue	-										XXX
5. Aggregate write ins for other health related revenues	-										XXX
6. Aggregate write ins for other non-health related revenues	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX
7. Total Revenue (1+2+3+4+5+6)	**129,802**	**-**	**-**	**-**	**-**	**-**	**-**	**129,802**	**-**	**-**	**-**
8. Hospital/medical benefits	82,612							82,612			
9. Other professional services	24,651							24,651			
10. Prescription Drugs	10,259							10,259			
11. Aggregatae writes for other hospital/ medical/health	-										XXX
12. Subtotal (8+9+10+11)	**117,522**	**-**	**-**	**-**	**-**	**-**	**-**	**117,522**	**-**	**-**	**-**
	-										
13. Net reinsurance recoveries								435.96			
14. Total hospital and medical (12-13)	**117,086**	**-**	**-**	**-**	**-**	**-**	**-**	**117,086**	**-**	**-**	**-**
15. Non health claims	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
16. Claims adjustment expenses	5,760							5760.014			
17. General admin expenses	7,040							7040.017			
18. Increase in reserves for accident and health contracts	-										
19. Aggregate write in for Other Expenses	-										
20. Total underwriting deductions (14 to19)	**129,886**	**-**	**-**	**-**	**-**	**-**	**-**	**129,886**	**-**	**-**	**-**
21. Net underwriting Gain (Loss) (7-20)	**(85)**	**-**	**-**	**-**	**-**	**-**	**-**	**(85)**	**-**	**-**	**-**

Nationwide
Year 2

NorthWest CCO
(Health Company)
Analysis of Operations by Line of Business
(In Thousands)

	Total	Comprehensive	Medicare Supplement	Dental	Vision	Federal Employees plan	Medicare	Medicaid	Other health	Other non-health	Aggregate of All Other Lines
1. Net Premiums (All Business)	134,061							134,061			
2. Change in unearned premium reserve	-										
3. Fee for service	-										XXX
4. Risk revenue	-										XXX
5. Aggregate write ins for other health related revenues	-										XXX
6. Aggregate write ins for other non-health related revenues	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX
7. Total Revenue (1+2+3+4+5+6)	**134,061**	**-**	**-**	**-**	**-**	**-**	**-**	**134,061**	**-**	**-**	**-**
	-										
8. Hospital/medical benefits	85,332							85,332			
9. Other professional services	25,463							25,463			
10. Prescription Drugs	10,596							10,596			
11. Aggregate write ins for other hospital/ medical/health	-										XXX
12. Subtotal (8+9+10+11)	**121,391**	**-**	**-**	**-**	**-**	**-**	**-**	**121,391**	**-**	**-**	**-**
	-										
13. Net reinsurance recoveries								457.758			
14. Total hospital and medical (12-13)	120,933	-	-	-	-	-	-	120,933	-	-	-
15. Non health claims	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
16. Claims adjustment expenses	5,950							5949.708			
17. General admin expenses	7,272							7271.865			
18. Increase in reserves for accident and health contracts	-										
19. Aggregate write in for Other Expenses	-										
20. Total underwriting deductions (14 to19)	**134,155**	**-**	**-**	**-**	**-**	**-**	**-**	**134,155**	**-**	**-**	**-**
21. Net underwriting Gain (Loss) (7-20)	**(93)**	**-**	**-**	**-**	**-**	**-**	**-**	**(93)**	**-**	**-**	**-**

Nationwide
Year 3

NorthWest CCO
(Health Company)
Analysis of Operations by Line of Business
(In Thousands)

	Total	Comprehensive	Medicare Supplement	Dental	Vision	Federal Employees plan	Medicare	Medicaid	Other health	Other non-health	Aggregate of All Other Lines
1. Net Premiums (All Business)	138,465							138464.8			
2. Change in unearned premium reserve	-										
3. Fee for service	-										XXX
4. Risk revenue	-										XXX
5. Aggregate write ins for other health related revenues	-										XXX
6. Aggregate write ins for other non-health related revenues	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX
7. Total Revenue (L1+L2+L3+L4+L5+L6)	**138,465**	**-**	**-**	**-**	**-**	**-**	**-**	**138,465**	**-**	**-**	**-**
	-										
8. Hospital/medical benefits	88,144							88,144			XXX
9. Other professional services	26,302							26,302			XXX
10. Prescription Drugs	10,946							10,946			XXX
11. Aggregatae writes for other hospital/ medical/health	-										XXX
12. Subtotal (L8+L9+L10+L11)	**125,391**	**-**	**-**	**-**	**-**	**-**	**-**	**125,391**	**-**	**-**	
13. Net reinsurance recoveries	481							480.6459			
14. Total hospital and medical (L12-L13)	124,910	-	-	-	-	-	-	124,910	-	-	-
15. Non health claims	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX
16. Claims adjustment expenses	6,146							6145.852			
17. General admin expenses	7,512							7511.597			
18. Increase in reserves for accident and health contracts	-										XXX
19. Aggregate write in for Other Expenses	-										
20. Total underwriting deductions (L14 : L19)	**138,568**	**-**	**-**	**-**	**-**	**-**	**-**	**138,568**	**-**	**-**	**-**
21. Net underwriting Gain (Loss) (L7-L20)	**(103)**	**-**	**-**	**-**	**-**	**-**	**-**	**(103)**	**-**	**-**	**-**

Nationwide
Year 1

NorthWest CCO
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	130,580,287		778,500	129,801,787
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	130,580,287	-	778,500	129,801,787

Nationwide
Year 2

NorthWest CCO
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	134,878,629		817,425	134,061,204
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	134,878,629	-	817,425	134,061,204

Nationwide
Year 3

NorthWest CCO
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	139,323,114		858,296	138,464,818
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	139,323,114	-	858,296	138,464,818

Nationwide
Year 1

NorthWest CCO
(Health Company)
Preliminary MLR
(In Thousands)

	Individual Comprehensive	Small group comprehensive	Large Group comprehensive	Individual mini-med	Small group mini-med	Large Group mini-med	Total
1. Premiums earned							-
2. Federal taxes/Federal asessments							-
3. State insurance, premium, and other taxes							-
4. Regulatory authority license and fees							-
5. Adjusted premium earned (L1-L2-L3-L4)	**-**	**-**	**-**	**-**	**-**	**-**	**-**
6. Incurred claims excluding prescription drugs							-
7. Prescription drugs							-
8. Pharmaceutical rebates							-
9. State stop loss, market stabilization and claim/census based assessments							-
10. Incurred medical incentive pools and bonuses							-
11. Total incurred claims (L6+L7-L8-L9+L10)	**-**	**-**	**-**	**-**	**-**	**-**	**-**
12. Deductible abuse detection/recovery expenses							**-**
13. Improved health outcomes							-
14. Activities to prevent hospital readmissions							-
15. Improve patient safety and reduce medical errors							-
16. Wellness and health promotion activities							-
17. QI Health information technology expenses							-
18. Total expenses incurred for improving health quality (L13+L14+L15+L16+L17)	**-**	**-**	**-**	**-**	**-**	**-**	**-**
19 Prelimary MLR (L11+L12+L18/L5)	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**

Nationwide
Year 2

NorthWest CCO
(Health Company)
Preliminary MLR
(In Thousands)

	Individual Comprehensive	Small group comprehensive	Large Group comprehensive	Individual mini-med	Small group mini-med	Large Group mini-med	Total
1. Premiums earned							-
2. Federal taxes/Federal asessments							-
3. State insurance, premium, and other taxes							-
4. Regulatory authority license and fees							
5. Adjusted premium earned (L1-L2-L3-L4)	-	-	-	-	-	-	-
6. Incurred claims excluding prescription drugs							-
7. Prescription drugs							-
8. Pharmaceutical rebates							-
9. State stop loss, market stabilization and claim/census based assessments							-
10. Incurred medical incentive pools and bonuses							-
11. Total incurred claims (L6+L7-L8L-9+L10)	-	-	-	-	-	-	-
12. Deductible abuse detection/recovery expenses							-
13. Improved health outcomes							-
14. Activities to prevent hospital readmissions							-
15. Improve patient safety and reduce medical errors							-
16. Wellness and health promotion activities							-
17. QI Health information technology expenses							-
18. Total expenses incurred for improving health quality (L13+L14+L15+L16+L17)	-	-	-	-	-	-	-
19 Prelimary MLR (L11+L12+L18/L5)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Nationwide
Year 3

NorthWest CCO
(Health Company)
Preliminary MLR
(In Thousands)

	Individual Comprehensive	Small group comprehensive	Large Group comprehensive	Individual mini-med	Small group mini-med	Large Group mini-med	Total
1. Premiums earned							-
2. Federal taxes/Federal asessments							-
3. State insurance, premium, and other taxes							-
4. Regulatory authority license and fees							-
5. Adjusted premium earned (1-2-3-4)	**-**	**-**	**-**	**-**	**-**	**-**	**-**
6. Incurred claims excluding prescription drugs							-
7. Prescription drugs							-
8. Pharmaceutical rebates							-
9. State stop loss, market stabilization and claim/census based assessments							-
10. Incurred medical incentive pools and bonuses							-
11. Total incurred claims (6+7-8-9+10)	-	-	-	-	-	-	-
12. Deductible abuse detection/recovery expenses							**-**
13. Improved health outcomes							-
14. Activities to prevent hospital readmissions							-
15. Improve patient safety and reduce medical errors							-
16. Wellness and health promotion activities							-
17. QI Health information technology expenses							-
18. Total expenses incurred for improving health quality (L13+L14+L15+L16+L17)	**-**	**-**	**-**	**-**	**-**	**-**	**-**
19 Prelimary MLR (L11+L12+L18/L5)	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**

UCAA Proforma Financial Statements
Assumptions

List all of the relevant assumptions used to create the proformas.
Note, assumptions enclosed within the Plan of Operation need not be disclosed again here.

The purpose of this proforma is to demonstrate the how the NorthWest CCO (NWCCO) could potentially be formed as well as to provide a forecast of the expected results over the next three-year period. The underlying assumption is that a partnership will be formed with provider partners similar to the Eastern Oregon CCO (EOCCO).

The six partners intend to contribute capital to cover the estimated minimum net worth requirement which, based on the Company's projected Authorized Control Level, would also allow the Company to exceed 200% RBC by year 2.

For discussion purposes only we have assumed six partners (as documented below) would be responsible to contribute the intitial funding of the NWCCO. The funding would cover the Minimum Net Worth Requirement, which based on the NWCCO's projected Authorized Control Level (ACL), would allow NWCCO to exceed the 200% Risk Based Capital (RBC) level from inception. It should be noted that the Minimum Net Worth Requirements have been stricted from the draft contract and replaced with RBC language. We have included the estimated Minimum Net Worth Requirement on the Proforma for comparative purposes. It is the expectation that ODS Community Health (Moda) will take a 51% interest.

Partner	Interest %	$ Contributions	
ODS Community Health (Moda)	51%	$ 4,641,000	
Columbia Memorial Hospital	%	$	
Adventist - Tillamook	%	$	
Greater Oregon Behavioral Health, Inc.	%	$	
Yakima Valley Farm Workers	%	$	
Reinhart Clinic	%	$	
	100%	$ 9,100,000	reflects MIN scenario

Region/Counties:
The geographic region that NorthWest CCO would operate in is Clatsop County, Columbia County and Tillamook County.

