Note: Since tribal consultation, the name Communities of Care Organizations (CCO) has been changed to Regional Care Organization (RCO). This change was made based on stakeholder feedback that CCO could be confusing due to the presence of two other major Oklahoma health organizations that also use the acronym CCO. Thus, references to CCO have been changed to RCO.

- Will tribes be included in the goal of 80% CCO participation?
    - We have a goal of 80% of state purchased healthcare payments to be value-based by 2020. State purchased includes Medicaid and the Employee Group Insurance Division. We would like the tribes to be included in this goal, but the mechanism and methodology will most likely look very different for tribal payments than for others in the system due to the nature of tribal Medicaid reimbursements. We are currently in talks with members and experts of various Oklahoma tribal health systems to determine precisely how tribes can best fit into this model.

- Will the model reflect the trust responsibility of the federal government?
    - Yes. During the waiver negotiations we will need to outline how this responsibility with the federal government is upheld through the model and ensure that the paramount importance of the trust responsibility is emphasized in all other negotiations that may arise during the implementation of this model.

- Will the model allow for tribal governance of a RCO either alone or in partnership?
    - Yes. With the tribal networks being a vital part of Oklahoma's healthcare ecosystem, our goal is to enable tribes to either partner in or be a RCO.

- How will the tribes be affected by the attribution model?
    - During the formation of the attribution process, this will be a key point to address. However, the SIM model has not reached that point of specificity at this time. This issue will be a point of discussion in our conversations with tribal health system experts.

- Will the model adjust payments for rural areas?
    - Yes. Many factors will influence the per-member-per-month payments from the RCO. Of those, a common adjustment is geographic location.

- How will the resources that are available to patients to utilize in one region be taken into account when judging the results of patient outcomes? The resources available to patients in Okemah are not as great as those for our patients in Koweta; this will affect the outcomes of health for some of those patients – how can this be judged fairly for the providers?
    - To account for regional variation in access, services available and other important determinants of health, we are looking to have regional benchmarking to set goals that can reflect these different environments in which healthcare is provided. This will enable region specific targets and benchmarking. We are looking to engage participants on how best to account for these regional variations.

- By developing RCOs will more services be available to tribal members?
    - We envision RCOs will allow more flexibility of spending to address regional variations and adapt to specific circumstances. Therefore, there is a possibility that more or different services can be provided by the local RCO than are currently enabled by the

statewide model. One such example we commonly see in other states is payment for housing assessments and mold remediation that are currently not considered "medically necessary" even though they have a major impact on a person's health status.

- Will this eliminate the need for contract health/purchase and referred services?
    - There is a possibility that the payment methodology and requirements put on RCOs for certification to operate in Oklahoma will reduce the need for contract health/purchase services. This is a topic we will be discussing with our tribal partners as the process moves forward, with the goal in mind that tribal systems' limited resources should be protected or enhanced as best as possible.

- How will this affect the tribal urban clinics?
    - We are currently in discussions with Oklahoma tribal health systems to discuss the effects this might have on tribal urban clinics and how we can ensure care for tribal members will be improved.

- With a global system, will the reimbursement rates for tribal agencies change?
    - Our goal is to protect any enhanced rate providers receive today. Tribal systems are unique in that they are reimbursed the OMB rate. We will work with tribal partners to determine how best to account for that reimbursement methodology in any payment changes we propose.

- How will you coordinate with Indian Health Service on this model?
    - As we move forward with this model, we will be required to coordinate with all HHS agencies involved in this model, including Indian Health Services. We will have discussions specific to IHS to determine the model's effect, if any, on IHS.

- If we move to this model, how will the OHCA be integrated?
    - As Oklahoma's Single State Agency for Medicaid, if we move to this model OHCA will be the administrator for RCOs for Medicaid members just as they are for the current SoonerCare Choice program.

- How will this be funded?
    - Funding will likely be from many different sources. The SIM team is identifying funding sources from federal, state, and private enterprises to carry out this model. We will be working closely with our CMS partners to identify programs and opportunities to advance the Oklahoma SIM.

- How will the payment structure (AIR) change for those of us who are IHS/Tribes/Urban clinics/facilities?
    - Please see above.

- Will this new program fall in line with the CMS VBP program we are already subjected to?
    - We are working with CMS to find ways for the RCO to be compliant with the new MACRA regulations and align with the Medicare alternate payment models so that burden on providers and system administrators is greatly reduced.

- Have we done any projections on standing the model up and the impact it will have on Oklahomans? If so may we receive a copy?
    - We are currently awaiting the results of a financial forecast from our actuary, Milliman. This should give an impact on overall costs as well as outcomes to be expected from the RCO model. This will be available in March and will be shared with all parties and posted publicly on our website.

- Attribution models with tribes need to be well understood by the Health Department and considered. Please remember that many of our patients are from out of state.
    - Thank you for keeping this at the forefront of our planning. We will continue to assess how attribution will be managed with tribal members and ensure an equitable process is in place.

- Quality measures, please align with CMS measures as best you can.
    - Thank you for this comment. We are work to align quality measures with several payers, including CMS, to ensure provider and administrative burden is reduced.

- Caution – tribal OMB rates and payment structure does not cost our state except for administration costs.
    - Thank you for this comment. We will keep this in mind during our planning.