Enrollment Levels:
The total membership for this area is estimated to be approximately 25,000. The current best estimate is that NWCCO will capture 100% of this market. It is believed that the proposed strong provider partnerships will allow it to deliver high-quality care while staying within the 3.4% annual medical trend target. It is expected that the NWCCO would be able to sucessfully manage membership levels between 75% and 125% of the total estimated enrollment and be able to stay within the 3.4% annual medical trend target while effectively managing fixed and variable administrative costs and maintaining the appropriate service and network adequacy levels.

Revenue:
The Company estimated revenues using the provided PMPM revenue amount from Attachment 12 - CCO 2.0 Procurement Rate Methodology Appendix. The company assumed the average gross rate ($570.43) excluding tax for its rating area. The gross rate was chosen because the Company intends to achieve 100% of the bonus pool. While the Company acknowledges that the performance metrics are progressively more difficult to achieve, it also believes that its structure and strong provider-partnerships and success record with administering the EOCCO through its affiliates demonstrates that this is achievable.

Included in the revenue amount is the projected maternity payments based on the projected rate from Attachment 12 - CCO 2.0 Procurement Rate Methodology Appendix. The Company assumed the average gross rate ($13,913.24) excluding tax for its rating area and multiplied that with the projected births for the region based on the projected enrollment targets.

Underwriting Expenses:
The Company estimated medical expenses at 90% of total revenues, based on the rate setting methodology and the projected non-medical load amounts. Total Pay-for-Performance amounts were also projected at 90% of total revenues.

Administrative Expenses:
The adminstrative expenses have been estimated using the rating methodology for the non-medical load administration and case management services. The 1% profit contingency has been factored into the underwriting results.

Other:
Reinsurance: Reinsurance premiums are based on the current market per member per month rate and increases 5% each year.
Reinsurance recoveries are based on a conservative 56% of premium.

Investment Income: Investment income is assumed at 1.5% of invested balances

Oregon
Year 1

NorthWest CCO
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	130,580,287		778,500	129,801,787
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	**130,580,287**	**-**	**778,500**	**129,801,787**

Oregon
Year 2

NorthWest CCO
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	134,878,629		817,425	134,061,204
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	**134,878,629**	**-**	**817,425**	**134,061,204**

Oregon
Year 3

NorthWest CCO
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	139,323,114		858,296	138,464,818
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	**139,323,114**	**-**	**858,296**	**138,464,818**

moda HEALTH

Attachment 13 — Attestations

Applicant Name: Northwest Coordinated Care Organization

Authorizing Signature: _____

Printed Name: Robin Richardson

Instructions: For each attestation, Applicant will check "yes," or "no." A "yes" answer is normal, and an explanation will be furnished if Applicant's response is "no". Applicant must respond to all attestations. If an attestation has more than one question and Applicant's answer is "no" to any question, check "no" and provide an explanation.

These attestations must be signed by a representative of Applicant.

Unless a particular item is expressly effective at the time of Application, each attestation is effective starting at the time of Readiness Review and continuing throughout the term of the Contract. Each section of attestations refers to a questionnaire in an Attachment, which may furnish background and related questions.

A. General Questions Attestations (Attachment 6)

1. Contract

a. Is Applicant willing to enter into a Contract for 2020 in the form of Appendix B?

☒ Yes ☐ No

If "no" please provide explanation: _____

b. Is Applicant willing to satisfy Readiness Review standards by September 30, 2019?

☒ Yes ☐ No

If "no" please provide explanation: _____

2. Subcontracts

a. Is Applicant willing to hold written agreements with Subcontractors that clearly describe the scope of work?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to provide to OHA an inventory of all work described in this Contract that is delegated or subcontracted and identify the entity performing the work?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to provide to OHA unredacted copies of written agreements with Subcontractors?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

3. Third Party Liability and Personal Injury Lien

a. Is Applicant willing to identify and require its Subcontractors and Providers to identify and promptly report the presence of a Member's Third Party Liability?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to document all efforts to pursue financial recoveries from third party insurers?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to report and require its Subcontractors to report all financial recoveries from third party insurers?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to provide and require its Affiliated entities and Subcontractors to provide to OHA all information related to TPL eligibility to assist in the pursuit of financial recovery?

☒Yes ☐No

If "no" please provide explanation: _____

_____

4. Oversight and Governance

a. Is Applicant willing to provide its organizational structure, identifying any relationships with subsidiaries and entities with an ownership or Control stake?

☒Yes ☐No

If "no" please provide explanation: _____

_____

B. Provider Participation and Operations Attestations (Attachment 7)

1. General Questions

a. Will Applicant have an individual accountable for each of the operational functions described below?

- Contract administration
- Outcomes and evaluation
- Performance measurement
- Health management and Care Coordination activities
- System coordination and shared accountability between DHS Medicaid-funded LTC system and CCO
- Behavioral Health (mental health and addictions) coordination and system management
- Communications management to Providers and Members
- Provider relations and network management, including credentialing
- Health information technology and medical records
- Privacy officer
- Compliance officer
- Quality Performance Improvement
- Leadership contact for single point of accountability for the development and implementation of the Health Equity Plan
- Traditional Health Workers Liaison

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Will Applicant participate in the Learning Collaboratives required by ORS 442.210?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Will Applicant collect, maintain and analyze race, ethnicity, and preferred spoken and written languages data for all Members on an ongoing basis in accordance with standards jointly established by OHA and DHS in order to identify and track the elimination of health inequities?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Will Applicant (i) authorize the provision of a drug requested by the Primary Care Physician (PCP) or Referral Provider, if the approved prescriber certifies medical necessity for the drug such as: the formulary's equivalent has been ineffective in the treatment or the formulary's drug causes or is reasonably expected to cause adverse or harmful reactions to the Member and (ii) reimburse Providers for dispensing a 72-hour supply of a drug that requires Prior Authorization?

☒Yes ☐No

If "no" please provide explanation: _____

_____

e. Will Applicant comply with all applicable Provider requirements of Medicaid law under 42 CFR Part 438, including Provider certification requirements, anti-discrimination requirements, Provider participation and consultation requirements, the prohibition on interference with Provider advice, limits on Provider indemnification, rules governing payments to Providers, and limits on physician incentive plans?

☒Yes ☐No

If "no" please provide explanation: _____

_____

f. Will Applicant ensure that all Provider, facility, and supplier contracts or agreements contain the required contract provisions that are described in the Contract?

☒Yes ☐No

If "no" please provide explanation: _____

_____

g. Will Applicant have executed Provider, facility, and supplier contracts in place to demonstrate adequate access and availability of Covered Services throughout the requested Service Area?

☒Yes ☐No

If "no" please provide explanation: _____

_____

h. Will Applicant have all Provider contracts or agreements available to OHA in unredacted form?

☒Yes ☐No

If "no" please provide explanation: _____

_____

i. Will Applicant's contracts for administrative and management services contain the OHA required Contract provisions?

☒Yes ☐No

If "no" please provide explanation: _____

_____

j. Will Applicant establish, maintain, and monitor the performance of a comprehensive network of Providers to ensure sufficient access to Medicaid Covered Services, including comprehensive behavioral and oral health services, as well as supplemental services offered by the CCO in accordance with written policies, procedures, and standards for participation established by the CCO? Participation status will be revalidated at appropriate intervals as required by OHA regulations and guidelines.

☒Yes ☐No

If "no" please provide explanation: _____

_____

k. Will Applicant have executed written agreements with Providers (first tier, downstream, or related entity instruments) structured in compliance with OHA regulations and guidelines?

☒Yes No

If "no" please ☐provide explanation: _____

_____

l. Will Applicant have executed written agreements with Local Mental Health Authorities throughout its Service Area, structured in compliance with OHA regulations and guidelines?

☒Yes ☐No

If "no" please provide explanation: _____

_____

m. Will Applicant develop a comprehensive Behavioral Health plan in collaboration with the Local Mental Health Authority and other Community partners?

☒Yes ☐No

If "no" please provide explanation: _____

_____

n. Will Applicant coordinate and collaborate on the development of the Community health improvement plan (CHP) under ORS 414.627 with the Local Mental Health Authority's comprehensive local plan for the delivery of mental health services (ORS 430.630)?

☒Yes ☐No

If "no" please provide explanation: _____

_____

o. Will Applicant, through its contracted Participating Provider Network, along with other specialists outside the network, Community resources or social services within the CCO's Service Area, provide ongoing primary care, Behavioral Health care, oral health care, and specialty care as needed and will guarantee the continuity of care and the integration of services as described below?

- Prompt, convenient, and appropriate access to Covered Services by Members 24 hours a day, 7 days a week;
- The coordination of the individual care needs of Members in accordance with policies and procedures as established by the Applicant;
- Member involvement in decisions regarding treatment, proper education on treatment options, and the coordination of follow-up care;
- Effectively addressing and overcoming barriers to Member compliance with prescribed treatments and regimens; and
- Addressing diverse patient populations in a linguistically diverse and culturally competent manner.

☒Yes ☐No

If "no" please provide explanation: _____

_____

p. Will Applicant establish policies, procedures, and standards that:

- Ensure and facilitate the availability, convenient, and timely access to all Medicaid Covered Services as well as any supplemental services offered by the CCO;
- Ensure access to medically necessary care and the development of medically necessary individualized care plans for Members;
- Promptly and efficiently coordinate and facilitate access to clinical information by all Providers involved in delivering the individualized care plan of the Member while following Timely Access to Services standards;
- Communicate and enforce compliance by Providers with medical necessity determinations; and
- Do not discriminate against Medicaid Members, including providing services to individuals with disabilities in the most integrated Community setting appropriate to the needs of those individuals.

☒Yes ☐No

If "no" please provide explanation: _____

_____

q. Will Applicant have verified that contracted Providers included in the CCO Facility Table are Medicaid certified and the Applicant certifies that it will only contract with Medicaid certified Providers in the future?

☒Yes ☐No

If "no" please provide explanation: _____

_____

r. Will Applicant provide all services covered by Medicaid and comply with OHA coverage determinations?

☒Yes ☐No

If "no" please provide explanation: _____

_____

s. Will Applicant have an Medicare plan to serve Fully Dual Eligibles either through contractual arrangement or owned by Applicant or Applicant parent company to create integrated Medicare-Medicaid opportunities during the contract period? [Plan can be a Dual Special Needs Plan or MA plan that offers low premiums and integrated Part D medications options].

☒Yes ☐No

If "no" please provide explanation:

t. Will Applicant, Applicant staff and its Affiliated companies, subsidiaries or Subcontractors (first tier, downstream, and related entities), and Subcontractor staff be bound by 2 CFR 376 and attest that they are not excluded by the Department of Health and Human Services Office of the Inspector General or by the General Services Administration? Please note that this attestation includes any member of the board of directors, key management or executive staff or major stockholder of the Applicant and its Affiliated companies, subsidiaries or Subcontractors (first tier, downstream, and related entities).

☒Yes ☐No

If "no" please provide explanation: _____

_____

u. Is it true that neither the state nor federal government has brought any past or pending investigations, legal actions, administrative actions, or matters subject to arbitration involving the Applicant (and Applicant's parent corporation, subsidiaries, or entities with an ownership stake, if applicable) or its Subcontractors, including key management or executive staff, or major shareholders over the past three years on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services?

☒Yes ☐No

If "no" please provide explanation: _____

_____

2. Network Adequacy

a. Is Applicant willing to monitor and evaluate the adequacy of its Provider Network?

☒ Yes ☐No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to remedy any deficiencies in its Provider Network within a specified timeframe when deficiencies are identified?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to report on its Provider Network in a format and frequency specified by OHA?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to collect data to validate that its Members are able to access care within time and distance requirements?

☒Yes ☐No

If "no" please provide explanation: _____

_____

e. Is Applicant willing to collect data to validate that its Members are able to make appointments within the required timeframes?

☒Yes ☐No

If "no" please provide explanation: _____

_____

f. Is Applicant willing to collect data to validate that its Members are able to access care within the required timeframes?

☒Yes ☐No

g. Is Applicant willing to arrange for Covered Services to be provided by Non-Participating Providers if the services are not timely available within Applicant's Provider Network?

☒Yes ☐No

3. Fraud, Waste and Abuse Compliance

a. Is Applicant willing to designate a Compliance Officer to oversee activities related to the prevention and detection of Fraud, Waste and Abuse?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to send two representatives, including the Applicant's designated Compliance Officer and another member of the senior executive team to attend a mandatory Compliance Conference on May 30, 2019?

☒Yes ☐No

If "no" please provide explanation: _____

_____

C. Value-Based Payment (VBP) Attestations (Attachment 8)

1. Have you reviewed the VBP Policy Requirements set forth in the VBP Questionnaire?

☒ Yes ☐No

If "no" please provide explanation: _____

_____

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

☒ Yes ☐No

If "no" please provide explanation: _____

_____

3. Can you implement and report on VBP as defined by VBP Questionnaire and the Health Care Payment Learning and Action Network's (LAN's) "Alternative Payment Model Framework White Paper Refreshed 2017" (https://hcp-lan.org/apm-refresh-white-paper/) and the OHA Value-Based Payment Roadmap Categorization Guidance for Coordinated Care Organizations?

☒Yes ☐No

If "no" please provide explanation: _____

_____

4. Will you begin CCO 2.0 – January 2020 – with at least 20% of your projected annual payments to your Providers under contracts that include a Value-Based Payment component as defined by the Health Care Payment Learning and Action Network's (LAN's) "Alternative Payment Model Framework White Paper Refreshed 2017" (https://hcp-lan.org/apm-refresh-white-paper/), Pay for Performance category 2C or higher and the OHA Value-Based Payment Roadmap Categorization Guidance for Coordinated Care Organizations?

☒Yes ☐No

If "no" please provide explanation: _____

_____

5. Do you permit OHA to publish your VBP data such as the actual VBP percent of spending that is LAN category 2C or higher and spending that is LAN category 3B or higher, as well as data pertaining to your care delivery areas, Patient-Centered Primary Care Home (PCPCH) payments, and other information about VBPs required by this RFA? (OHA does not intend to publish specific payments amounts from an Applicant to a specific rovider.)

☒Yes ☐No

If "no" please provide explanation: _____

_____

6. Do you agree to develop mitigation plans for adverse effects VBPs may have on health inequities, health disparities, or any adverse health-related outcomes for any specific population (including racial, ethnic and culturally-based communities; LGBTQ people; persons with disabilities; people with limited English proficiency; and immigrants or refugees and Members with complex health care needs, as well as populations at the intersections of these groups) and to report on these plans to OHA annually?

☒Yes ☐No

If "no" please provide explanation: _____

_____

7. Do you agree to the requirements for VBP targets, care delivery areas and PCPCH clinics for years 2020 through 2024, as set forth in the VBP Questionnaire?

☒Yes ☐No

If "no" please provide explanation: _____

_____

8. Do you agree to the requirements for VBP data reporting for years 2020 through 2024, as set forth in the VBP Questionnaire?

☒Yes ☐No

If "no" please provide explanation: _____

_____

9. Should OHA contract with one or more other CCOs serving Members in the same geographical area, will you participate in OHA-facilitated discussions to select performance measures to be incorporated into each CCO's VBP Provider contracts for common Provider types and specialties?

☒Yes ☐No

If "no" please provide explanation: _____

_____

10. If, after the discussion described in the previous question, OHA informs you of the Provider types and specialties for which the performance measures apply, will you incorporate all selected measures into applicable Provider contracts?

☒Yes ☐No

If "no" please provide explanation: _____

_____

D. Health Information Technology (HIT) Attestations (Attachment 9)

1. HIT Roadmap

a. Does Applicant agree to participate in an interview/demonstration and deliver an HIT Roadmap with any refinements/adjustments agreed to with OHA during Readiness Review, for OHA approval?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Does Applicant agree to provide an annual HIT Roadmap update for OHA approval to include status/progress on CCO-identified milestones, and any adjustments to the HIT Roadmap; as well as participate in an annual interview with OHA?

☒Yes ☐No

If "no" please provide explanation: _____

_____

2. HIT Partnership

a. Does Applicant agree to participate in the HIT Commons beginning 2020, including agreeing to do all of the following:

- Maintaining an active, signed HIT Commons MOU and adhering to its terms,
- Paying annual HIT Commons assessments, and
- Serving, if elected, on the HIT Commons Governance Board or one of its committees?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Does Applicant agree to participate in OHA's HIT Advisory Group, (HITAG), at least once annually?

☒Yes ☐No

If "no" please provide explanation: _____

_____

3. Support for EHR Adoption

a. Will Applicant support EHR adoption for its contracted physical health Providers?

☒ Yes ☐No

If "no" please provide explanation: _____

_____

b. Will Applicant support EHR adoption for its contracted Behavioral Health Providers?

☒ Yes ☐No

If "no" please provide explanation: _____

_____

c. Will Applicant support EHR adoption for its contracted oral health Providers?

☒ Yes ☐No

If "no" please provide explanation: _____

_____

d. During Year 1, will Applicant report on the baseline of EHR adoption among its contracted physical health Providers, set Improvement Targets, and provide supporting detail about its implementation approach?

☒Yes ☐No

If "no" please provide explanation: _____

_____

e. During Year 1, will Applicant report on the baseline of EHR adoption among its contracted Behavioral Health Providers, set Improvement Targets, and provide supporting detail about its implementation approach?

☒Yes ☐No

If "no" please provide explanation: _____

_____

f. During Year 1, will Applicant report on the baseline of EHR adoption among its contracted oral health Providers, set Improvement Targets, and provide supporting detail about its implementation approach?

☒Yes ☐No

If "no" please provide explanation: _____

_____

g. Will Applicant report to the state annually on which EHR(s) each of its contracted physical health Providers is using, by means of definitions and data sources agreed upon during Readiness Review? Will reports include product and vendor name, version, and, if applicable, certification year the ONC Certification (CHPL) number for Certified EHR Technology? See https://chpl.healthit.gov/ and https://www.healthit.gov/topic/certification-ehrs/2015-edition for more information about Certified EHR Technology.

☒Yes ☐No

If "no" please provide explanation: _____

_____

h. Will Applicant report to the state annually on which EHR(s) each of its contracted Behavioral Health Providers are using, by means of definitions and data sources agreed upon during Readiness Review? Will reports include product and vendor name, version, and, if applicable, certification year the ONC Certification (CHPL) number for Certified EHR Technology? See https://chpl.healthit.gov/ and https://www.healthit.gov/topic/certification-ehrs/2015-edition for more information about Certified EHR Technology.

☒Yes ☐No

If "no" please provide explanation: _____

_____

i. Will Applicant report to the state annually on which EHR(s) each of its contracted oral health Providers is using, by means of definitions and data sources agreed upon during Readiness Review? Will reports include product and vendor name, version, and, if applicable, certification year the ONC Certification (CHPL) number for Certified EHR Technology? See https://chpl.healthit.gov/ and https://www.healthit.gov/topic/certification-ehrs/2015-edition for more information about Certified EHR Technology.

☒Yes ☐No

If "no" please provide explanation: _____

_____

4. Support for HIE

a. Will Applicant ensure access to timely Hospital event notifications for its contracted physical health Providers? If there are costs associated with ensuring access to timely Hospital event notifications for contracted Providers, will the Applicant be responsible for those costs?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Will Applicant ensure access to timely Hospital event notifications for its contracted Behavioral Health Providers? If there are costs associated with ensuring access to timely Hospital event notifications for contracted Providers, will the Applicant will be responsible for those costs?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Will Applicant ensure access to timely Hospital event notifications for its contracted oral health Providers? If there are costs associated with ensuring access to timely Hospital event notifications for contracted Providers, will the Applicant will be responsible for those costs.

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Will Applicant use Hospital event notifications within the CCO, for example to support Care Coordination and/or population health efforts?

☒Yes ☐No

If "no" please provide explanation: _____

_____

e. Will Applicant support access to health information exchange that enables sharing patient information for Care Coordination for its contracted physical health Providers?

☒Yes ☐No

If "no" please provide explanation: _____

_____

f. Will Applicant support access to health information exchange that enables sharing patient information for Care Coordination for its contracted Behavioral Health Providers?

☒Yes ☐No

If "no" please provide explanation: _____

_____

g. Will Applicant support access to health information exchange that enables sharing patient information for Care Coordination for its contracted oral health Providers?

☒Yes ☐No

If "no" please provide explanation: _____

_____

h. During Year 1, will Applicant report on the baseline of HIE access and use among its contracted physical health Providers (inclusive of Hospital event notifications and HIE for Care Coordination), set Improvement Targets, and provide supporting detail about its implementation approach?

☒Yes ☐No

If "no" please provide explanation: _____

_____

i. During Year 1, will Applicant report on the baseline of HIE access and use among its contracted Behavioral Health Providers (inclusive of Hospital event notifications and HIE for Care Coordination), set Improvement Targets, and provide supporting detail about its implementation approach?

☒Yes ☐No

If "no" please provide explanation: _____

_____

j. During Year 1, will Applicant report on the baseline of HIE access and use among its contracted oral health Providers (inclusive of Hospital event notifications and HIE for Care Coordination), set Improvement Targets, and provide supporting detail about its implementation approach?

☒Yes ☐No

If "no" please provide explanation: _____

_____

k. Will Applicant report to the state annually on which HIE tool(s) each of its contracted physical health Providers is using, using definitions and data sources agreed upon during Readiness Review?

☒Yes ☐No

If "no" please provide explanation: _____

_____

l. Will Applicant report to the state annually on which HIE tool(s) each of its contracted Behavioral Health Providers is using, using definitions and data sources agreed upon during Readiness Review?

☒Yes ☐No

If "no" please provide explanation: _____

_____

m. Will Applicant report to the state annually on which HIE tool(s) each of its contracted oral health Providers is using, using definitions and data sources agreed upon during Readiness Review?

☒Yes ☐No

If "no" please provide explanation: _____

_____

5. Health IT for VBP and Population Management.

a. For the initial VBP arrangements, will Applicant have by the start of Year 1 the HIT needed to administer the arrangements (as described in its supporting detail)?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. For the planned VBP arrangements for Years 2 through 5, does Applicant have a roadmap to obtain the HIT needed to administer the arrangements (as described in its supporting detail)?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. By the start of Year 1, will the Applicant provide contracted Providers with VBP arrangements with timely (e.g., at least quarterly) information on measures used in the VBP arrangement(s) applicable to the Providers?

☒Yes ☐No

If "no" please provide explanation: _____

d. By the start of Year 1, will the Applicant provide contracted Providers with VBP arrangements with accurate and consistent information on patient attribution?

☒Yes ☐No

If "no" please provide explanation: _____

e. By the start of Year 1, will the Applicant identify for contracted Providers with VBP arrangements specific patients who need intervention through the year, so they can take action before the year end?

☒Yes ☐No

If "no" please provide explanation: _____

f. By the start of Year 1, will the Applicant have the capability to risk stratify and identify and report upon Member characteristics, including but not limited to past diagnoses and services, that can inform the targeting of interventions to improve outcomes?

☒Yes ☐No

If "no" please provide explanation: _____

g. By the start of each subsequent year for Years 2 through 5, will the Applicant CCO provide risk stratification and Member characteristics to your contracted Providers with VBP arrangements for the population(s) included in the arrangement(s) in place for each year?

☒Yes ☐No

If "no" please provide explanation: _____

E. Social Determinants of Health and Health Equity (SDOH-HE) Attestations (Attachment 10)

1. Social Determinants of Health and Health Equity Spending, Priorities, and Partnership

a. Is Applicant willing to direct a portion of its annual net income or reserves, as required by Oregon State Statute and defined by OHA in rule, to addressing health disparities and SDOH-HE?

☒Yes ☐No

If "no" please provide explanation: _____

b. Is Applicant willing to enter into written agreements with SDOH-HE partners that describe the following: any relationship or financial interest that may exist between the SDOH-HE partner and the CCO, how funds will be distributed, the scope of work including the domain of SDOH-HE addressed and the targeted population, whether CCO will refer Members to the SDOH-HE partner, the geographic area to be covered, how outcomes will be evaluated and measured, and how the CCO will collect and report data related to outcomes?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. When identifying priorities for required SDOH-HE spending, is Applicant willing to designate, define and document a role for the CAC in directing, tracking and reviewing spending?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to align its SDOH-HE spending priorities with the priorities identified in the Community Health Improvement Plan and its Transformation and Quality Strategy, and to include at least one statewide priority (e.g. housing-related services and supports, including Supported Housing) in addition to its Community priorities?

☒Yes ☐No

If "no" please provide explanation: _____

_____

2. Health-related Services

a. Is Applicant willing to align HRS Community benefit initiatives with Community priorities from the CCO's Community Health Improvement Plan?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to align HRS Community benefit initiatives with a designated statewide priority should OHA require it?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to designate, define and document a role for the CAC when determining how Health-Related Services Community benefit initiatives decisions are made?

☒Yes ☐No

If "no" please provide explanation: _____

_____

3. Community Advisory Council membership and role

a. Is the Applicant willing to provide to OHA an organizational chart that includes the Community Advisory Council, and notes relationships between entities, including the CAC and the Board, how information flows between the bodies, the CAC and Board connection to various committees, and CAC representation on the board?

☒Yes ☐No

If "no" please provide explanation: _____

_____

4. Health Equity Assessment and Health Equity Plan

a. Is Applicant willing to develop and implement a Health Equity Plan according to OHA guidance, which includes a plan to provide cultural responsiveness and implicit bias education and training across the Applicant's organization and Provider Network? See Sample Contract and Cultural Responsiveness Training Plan Guidance Document.

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to include in its Health Equity Plan at least one initiative using HIT to support patient engagement?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to adopt potential health equity plan changes, including requirements, focus areas and components, based on OHA plan review feedback and, when applicable, based on guidance provided by the Oregon Health Policy Board's Health Equity Committee?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to designate a single point of accountability within the organization, who has budgetary decision-making authority and health equity expertise, for the development and implementation of the Health Equity Plan?

☒Yes ☐No

If "no" please provide explanation: _____

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

☒ Yes ☐No

If "no" please provide explanation: _____

f. Is Applicant willing to a) ask vendors for cultural and linguistic accessibility when discussing bringing on new HIT tools for patient engagement and b) when possible, seek out HIT tools for patient engagement that are culturally and linguistically accessible?

☒Yes ☐No

If "no" please provide explanation: _____

5. Traditional Health Workers (THW) Utilization and Integration

a. Is Applicant willing to develop and fully implement a Traditional Health Workers Integration and Utilization Plan?

☒Yes ☐No

If "no" please provide explanation: _____

b. Is Applicant willing to work in collaboration with the THW Commission to implement the Commission's best practices for THW integration and utilization?

☒Yes ☐No

If "no" please provide explanation: _____

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

☒Yes ☐No

If "no" please provide explanation: _____

d. Is Applicant willing to develop and implement a payment strategy for THWs that is informed by the recommendations from the Payment Model Committee of the THW Commission?

☒Yes ☐No

If "no" please provide explanation: _____

e. Is Applicant willing to designate an individual within the organization as a THW Liaison as of the Effective Date of the Contract?

☒Yes ☐No

If "no" please provide explanation: _____

_____

f. Is Applicant willing to engage THWs during the development of the CHA and CHP?

☒ Yes ☐No

If "no" please provide explanation: _____

_____

g. For services that are not captured on encounter claims, is Applicant willing to track and document Member interactions with THWs?

☒Yes ☐No

If "no" please provide explanation: _____

_____

6. Community Health Assessment and Community Health Improvement Plan

a. Is Applicant willing to partner with local public health authorities, non-profit Hospitals, any CCO that shares a portion of its Service Area, and any Tribes that are developing a CHA/CHP to develop shared CHA and CHP priorities?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to align CHP priorities with at least two State Health Improvement Plan (SHIP) priorities and implement statewide SHIP strategies based on local need?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to submit its Community Health Assessment and Community Health Improvement Plan to OHA?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to develop and fully implement a community engagement plan?

☒ Yes ☐No

If "no" please provide explanation:

F. Behavioral Health Attestations (Attachment 11)

1. Behavioral Health Benefit

a. Will Applicant report performance measures and implement Evidence-Based outcome measures, as developed by the OHA Metrics and Scoring Committee, and as specified in the Contract?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Will Applicant work collaboratively with OHA and its partners to implement all of the requirements in Exhibit M of the Contract?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Will Applicant be fully responsible for the Behavioral Health benefit for Members beginning in CY 2020?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Will Applicant manage the Global Budget (as defined in ORS 414.025) in a fully integrated manner? Fully integrated manner means that Applicant will not sub-capitate any Provider or entity for Behavioral Health services separately from physical health services nor will Applicant enter into any Value-Based Payment arrangements under which Behavioral Health spending is tracked separately from physical health services.

☒Yes ☐No

If "no" please provide explanation: _____

_____

e. Will Applicant report on the information and data specified in the Performance Expectations section as specified in the Contract and submit an annual report to OAH for review and approval?

☒Yes ☐No

If "no" please provide explanation: _____

_____

f. Will Applicant have sufficient resources, including technological, financial, Provider and workforce, to integrate the Behavioral Health benefit with oral and physical health care benefits?

☒Yes ☐No

If "no" please provide explanation: _____

_____

g. Will Applicant ensure the provision of cost-effective, comprehensive, person-centered, Culturally Responsive, and integrated Community-based Behavioral Health services for Members?

☒Yes ☐No

If "no" please provide explanation: _____

_____

h. Will Applicant provide oversight, Care Coordination, transition planning and management of the Behavioral Health needs of Members to ensure Culturally Responsive and linguistically appropriate Behavioral Health services are provided in a way that Members are served in a most natural and integrated environment possible and that minimizes the use of institutional care?

☒Yes ☐No

If "no" please provide explanation: _____

_____

i. Will Applicant follow Intensive Care Coordination standards as identified in OAR 410-141-3160/70?

☒Yes ☐No

If "no" please provide explanation: _____

_____

j. Will Applicant ensure Members have access to Referral and screening at multiple health system or health care entry points?

☒Yes ☐No

If "no" please provide explanation: _____

_____

k. Will Applicant use a standardized Assessment tool, to adapt the intensity and frequency of Behavioral Health services to the Behavioral Health needs of the Member?

☒Yes ☐No

If "no" please provide explanation: _____

_____

l. Will Applicant work collaboratively to improve services for adult Members with SPMI as a priority population? Will Applicant make significant commitments and undertake significant efforts to continue to improve treatment and services so that adults with SPMI can live and prosper in integrated Community settings?

☒Yes ☐No

If "no" please provide explanation: _____

_____

m. Will Applicant ensure Members have timely access to all services under the Behavioral Health benefit in accordance with access to service standards as developed in Appendix C, the Administrative Rules Concept Document, under OHPB #17?

☒Yes ☐No

If "no" please provide explanation: _____

_____

n. Will Applicant have an adequate Provider Network to ensure Members have timely access to Behavioral Health services and effective treatment in accordance with the Delivery System and Provider Capacity section of the Contract?

☒Yes ☐No

If "no" please provide explanation: _____

_____

o. Will Applicant establish written policies and procedures for Prior Authorizations, in compliance with the Mental Health Parity and Addiction Equity Act of 2008, and be responsible for any inquiries or concerns and not delegate responsibility to Providers?

☒Yes ☐No

If "no" please provide explanation: _____

_____

p. Will Applicant establish written policies and procedures for the Behavioral Health benefit and provide the written policies and procedures to OHA by the beginning of CY 2020?

☒Yes ☐No

If "no" please provide explanation: _____

_____

q. Will Applicant require mental health and substance use disorder programs be licensed or certified by OHA to enter the Provider Network?

☒Yes ☐No

If "no" please provide explanation: _____

_____

r. Will Applicant require Providers to screen Members for adequacy of supports for the Family in the home (e.g., housing adequacy, nutrition/food, diaper needs, transportation needs, safety needs and home visiting)?

☒Yes ☐No

If "no" please provide explanation: _____

_____

n. Will Applicant ensure Applicant's staff and Providers are trained in recovery principles, motivational interviewing, integration, and Foundations of Trauma Informed Care (https://traumainformedoregon.org/tic-intro-training-modules/)?

☒Yes ☐No

If "no" please provide explanation: _____

_____

t. Will Applicant ensure Providers are trained in Trauma Informed approaches and provide regular periodic oversight and technical assistance to Providers?

☒Yes ☐No

If "no" please provide explanation: _____

_____

u. Will Applicant require Providers, in developing Individual Service and Support Plans for Members, to assess for Adverse Childhood Experiences (ACEs) and trauma in a Culturally Responsive and Trauma Informed framework and approach?

☒Yes ☐No

If "no" please provide explanation: _____

_____

v. Will Applicant ensure Behavioral Health services are Culturally Responsive and Trauma Informed?

☒Yes ☐No

If "no" please provide explanation: _____

_____

w. Will Applicant assume responsibility for the entire Behavioral Health residential benefit by the beginning of CY 2022?

☒Yes ☐No

If "no" please provide explanation: _____

_____

x. Will Applicant include OHA approved Behavioral Health homes (BHHs) in Applicant's network as the BHHs qualify in Applicant's Region?

☒Yes ☐No

If "no" please provide explanation: _____

_____

y. Will Applicant assist Behavioral Health organizations within the delivery system to establish BHHs?

☒Yes ☐No

If "no" please provide explanation: _____

_____

z. Will Applicant utilize BHHs in their network for Members to the greatest extent possible?

☒Yes ☐No

If "no" please provide explanation: _____

_____

aa. Will Applicant provide a full psychological evaluation and child psychiatric consultation for children being referred to the highest levels of care (day treatment, subacute or PRTS)?

☒Yes ☐No

If "no" please provide explanation: _____

_____

2. MOU with Community Mental Health Program (CMHP)

a. Will Applicant enter into a written memorandum of understanding (MOU) with the local Community Mental Health Program (CMHP) in Applicant's Region by beginning of CY 2020, in accordance with ORS 414.153?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Will Applicant develop a comprehensive Behavioral Health plan for Applicant's Region in collaboration with the Local Mental Health Authority and other Community partners (e.g., education/schools, Hospitals, corrections, police, first responders, Child Welfare, DHS, public health, Peers, families, housing authorities, housing Providers, courts)?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Will Applicant coordinate and collaborate on the development of the Community health improvement plan (CHP) under ORS 414.627 with the local Community Mental Health Program (CMHP) for the delivery of mental health services under ORS 430.630

☒Yes ☐No

If "no" please provide explanation: _____

_____

3. Provisions of Covered Services – Behavioral Health

a. Will Applicant provide services as necessary to achieve compliance with the mental health parity requirements of 42 CFR§ 438, subpart K and ensure that any quantitative treatment limitations (QTLs), or non-quantitative treatment limitations (NQTLs) placed on Medically Necessary Covered Services are no more restrictive than those applied to fee-for-service medically necessary covered benefits, as described in 42 CFR 438.210(a)(5)(i)?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Will Applicant assume accountability for Members that are civilly committed and are referred to and enter Oregon State Hospital; be financially responsible for the services for Members on waitlist for Oregon State Hospital after the second year of the Vontract, with timeline to be determined by OHA; and be financially responsible for services for Members admitted to Oregon State Hospital after the second year of the Vontract, with timeline to be determined by OHA?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Will Applicant reimburse for covered Behavioral Health services rendered in a primary care setting by a qualified Behavioral Health Provider, and reimburse for covered physical health services in Behavioral Health care settings, by a qualified medical Provider?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Will Applicant ensure Members receive services from Non-Participating Providers for Behavioral Health services if those services are not available from Participating Providers or if a Member is not able to access services within the timely access to care standards? Will Applicant remain responsible for coordinating Behavioral Health services with Non-Participating Providers and reimbursing for services?

☒Yes ☐No

If "no" please provide explanation: _____

_____

e. Will Applicant ensure continuity of care throughout episodes of care and provide Intensive Care Coordination and general Care Coordination as specified in the Contract?

☒Yes ☐No

If "no" please provide explanation: _____

_____

4. Covered Services Component – Behavioral Health

a. Will Applicant establish written policies and procedures for an emergency response system, including post-stabilization care services and Urgent Services for all Members on a 24-hour, 7-day-a-week basis consistent with OAR 410-141-3140 and 42 CFR 438.114? Will the emergency response system provide an immediate, initial or limited duration response for emergency situations or potential Behavioral Health emergency situations that may include Behavioral Health conditions?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Will Applicant ensure access to Mobile Crisis Services for all Members in accordance with OAR 309-019-0105, OAR 309-019-0150, 309-019-0242, and 309-019-0300 to 309-019-0320 to promote stabilization in a Community setting rather than arrest, presentation to an Emergency Department, or admission to an Acute psychiatric care facility?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Will Applicant establish written policies and procedures for a Quality Improvement plan for the emergency response system?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Will Applicant collaboratively work with OHA and CMHPs to develop and implement plans to better meet the needs of Members in Community integrated settings and to reduce recidivism to Emergency Departments for Behavioral Health reasons?

☒Yes ☐No

If "no" please provide explanation: _____

_____

e. Will Applicant work with Hospitals to provide data on Emergency Department (ED) utilization for Behavioral Health reasons and length of time in the ED? Will Applicant develop remediation plans with EDs with significant numbers of ED stays longer than 23 hour?

☒Yes ☐No

If "no" please provide explanation: _____

_____

f. Will Applicant establish a policy and procedure for developing a management plan for contacting and offering services to each Member who has two or more readmissions to an ED in a six-month period?

☒Yes ☐No

If "no" please provide explanation: _____

g. Will Applicant make a reasonable effort to provide Covered Services on a voluntary basis and consistent with current Declaration for Mental Health Treatment as provided at: http://www.oregon.gov/oha/amh/forms/declaration.pdf in lieu of involuntary treatment?

☒Yes ☐No

If "no" please provide explanation: _____

h. Will Applicant establish written policies and procedures describing the appropriate use of Emergency Psychiatric Holds consistent with ORS 426 and alternatives to involuntary psychiatric care when a less restrictive voluntary service will not meet the Medically Appropriate needs of the Member and the behavior of the Member meets legal standards for the use of an Emergency Psychiatric Hold?

☒Yes ☐No

If "no" please provide explanation: _____

i. Will Applicant assure that any involuntary treatment provided under the Contract is provided in accordance with administrative rule and statute, and coordinate with the CMHP Director in assuring that all statutory requirements are met? Will Applicant also work with the CMHP Director in assigning a civilly committed Member to any placement and participate in circuit court hearings related to planned placements, if applicable?

☒Yes ☐No

If "no" please provide explanation: _____

j. If Applicant identifies a Member, over age 18 with no significant nursing care needs due to a general medical condition, Acute medical condition or physical disorder, is appropriate for Long Term Psychiatric Care (State Facility level of care), will Applicant request a LTPC determination from the OHA LTPC reviewer?

☒Yes ☐No

If "no" please provide explanation: _____

k. If Applicant identifies a Member, age 18 to age 64, with no significant nursing care needs due to a general medical condition, Acute medical condition or physical disorder of an enduring nature, is appropriate for LTPC, will Applicant request a LTPC determination from the applicable HSD Adult Mental Health Services Unit, as described in Procedure for LTPC Determinations for Members 18 to 64, available on the Contract Reports Web Site?

☒Yes ☐No

If "no" please provide explanation: _____

_____

l. If Applicant identifies a Member, age 65 and over, or age 18 to age 64 with significant nursing care needs due to a general medical condition, Acute medical condition or physical disorder of an enduring nature, is appropriate for LTPC, will Applicant request a LTPC determination from the State hospital-NTS, Outreach and Consultation Service (OCS) Team as described in Procedure for LTPC Determinations for Member Requiring Neuropsychiatric Treatment, available on the Contract Reports Web Site?

☒Yes ☐No

If "no" please provide explanation: _____

_____

m. For the Member age 18 and over, will Applicant work with the Member to assure timely discharge and transition from LTPC to the most appropriate, independent and integrated Community-based setting possible consistent with Member choice?

☒Yes ☐No

If "no" please provide explanation: _____

_____

n. Will Applicant authorize and reimburse Care Coordination services, in particular for Members who receive ICC, that are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are provided to Members receiving care through licensed Community treatment programs? Will Applicant authorize and reimburse for ICC services, in accordance with standards identified in OAR 410-141-3160-70?

☒Yes ☐No

If "no" please provide explanation: _____

_____

o. Will Applicant ensure that any involuntary treatment provided under the Contract is provided in accordance with administrative rule and statute and coordinate with the CMHP Director in assuring that all statutory requirements are met? Will Applicant work with the CMHP Director in assigning a civilly committed Member to any placement and participate in circuit court hearings related to planned placements, if applicable?

☒Yes ☐No

If "no" please provide explanation: _____

_____

p. Will Applicant provide Acute Inpatient Hospital Psychiatric Care for Members who do not meet the criteria for LTPC?

☒Yes ☐No

If "no" please provide explanation: _____

_____

q. Will Applicant ensure that all Members discharged from Acute Care Psychiatric Hospitals are provided a Warm Handoff to a Community case manager, Peer bridger, or other Community provider prior to discharge, and that all such Warm Handoffs are documented?

☒Yes ☐No

If "no" please provide explanation: _____

_____

r. Will Applicant ensure that all Members discharged from Acute Care Psychiatric Hospitals have linkages to timely, appropriate behavioral and primary health care in the Community prior to discharge and that all such linkages are documented, in accordance with OAR provisions 309-032-0850 through 309-032-0870?

☒Yes ☐No

If "no" please provide explanation: _____

_____

s. Will Applicant ensure all adult Members receive a follow-up visit with a Community Behavioral Health Provider within seven (7) days of their discharge from an Acute Care Psychiatric Hospital?

☒Yes ☐No

If "no" please provide explanation: _____

_____

t. Will Applicant reduce readmissions of adult Members with SPMI to Acute Care Psychiatric Hospitals?

☒Yes ☐No

If "no" please provide explanation: _____

_____

u. Will Applicant coordinate with system Community partners to ensure Members who are homeless and who have had two or more readmissions to an Acute Care Psychiatric Hospital in a six-month period are connected to a housing agency or mental health agency to ensure these Members are linked to housing in an integrated Community setting, Supported Housing to the extent possible, consistent with the individual's treatment goals, clinical needs and the individual's informed choice?

☒Yes ☐No

If "no" please provide explanation: _____

_____

v. Will Applicant ensure coordination and appropriate Referral to Intensive Care Coordination to ensure that Member's rights are met and there is post-discharge support? If Member is connected to ICC coordinator, will Applicant ensure coordination with this person as directed in OAR 410-141-3160-3170?

☒Yes ☐No

If "no" please provide explanation: _____

_____

w. Will Applicant work with OHA and the CMHPs to ensure that Members who are discharged from Acute Care Psychiatric Hospitals are discharged to housing that meets the individuals' immediate need for housing and work with Acute Care Psychiatric Hospitals in the development of each individual's housing assessment?

☒Yes ☐No

If "no" please provide explanation: _____

_____

x. Will Applicant establish a policy and procedure for developing a management plan for contacting and offering services to each Member who has two (2) or more readmissions to an Acute Care Psychiatric Hospital in a six-month period?

☒Yes ☐No

If "no" please provide explanation: _____

_____

y. Will Applicant work with OHA, other state agencies, and other state funded or operated entities to identify areas where treatment and services for adult Members with SPMI can be improved?

☒Yes ☐No

If "no" please provide explanation: _____

_____

z. Will Applicant coordinate services for each adult Member with SPMI who needs assistance with Covered or Non-covered Services?

☒Yes ☐No

If "no" please provide explanation: _____

_____

aa. Will Applicant provide oversight, Care Coordination, transition planning and management for Members receiving Behavioral Health services, including Mental Health Rehabilitative Services and Personal Care Services, in licensed and non-licensed home and Community-based settings, ensuring that individuals who no longer need placement in such settings are transitioned to a Community placement in the most integrated Community setting appropriate for that person?

☒Yes ☐No

If "no" please provide explanation: _____

_____

bb. Will Applicant provide Utilization Review and utilization management, for Members receiving Behavioral Health Services, including Mental Health Rehabilitative Services and Personal Care Services, in licensed and non-licensed home and Community-based settings, ensuring that individuals who no longer need placement in such setting transition to the most integrated Community setting, Supported Housing to the extent possible, consistent with the individual's treatment goals, clinical needs, and the individual's informed choice?

☒Yes ☐No

If "no" please provide explanation: _____

_____

cc. Will Applicant encourage utilization of Peer-Delivered Services (PDS) and ensure that Members are informed of their benefit to access and receive PDS from a Peer Support Specialist, Peer Wellness Specialist, Family Support Specialist, or Youth Support Specialist as applicable to the Member's diagnosis and needs?

☒Yes ☐No

If "no" please provide explanation: _____

_____

dd. Will Applicant ensure that Members with SPMI receive Intensive Care Coordination (ICC) support in finding appropriate housing and receive coordination in addressing Member's housing needs?

☒Yes ☐No

If "no" please provide explanation: _____

_____

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

☒Yes ☐No

If "no" please provide explanation: _____

_____

ff. Will Applicant ensure ACT services are provided for all adult Members with SPMI who are referred to and eligible for ACT services in accordance with OAR 309-019-0105 and 309-019-0225 through 309-019-0255?

☒Yes ☐No

If "no" please provide explanation: _____

_____

gg. Will Applicant ensure additional ACT capacity is created to serve adult Members with SPMI as services are needed?

☒Yes ☐No

If "no" please provide explanation: _____

_____

hh. Will Applicant, when ten (10) or more of Applicant's adult Members with SPMI in Applicant's Service Area are on a waitlist to receive ACT for more than thirty (30) days, without limiting other Applicant solutions, create additional capacity by either increasing existing ACT team capacity to a size that is still consistent with Fidelity standards or by adding additional ACT teams?

☒Yes ☐No

If "no" please provide explanation: _____

_____

If Applicant lacks qualified Providers to provide ACT services, will Applicant consult with OHA and develop a plan to develop additional qualified Providers? Will lack of capacity not be a reason to allow individuals who are determined to be eligible for ACT to remain on the waitlist? Will no individual on a waitlist for ACT services be without such services for more than 30 days?

☒Yes ☐No

If "no" please provide explanation: _____

_____

ii. Will Applicant ensure all denials of ACT services for all adult Members with SPMI are: based on established, evidence-based medical necessity criteria; reviewed, recorded and compiled in a manner that allows denials to be accurately reported out as appropriate or inappropriate; and follow the Notice of Adverse Benefit Determination process for all denials as described in the Contract?

☒Yes ☐No

If "no" please provide explanation: _____

_____

jj. Will Applicant be responsible for finding or creating a team to serve Members who have appropriately received a denial for a particular ACT team but who meet ACT eligibility standards?

☒Yes ☐No

If "no" please provide explanation: _____

_____

kk. Will Applicant be responsible for engaging with all eligible Members who decline to participate in ACT in an attempt to identify and overcome barriers to the Member's participation?

☒Yes ☐No

If "no" please provide explanation: _____

_____

ll. Will Applicant require that a Provider or care coordinator meets with the Member to discuss ACT services and provide information to support the Member in making an informed decision regarding participation? Will this include a description of ACT services and how to access them, an explanation of the role of the ACT team and how supports can be individualized based on the Member's self-identified needs, and ways that ACT can enhance a Member's care and support independent Community living?

☒Yes ☐No

If "no" please provide explanation: _____

_____

mm. Will Applicant provide alternative evidence-based intensive services if Member continues to decline participation in ACT, which must include coordination with an ICC?

☒Yes ☐No

If "no" please provide explanation: _____

_____

nn. Will Applicant report the number of individuals referred to ACT, number of individuals admitted to ACT programs, number of denials for the ACT benefit, number of denials to ACT programs, and number of individuals on waitlist by month?

☒Yes ☐No

If "no" please provide explanation: _____

_____

oo. Will Applicant ensure a Member discharged from OSH who is appropriate for ACT shall receive ACT or an evidence-based alternative?

☒Yes ☐No

If "no" please provide explanation: _____

_____

pp. Will Applicant document efforts to provide ACT to individuals who initially refuse ACT services, and document all efforts to accommodate their concerns?

☒Yes ☐No

If "no" please provide explanation: _____

_____

qq. Will Applicant offer alternative evidence-based intensive services for individuals discharged from OSH who refuse ACT services?

☒Yes ☐No

If "no" please provide explanation: _____

_____

rr. Will Applicant ensure a Member discharged from OSH who is determined not to meet the level of care for ACT shall be discharged with services appropriate to meet their needs?

☒Yes ☐No

If "no" please provide explanation: _____

_____

ss. Will Applicant coordinate with system partners as needed regarding Oregon State Hospital discharges for all adult Members with SPMI in accordance with OAR 309-091-0000 through 0050?

☒Yes ☐No

If "no" please provide explanation: _____

_____

tt. Will Applicant ensure access to Supported Employment Services for all adult Members eligible for these services, in accordance with OAR 309-019-0275 through 309-019-0295? ("Supported Employment Services" means the same as "Individual Placement and Support (IPS) Supported Employment Services" as defined in OAR 309-019-0225.)

☒Yes ☐No

If "no" please provide explanation: _____

_____

uu. Will Applicant work with local law enforcement and jail staff to develop strategies to reduce contacts between Members and law enforcement due to Behavioral Health reasons, including reduction in arrests, jail admissions, lengths of stay in jails and recidivism?

☒Yes ☐No

If "no" please provide explanation: _____

_____

vv. Will Applicant work with SRTFs to expeditiously move civilly committed adult Members with SPMI who no longer need placement in an SRTF to a Community placement in the most integrated setting, Supported Housing to the extent possible, consistent with the individual's treatment goals, clinical needs, and the individual's informed choice?

☒Yes ☐No

If "no" please provide explanation: _____

_____

ww. Will Applicant provide Substance Use Disorder (SUD) services to Members, which include outpatient, intensive outpatient, medication assisted treatment including Opiate Substitution Services, residential and detoxification treatment services consistent with OAR Chapter 309, Divisions 18, 19 and 22, and OAR Chapter 415 Divisions 20, and 50?

☒Yes ☐No

If "no" please provide explanation: _____

_____

xx. Will Applicant comply with Substance Use Disorder (SUD) waiver program designed to improve access to high quality, clinically appropriate treatment for opioid use disorder and other SUDs, upon approval by Centers for Medicare and Medicaid Services (CMS)?

☒Yes ☐No

If "no" please provide explanation: _____

_____

yy. Will Applicant inform all Members using Culturally Responsive and linguistically appropriate means that Substance Use Disorder outpatient, intensive outpatient, residential, detoxification and medication assisted treatment services, including opiate substitution treatment, are Covered Services consistent with OAR 410-141-3300?

☒Yes ☐No

If "no" please provide explanation: _____

_____

zz. Will Applicant participate with OHA in a review of OHA provided data about the impact of these criteria on service quality, cost, outcome, and access?

☒Yes ☐No

If "no" please provide explanation: _____

_____

5. Children and Youth

a. Will Applicant develop and implement cost-effective comprehensive, person-centered, individualized, and integrated Community-based Child and Youth Behavioral Health services for Members, using System of Care (SOC) principles?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Will Applicant utilize evidence-based Behavioral Health interventions for the needs of children 0-5, and their caregivers, with indications of Adverse Childhood Experiences (ACEs) and high complexity?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Will Applicant provide Intensive Care Coordination (ICC) that is Family and youth-driven, strengths based and Culturally Responsive and linguistically appropriate and abide by ICC standards as set forth in Appendix C, Administrative Rules Concept under OHPB #24 and in accordance with the ICC section in the Contract? Will Applicant abide by ICC standards as forth in Appendix C, Administrative Rules Concept, under OHPB #24, and in accordance with the ICC section in the Contract?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Will Applicant provide services to children, young adults and families of sufficient frequency, duration, location, and type that are convenient to the youth and Family? Will Services alleviate crisis while allowing for the development of natural supports, skill development, normative activities and therapeutic resolution to Behavioral Health disorders and environmental conditions that may impact the remediation of a Behavioral Health disorder?

☒Yes ☐No

If "no" please provide explanation: _____

_____

e. Will Applicant adopt policies and guidelines for admission into Psychiatric Residential Treatment Services (PRTS), Psychiatric Day Treatment Services (PDTS) and/or Intensive Outpatient Services and Supports?

☒Yes ☐No

If "no" please provide explanation: _____

_____

f. Will Applicant ensure the availability of service, supports or alternatives 24 hours a day/7 days a week to remediate a Behavioral Health crisis in a non-emergency department setting?

☒Yes ☐No

If "no" please provide explanation: _____

_____

g. Will Applicant encourage utilization of Peer-Delivered Services (PDS) and ensure that Members are informed of their benefit to access and receive PDS from a Peer Support Specialist, Peer Wellness Specialist, Family Support Specialist, or Youth Support Specialist as applicable to the Member's diagnosis and needs?

☒Yes ☐No

If "no" please provide explanation: _____

_____

h. If Applicant identifies a Member is appropriate for LTPC Referral, will Applicant request a LTPC determination from the applicable HSD Child and Adolescent Mental Health Specialist, as described in Procedure for LTPC Determinations for Members 17 and Under, available on the Contract Reports Web Site?

☒Yes ☐No

If "no" please provide explanation: _____

_____

i. Will Applicant arrange for the provision of non-health related services, supports and activities that can be expected to improve a Behavioral Health condition?

☒Yes ☐No

If "no" please provide explanation: _____

_____

j. Will Applicant coordinate admissions to and discharges from Acute Inpatient Hospital Psychiatric Care and Sub-Acute Care for Members 17 and under, including Members in the care and custody of DHS Child Welfare or OYA? For a Member 17 and under, placed by DHS Child Welfare through a Voluntary Placement Agreement (CF 0499), will Applicant also coordinate with such Member's parent or legal guardian?

☒Yes ☐No

If "no" please provide explanation: _____

_____

k. Will Applicant ensure a CANS Oregon is administered to a Member who is a child or youth and the data is entered into OHA approved data system according to the eligibility and timeline criteria in the Contract?

☒Yes ☐No

If "no" please provide explanation: _____

_____

l. Will Applicant have funding and resources to implement, to fidelity, Wraparound Services?

☒Yes ☐No

If "no" please provide explanation: _____

_____

m. Will Applicant enroll all eligible youth in Wraparound and place no youth on a waitlist?

☒ Yes ☐No

If "no" please provide explanation: _____

_____

n. Will Applicant screen all eligible youth with a Wraparound Review Committee in accordance with Wraparound Services as described in the OHA System of Care Wraparound Initiative (SOCWI) guidance document found at the link below and in Wraparound Service OARs? http://www.oregon.gov/oha/hsd/amh/pages/index.aspx.

☒Yes ☐No

If "no" please provide explanation: _____

_____

o. Will Applicant establish and maintain a functional System of Care in its Service Area in accordance with the Best Practice Guide located at https://www.pdx.edu/ccf/best-practice-guide including a Practice Level Workgroup, Advisory Committee and Executive Council with a goal of youth and Family voice representation to be 51 percent?

☒Yes ☐No

If "no" please provide explanation: _____

_____

p. Will Applicant have a functional SOC governance structure by the beginning of CY 2020 that consists of a practice level work group, advisory council, and executive council?

☒Yes ☐No

If "no" please provide explanation: _____

_____

q. By end of CY 2020, will Applicant have written Charters and new Member handbooks for Practice Level Work group, Advisory Council and Executive Council?

☒Yes ☐No

If "no" please provide explanation: _____

_____

G. Cost and Financial Attestations (Attachment 12)

1. Rates

Does Applicant accept the CY 2020 Rate Methodology appended to Attachment 12?

☒Yes ☐No

If "no" please provide explanation: _____

_____

2. Evaluate CCO performance to inform CCO-specific profit margin

a. Does Applicant agree to performance and efficiency evaluation being used to set profit margins in CCO capitation rates?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Does Applicant agree to accept the CCO 2.0 capitation rate methodology as described in the Oregon CY20 Procurement Rate Methodology document and also accept the performance evaluation methodology and its use in setting CCO-specific profit margins?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Does Applicant agree to report additional data as needed to inform the performance evaluation process, including data on utilization of Health-Related Services?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to have OHA use efficiency analysis to support managed care efficiency adjustments that may result in adjustments to the base data used in capitation rate development to further incentivize reductions in Waste in the system?

☒Yes ☐No

If "no" please provide explanation: _____

_____

3. Qualified Directed Payments to Providers

a. Is Applicant willing to make OHA-directed payments to certain Hospitals within five Business Days after receipt of a monthly report prepared and distributed by OHA?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to report to OHA promptly if it determines payments to Hospitals will be significantly delayed?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to exclude the portion of OHA-directed payments for provider tax repayment when negotiating alternative or Value-Based Payment reimbursement arrangements?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to provide input and feedback to OHA on the selection of measures of quality and value for OHA-directed payments to Providers?

☒Yes ☐No

If "no" please provide explanation: _____

_____

4. Quality Pool Operations and Reporting

a. Does Applicant agree to having a portion of capitation withheld from monthly Capitation Payment and awarded to the Applicant based on performance on metrics based on the Quality Incentive Pool program?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Does Applicant agree to report to OHA separately on expenditures incurred based on Quality Pool revenue earned?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Does Applicant agree to report on the methodology it uses to distribute Quality Pool earnings to Providers, including SDOH-HE partners and public health partners?

☒Yes ☐No

If "no" please provide explanation: _____

_____

d. Does Applicant have a plan to evaluate contributions made by SDOH-HE and public health partners toward the achievement of Quality Pool metrics?

☒Yes ☐No

If "no" please provide explanation: _____

_____

5. Transparency in Pharmacy Benefit Management Contracts

a. Will Applicant select and contract with the Oregon Prescription Drug Program to provide Pharmacy Benefit Management services? If yes, please skip to section 5. If not, please answer parts b-f of this question.

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Will Applicant use a pharmacy benefit manager that will provide pharmacy cost passthrough at 100% and pass back 100% of rebates received to Applicant?

☐Yes ☐No

If "no" please provide explanation: _____

_____

c. Will Applicant separately report to OHA any and all administrative fees paid to its PBM?

☐ Yes ☐No

If "no" please provide explanation: _____

_____

d. Will Applicant require reporting from PBM that provides paid amounts for pharmacy costs at a claim level?

☐Yes ☐No

If "no" please provide explanation: _____

_____

e. Will Applicant obtain market check and audits of their PBMs by a third party on an annual basis, and share the results of the market check with the OHA?

☐Yes ☐No

If "no" please provide explanation: _____

_____

f. Will Applicant require its PBM to remain competitive with enforceable contract terms and conditions driven by the findings of the annual market check and report auditing?

☐Yes ☐No

If "no" please provide explanation: _____

_____

6. Alignment Preferred Drug Lists (PDLs) and Prior Authorization Criteria

a. Will Applicant partner with OHA on the goal of increasing the alignment of CCO preferred drug lists (PDL) with the Fee-For-Service PDL set every year by OHA?

☒Yes ☐No

If "no" please provide explanation: _____

_____

b. Will Applicant align its PDL in any and all categories of drugs as recommended by the P&T committee and as required by OHA?

☒Yes ☐No

If "no" please provide explanation: _____

_____

c. Will Applicant post online in a publicly accessible manner the Applicant's specific PDL with coverage and Prior Authorization criteria in a format designated by OHA and update the posting concurrently or before any changes to the PDL or coverage/PA criteria become effective?

☐Yes ☒No

If "no" please provide explanation: NWCCO will post its PDL coverage and prior authorization in a self prescribed format.

7. Financial Reporting Tools and Requirements

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

☒Yes ☐No

If "no" please provide explanation: _____

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

☒Yes ☐No

If "no" please provide explanation: _____

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

☒Yes ☐No

If "no" please provide explanation: _____

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

☒Yes ☐No

If "no" please provide explanation: _____

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

☒Yes ☐No

If "no" please provide explanation: _____

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

☒Yes ☐No

If "no" please provide explanation: _____

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

☒Yes ☐No

If "no" please provide explanation: _____

_____

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

☒Yes ☐No

If "no" please provide explanation: _____

_____

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

☒Yes ☐No

If "no" please provide explanation: _____

_____

8. Accountability to Oregon's Sustainable Growth Targets

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

☒Yes ☐No

If "no" please provide explanation: NWCCO commits to achieving sustainable growth in expenditures each calendar year equal or below target of 3.4% as long as uncontrollable costs are taken into consideration.

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

☒Yes ☐No

If "no" please provide explanation: _____

_____

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

☒Yes ☐No

If "no" please provide explanation: _____

_____

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

☒Yes ☐No

If "no" please provide explanation: _____

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

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

☒Yes ☐No

If "no" please provide explanation: NWCCO will participate in a fair and equitable program-wide reinsurance program after 2020.

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

☒Yes ☐No

If "no" please provide explanation: _____

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

☒Yes ☐No

If "no" please provide explanation: NWCCO agrees in concept. A complete understanding of the program including funding and coverage would need to be better understood.

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

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

☒Yes ☐No

If "no" please provide explanation: _____

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

☒Yes ☐No

If "no" please provide explanation: _____

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

☒Yes ☐No

If "no" please provide explanation: _____

_____

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

☒Yes ☐No

If "no" please provide explanation: _____

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

☒ Yes ☐No

If "no" please provide explanation: _____

11. Encounter Data Validation Study

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

☒Yes ☐No

If "no" please provide explanation: _____

_____

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

☒Yes ☐No

If "no" please provide explanation: _____

_____

H. Member Transition Plan (Attachment 16)

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

☒Yes ☐No

If "no" please provide explanation: _____

_____

moda HEALTH

Attachment 14 — Assurances

Applicant Name: Northwest Coordinated Care Organization

Authorizing Signature: _____

Printed Name: Robin Richardson

Instructions: Assurances focus on the Applicant's compliance with federal Medicaid law and related Oregon rules. For each assurance, Applicant will check "yes," or "no." A "yes" answer is normal, and an explanation will be furnished if Applicant's response is "no". Applicant must respond to all assurances. If an assurance has more than one question and Applicant's answer is "no" to any question, check "no" and provide an explanation.

These assurances must be signed by a representative of Applicant.

Each assurance is effective starting at the time of Readiness Review and continuing throughout the term of the Contract.

1. **Emergency and Urgent Care Services.** Will Applicant have written policies and procedures, and oversight and monitoring systems to ensure that emergency and urgent services are available for all Members on a 24-hour, 7-days-a-week basis? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? (See 42 CFR 438.114 and OAR 410-141-3140]

   ☒Yes ☐No

   If "no" please provide explanation: _____

2. **Continuity of Care.** Will Applicant implement written policies and procedures that ensure a system for the coordination of care and the arrangement, tracking and documentation of all Referrals and Prior Authorizations to other Providers? Will Applicant follow Intensive Care Coordination (ICC)/ENCC standards and Care Coordination standards, including transition meetings, as directed in OAR 410-141-3170? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.208 and OAR 410-141-3160]

   ☒Yes ☐No

   If "no" please provide explanation: _____

3. Will Applicant implement written policies and procedures that ensure maintenance of a record keeping system that includes maintaining the privacy and security of records as required by the Health Insurance Portability and Accountability Act (HIPAA), 42 USC § 1320-d et seq., and the federal regulations implementing the Act, and complete Clinical Records that document the care received by Members from the Applicant's Primary Care and Referral Providers? Will Applicants communicate these policies and procedures to Participating Providers, regularly monitor Participating Providers' compliance with these policies and procedures and take any Corrective Action necessary to ensure Participating Provider compliance? Will Applicants document all monitoring and Corrective Action activities? Will such policies and procedures will ensure that records are secured, safeguarded and stored in accordance with applicable Law? [See 45 CFR Parts 160 – 164, 42 CFR 438.242, ORS 414.679 and OAR 410-141-3180]

   ☒Yes ☐No

   If "no" please provide explanation: _____

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

☒Yes ☐No

If "no" please provide explanation: _____

_____

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

☒Yes ☐No

If "no" please provide explanation: _____

_____

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

☒Yes ☐No

If "no" please provide explanation: _____

_____

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

☒Yes ☐No

If "no" please provide explanation: _____

_____

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

☒Yes ☐No

If "no" please provide explanation: _____

_____

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

☒Yes ☐No

If "no" please provide explanation: _____

_____

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

☒Yes ☐No

If "no" please provide explanation: _____

_____

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

☒Yes ☐No

If "no" please provide explanation: _____

_____

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

☒Yes ☐No

If "no" please provide explanation: _____

_____

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

☒Yes ☐No

If "no" please provide explanation: _____

_____

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

☒Yes ☐No

If "no" please provide explanation: _____

_____

15. Assurances of Compliance with Medicaid Regulations

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

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

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

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

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

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

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

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

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

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

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

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

We have provided a separate document titled "Assurances of Compliance with Medicaid Regulations" per instructions in Addendum 5 with our response.

Attachment 15 — Representations

Applicant Name: Northwest Coordinated Care Organization

Authorizing Signature: _____

Printed Name: Robin Richardson

Instructions: For each representation, Applicant will check "yes," or "no,". On representations, no particular answer is normal, and an explanation will be furnished in all cases. Applicant must respond to all representations.

These representations must be signed by a representative of Applicant.

Each representation is effective starting at the time of Readiness Review and continuing throughout the term of the Contract.

1. Will Applicant have an administrative or management contract with a contractor to manage/handle all staffing needs with regards to the operation of all or a portion of the CCO program?

☒ Yes ☐ No

Explanation: Yes, we will have administrative agreements with one or more affiliates to manage staffing and operations for all CCO program functions.

2. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the systems or information technology to operate the CCO program for Applicant?

☒ Yes ☐ No

Explanation: Yes, we will have an administrative agreement with our affiliate to manage system and information technology to operate the CCO program.

3. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the claims administration, processing and/or adjudication functions?

☒ Yes ☐ No

Explanation: Yes, we will have administrative agreements with one or more affiliates to perform all claims administration, processing and adjudication functions.

4. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the Enrollment, Disenrollment and membership functions?

☒ Yes ☐ No

Explanation: Yes, we will have an administrative agreement with our affiliate to perform all enrollment, disenrollment and membership functions.

5. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the credentialing functions?

☒Yes ☐ No

Explanation: Yes, we will have administrative agreements with one or more affiliates to perform all credentialing functions.

6. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the utilization operations management?

☒Yes ☐ No

Explanation: Yes, we will have administrative agreements with one or more affiliates to perform all utilization operations management.

7. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the Quality Improvement operations?

☒Yes ☐ No

Explanation: Yes, we will have an administrative agreement with our affiliate to perform all Quality Improvement operations.

8. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of its call center operations?

☒Yes ☐ No

Explanation: Yes, we will have an administrative agreement with our affiliate to perform all call center operations.

9. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the financial services?

☒Yes ☐ No

Explanation: Yes, we will have an administrative agreement with our affiliate to perform all financial services.

10. Will Applicant have an administrative or management contract with a contractor to delegate all or a portion of other services that are not listed?

☒Yes ☐ No

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

ODSCH will perform all medical administration including all corporate functions for NWCCO such as staffing, information technology, claims, enrollment, credentialing, utilization management, quality improvement, compliance, customer service, encounter data, data analytics, actuarial, financial, legal, etc. GOBHI will provide all behavioral health administration.

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

☒Yes ☐ No

Explanation: Yes, NWCCO intends to subcontract with entities to perform Dental administration, Pharmacy/PBM administration, NEMT administration, high tech imaging utilization management and dialysis utilization management.

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

☒Yes ☐ No

Explanation: NWCCO will have a value based payment arrangement with its affiliate/equity partner, GOBHI for behavioral health services. GOBHI will receive a capitated premium for these services and will share in both upside and downside financial risk for this benefit.

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: NWCCO affiliates ODS Community Health, Inc. and GOBHI are equity partners and administrators of EOCCO which currently holds a 2019 CCO contract with OHA.

ATTACHMENT 16 — MEMBER TRANSITION PLAN

1. Background and Supporting Sources

As described in Section 5.8 Member Enrollment, OHA will hold an Open Enrollment period for Members in Choice Areas of the state. Members in these areas may move from their current plan to another plan during the Open Enrollment period. For purposes of its Application, Applicant should assume that all of its service areas will be Choice Areas.

The Member Transition Plan should describe the process for the safe and orderly transfer of Members to another CCO and receiving Members from another CCO during the Open Enrollment period and how the plan will maximize and maintain continuity of care for Members. This includes, but is not limited to, continuity of care with primary and specialty care Providers, primary care and Behavioral Health homes, plans of care, Prior Authorizations, prescription medications, medical Case Management Services, and Transportation.

The Member Transition Plan should include specific processes for Members who may suffer serious detriment to their physical and mental health or who are at-risk of hospitalization or institutionalization, if any breakdown in service provisions or access to care were to occur, including services provided by Practitioners that may not be contracted with the new CCO. OHA considers these populations to include, but not limited to:

- **Prioritized Populations;**
- **Medically fragile children;**
- **Breast and Cervical Cancer Treatment program Members;**
- **Members receiving CareAssist assistance due to HIV/AIDS;**
- **Members receiving services for end stage renal disease, prenatal or postpartum care, transplant services, radiation, or chemotherapy services;**
- **Members discharged from the Oregon State Hospital or Medicaid funded residential Behavioral Health programs in the last 12 calendar months; and**
- **Members participating in Oregon's CMS approved 1915 (k) and 1915 (c) programs for individuals who have met institutional level of care requirements in order to access Home and Community- Based Services (HCBS) under these federal authorities. These individuals are at risk of institutionalization or would require services in an institution within 30 days. Institution is defined as Hospital, Nursing Facility or intermediate care facility for individuals with intellectual disabilities.**

A successful Member Transition Plan will result in a seamless transition experience for Members changing CCOs during the Open Enrollment period, with minimal and ideally no disruptions of care.

OHA will inform Applicants, in connection with RFA awards, which of its service areas are likely to be Choice Areas. In light of that information, Applicants are expected to submit a complete Member Transition Plan (not subject to the page limits of this RFA), gain OHA approval of its Plan, and update the Plan as part of negotiation activities, contracting, and Open Enrollment period processes.

2. Plan Contents

a. Coordination between Transferring and Receiving CCOs

OHA expects the Transferring and Receiving CCOs to work together and cooperate to achieve a successful transition for Members who change CCO during the Open Enrollment period.

This section should describe the Applicant's plan to coordinate with other CCOs as the Transferring and/or Receiving CCO. This include but is not limited to establishing working relationships and agreements between CCOs to facilitate data sharing and validation, Member Prior Authorization history, Provider matching and Assignment, continuity of care and customer support.

b. Transferring CCOs with Outgoing Members

This section of the Member Transition Plan is required if Applicant (1) has a 2019 CCO contract, (2) is a risk-accepting entity or Affiliate of a 2019 CCO, or (3) has a management services agreement with or is under common management with a 2019 CCO.

NWCCO currently does not have any membership in 2019 to transfer data to another CCO for 1/1/2020. However, NWCCO is dedicated to ensuring a smooth transition for all members by providing continued access to care while a member is transitioning from/to NWCCO to/from another CCO at any point after 1/1/2020. NWCCO will provide medically necessary covered services and care coordination, without delay, during a member's transition. This includes prioritized populations and all members transferring to and from one CCO to another. NWCCO is also dedicated to providing input, followed by compliance with Oregon Health Authority (OHA) ruling on the Transition of Care, determined through the collaboration of the CCO Operations Collaborative Meeting, associated workgroups and ultimately, the final rule from OHA.

(1) Data Sharing

This section should describe the plan to compile and share electronic health information regarding the Member, their treatment and services. Include data elements to be shared, formatting and transmittal methods, and staffing/resource plans to facilitate data transfers to the Receiving CCO(s).

From a data sharing perspective, NWCCO is flexible and has a robust analytics team and software that has the ability to provide reporting to a receiving CCO. As required, through collaboration with the receiving CCO, NWCCO will execute required written and/or legal agreements necessary to transfer data. This is to ensure the protection and safe transmission of Protected Health Information (PHI).

NWCCO is able to pull customized reports and provide historical data for all services provided to NWCCO members. As proposed by OHA to the CCOs in

November 2018, as a result of the OHA Transition of Care Survey to CCO, NWCCO is able to provide the requirements outlined below. This would be a starting point in the discussion with the receiving CCO and NWCCO may be able to be adjusted to suit the needs of the receiving CCO. NWCCO will comply with all request from the receiving CCO for complete historical utilization data within 21 calendar days of the member's effective date with the receiving CCO.

Member ID
Member Name
DOB
Address
Phone
ALL diagnosis codes
CPT codes
PCP and treating provider
Claim status (paid/denied CARC code)
Rendering Provider NPI and name
Referring Provider NPI and name
Date of Service
Place of Service
ICD-10 Code
Service code (CPT,HCPC,REV)
Service code description
ED utilization
Hospitalizations
Utilization of behavioral or mental health services
Pharmacy claims data—both via pharmacy claims and PADs
Medical claims—especially for these receiving services for ESRD, transplant services, radiation, chemotherapy services, prenatal or postpartum care
Members receiving CareAssist services and associated covered medications
Recent Dental claims
Existing Authorizations—both physical and pharmacy with the duration of the existing PA, specialist services
Any current authorizations in place by previous CCO
Psychological Trauma History

In addition to the requirements outlined above, NWCCO is able to provide data on non-emergent medical transportation rides and information on members accessing case management services.

NWCCO is able to format the data in other formats, as discussed and agreed upon with the receiving CCO. Some examples are ASCII text file formatted in pipe delimited format, SQL, or Excel.

Transmission of the agreed upon data can be passed to the receiving CCO through an upload to an SFTP server, through secure email or other channels identified by the receiving CCO.

Staffing will be allocated based on the size of the transfer population. However, on all transfer requests, the Medicaid Services Supervisor and Medicaid Services Provider Relations Rep for NWCCO will be direct points of contact for the receiving CCO. Collaborative meetings will include these two participants and other staff, as necessary and defined by the scope of the receiving CCO requests. This includes technical assistance with file transfers or data validation.

(2) Provider Matching

This section should describe the methods for identifying Members' primary care and Behavioral Health home Providers and any specialty Providers, and transmitting that information to the Receiving CCO(s).

NWCCO will provide the PCP and treating provider information, which will include Behavioral Health home Providers, as outlined in the table in the data sharing section. As desired by the receiving CCO, NWCCO can provide the PCP assignment history as well.

(3) Continuity of Care

This section should describe plans to support Member continuity of care, including but not limited to Prior Authorizations, prescription medications, medical Case Management Services, and Transportation. This section should include all Members regardless of health status with specific details to address those Members at risk as described in Section (1).

NWCCO is dedicated to support the continuity of care. Through providing the information outlined in the table the data sharing section, establishing single points of contact and by collaborating on the specific needs of the receiving CCO, NWCCO will support the continuity of care of outgoing members.

(4) Member/Provider Outreach for Transition Activities

This section should describe plans to work directly with outgoing Members and their Providers to perform Warm Handoff activities for high-need Members and other specific Member groups identified as requiring additional support during the transition. This includes, but is not limited to, helping Members and Providers understand the coverage in place and the plan for transition of care, monitoring the transition of care to identify and address issues during the transition process, and collaborating with stakeholders and the Receiving CCO to ensure a seamless transition of care for the Member.

NWCCO's care coordinators, care managers and staff will support outgoing Members and their Providers and will conduct Warn Handoff activities for high-need Members and priority populations. This member population will be discussed with the receiving CCO, through the collaborative meetings. Meetings will be scheduled on a regular interval to address any concerns or to address any issues prior, during and after the transition.

c. Receiving CCOs with Incoming Members

(1) Data Sharing

This section should describe the data reception plan for incoming Members, including but not limited to receiving and storing data files, front-end validation, system entry, output validation, and distribution.

NWCCO will request collaborative meetings with the transferring CCO to identify the data capabilities, formats, timelines for transfer and set a meeting schedule that spans beyond the transition period.

NWCCO has a robust analytics team and software that has the ability to load incoming data and transforms it via an automated process to match the file format, naming convention and business logic used in the Analytics Data Warehouse (ADW).

NWCCO has secure processes and IT staff that will securely store data files, perform front-end validation and automatically load the data into our system and ADW. NWCCO has pre-established methods of sharing data with some partners. This transfer would follow current processes and file formats established partners.

(2) Provider Matching

This section should describe the methods for identifying Members' primary care and Behavioral Health home Providers and any specialty Providers, and enrolling Members with their assigned Providers. This includes contingency plans for assigning Members to appropriate Providers if they cannot be enrolled with the Provider from the Transferring CCO.

NWCCO would request data from the transferring CCO that our analytics team would be able to identify the Member's primary care provider, Behavioral Health Home and any specialty providers. NWCCO would assign members to their current PCP and Behavioral Health home to promote continuity of care.

NWCCO would allow services without referral and authorization for the first 30 days of enrollment for physical and oral health, sixty days for behavioral health or until the enrollee's new provider review's the member's treatment plan, whichever comes first. There will be a 90 days allowance for members who are Medicare and Medicaid Dual Eligible Members.

If a Member is unable to be enrolled with the provider from the transferring CCO, member outreach will be conducted to assist member's selecting a new provider. These members will be identified through analytics reporting.

(3) Continuity of Care

This section should describe plans to support Member continuity of care, including but not limited to honoring Prior Authorizations, prescription medications, and Treatment Plans from the Transferring CCO, medical Case Management Services, and Transportation. This section should address the approach for all Members regardless of health status with specific details to address those persons described in Section (1). As the receiving CCO, the plan

should address how the Receiving CCO will ensure access to all medically necessary services for Members at risk of serious detriment to their physical and mental health, hospitalization, or institutionalization.

NWCCO is dedicated to support Member continuity of care. As outlined in OAR 410-141-3061, NWCCO will waive referral and authorization requests systemically, for the necessary timeframes, based on service type. This will assist in ensuring access to all medically necessary services for members at risk of serious detriment. Additionally, through the data request from the transferring CCO, our analytics team would be able to auto load referral and prior authorization, including prescription medications, for members.

Priority populations will be identified by requesting data on members that are in case management from the transferring CCO. Additionally, our analytics team will identify members in the priority populations and NWCCO care coordinators, case managers, member health advocates and/or health coaches will contact priority population members, based on diagnosis drivers. These calls will assist in identifying the specific member needs and providing for the appropriate care plans to be established, if not already sent by the transferring CCO.

Through the collaboration meeting with the transferring CCO, a request for an in-person or call with the case management team to discuss critical cases would be requested. This meeting would be to discuss specific details of a case that are not in the data or that simply needs to be done with a voice, from one case manager to another that can be lost in an email or in data.

(4) Member/Provider Outreach for Transition Activities

This section should describe plans to work directly with incoming Members and their Providers to perform Warm Handoff activities for high-need Members and other specific Member groups identified as requiring additional support during the transition. This includes, but is not limited to, helping Members and Providers understand the coverage in place and the plan for transition of care, monitoring the transition of care to identify and address issues during the transition process, and collaborating with stakeholders and the Transferring CCO to ensure a seamless transition of care for the Member.

NWCCO's care coordinators, care managers, member health advocates and/or health coaches will support incoming Members and their Providers and will conduct Warm Handoff activities, in collaboration with the transferring CCO, for high-need Members and priority populations. This member population will be discussed with the transferring CCO, through the collaborative meetings. Meetings will be scheduled on a regular interval to address any concerns or to address any issues prior, during and after the transition.

The care coordinators, care managers, member health advocates, and/or health coaches will work directly with Members and their Providers to assist in explaining benefits and coverage, assist in provider network navigation and also support for social services and community resources available based on the member's health condition and psychosocial factors.

NWCCO CCO 2.0 DSN Report

This report has been redacted per ORS 192.355(2)