ATTACHMENT 1 – Application Cover Sheet

Applicant Information - RFA # 3402

Applicant Name: PacificSource Community Solutions, Inc.

Form of Legal Entity (business corporation, etc.) Corporation

State of domicile: Oregon

Primary Contact Person: Rhonda Busek Title: Director of Medicaid Programs

Address: 110 International Way

City, State, Zip: Springfield, OR 97478

Telephone: Direct Line: 541-225-3782 Fax: 541-225-3690

E-mail Address: rbusek@pacificsource.com

Name and title of the person(s) authorized to represent the Applicant in any negotiations and sign any Contract that may result:

Name: Kenneth P. Provencher Title: President and Chief Executive Officer

By signing this page and submitting an Application, the Authorized Representative certifies that the following statements are true:

1. Applicant does not discriminate in its employment practices with regard to race, creed, age, religious affiliation, sex, disability, sexual orientation or national origin, nor has Applicant or will Applicant discriminate against a subcontractor in the awarding of a subcontract because the subcontractor is a minority, women or emerging small business enterprise certified under ORS 200.055.
2. Information and costs included in this Application will remain valid for 180 days after the Application due date or until a Contract is approved, whichever comes first.
3. The statements contained in this Application are true and, so far as is relevant to the Application, complete. Applicant accepts as a condition of the Contract, the obligation to comply with the applicable state and federal requirements, policies, standards, and regulations.
4. The undersigned recognizes that this is a public document and will become open to public inspection, except as described in Section 7.8.
5. Applicant has followed the instructions provided and has identified any deviations from specifications within its response. Applicant confirms that any instructions or specifications that it felt were unclear have been questioned in advance of this Application.
6. Applicant acknowledges receipt of all addenda issued under this RFA, as listed on OHA's web portal.
7. If awarded a Contract, Applicant will be required to complete, and will be bound by, a Contract described in this RFA. Applicant agrees to the Core Contract terms and conditions in Appendix G, except to the extent Applicant has timely requested a change or clarification or filed a protest in accordance with the RFA.
8. If awarded a Contract, Applicant will meet the highest standards prevalent among Medicaid health plans in Oregon.
9. Applicant and its Affiliates complied with the Code of Conduct in Section 7.15 of the RFA in connection with the RFA.
10. Applicant accepts the terms and conditions for OHA's web portal, as posted on the web portal.
11. Applicant will negotiate in good faith regarding the statement of work for the Contract.

Signature: Title: President/CEO Date: 4/30/12

(Authorized to Bind Applicant)

ATTACHMENT 6 – ATTESTATIONS, ASSURANCES AND REPRESENTATIONS

Applicant Name: PacificSource Community Solutions, Inc.

Instructions: For each attestation, assurance or descriptive representation below, Applicant will check "yes," "no," or "qualified." On attestations and assurances, a "yes" answer is normal, and an explanation will be furnished if Applicant's response is "no" or "qualified." On informational representations, no particular answer is normal, and an explanation will be furnished in all cases. Applicant must respond to all attestations, assurances, and informational representations. The table headings indicate if an item is an attestation, assurance, or informational representation.

These attestations, assurances, and informational representations must be signed by one or more representatives of Applicant who have knowledge of them after due inquiry. They may be signed in multiple counterparts, with different representatives of Applicant signing different counterparts.

Unless a particular item is expressly effective at the time of Application, each attestation, assurance or informational representation is effective starting at the time of readiness review and continuing throughout the term of the Contract.

Attestations for Appendix A – CCO Criteria

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
Attestation A-1. Applicant will have an individual accountable for each of the following operational functions: • 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 • 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	✓			

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
• Privacy officer • Compliance officer				
Attestation A-2. Applicant will participate in the learning collaboratives required by ORS 442.210.	✓			
Attestation A-3. Applicant will collect, maintain and analyze race, ethnicity, and primary language 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.	✓			

Attestations for Appendix B – Provider Participation and Operations Questionnaire

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
Attestation B-1. Applicant will, as demonstrated with policies and procedures, (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 in accordance with OAR 410-141-0070.	✓			
Attestation B-2. Applicant will 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.	✓			
Attestation B-3. Applicant will assure that all provider and supplier contracts or agreements contain the required contract provisions that are described in the Contract.	✓			
Attestation B-4. Applicant will have executed provider, facility, and supplier contracts in place to demonstrate adequate access and availability of	✓			

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
Covered Services throughout the requested service area.				
Attestation B-5. Applicant will have all provider contracts or agreements available upon request.	✓			
Attestation B-6. As Applicant implements, acquires, or upgrades health information technology (HIT) systems, where available, the HIT systems and products will meet standards and implementation specifications adopted under section 3004 of the Public Health Services Act as added by section 13101 of the American Recovery and Reinvestment Act of 2009, P.L. 111-5.			✓	PacificSource Community Solutions will work with contracted providers to implement HIT and EMRs as appropriate per state regulations.
Attestation B-7. Applicant's contracts for administrative and management services will contain the OHA required contract provisions.	✓			
Attestation B-8. Applicant will establish, maintain, and monitor the performance of a comprehensive network of providers to assure sufficient access to Medicaid Covered 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.	✓			
Attestation B-9. Applicant will have executed written agreements with providers (first tier, downstream, or related entity instruments) structured in compliance with OHA regulations and guidelines.	✓			
Attestation B-10. Applicant, through its contracted or deemed Participating Provider network, along with other specialists outside the network, community resources or social services within the CCO's service area, will provide ongoing primary care and specialty care as needed and guarantee the continuity of care and the integration of services through: • Prompt, convenient, and appropriate access to Covered Services by enrollees 24 hours a day, 7 days a week; • The coordination of the individual care needs of enrollees in accordance with policies and procedures as established by the Applicant; • Enrollee involvement in decisions regarding treatment, proper education on treatment options, and the coordination of follow-up care;	✓			

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
• Effectively addressing and overcoming barriers to enrollee compliance with prescribed treatments and regimens; and • Addressing diverse patient populations in a culturally competent manner.				
Attestation B-11. Applicant will establish policies, procedures, and standards that: • Assure 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 enrollees; • Promptly and efficiently coordinate and facilitate access to clinical information by all providers involved in delivering the individualized care plan of the enrollee; • Communicate and enforce compliance by providers with medical necessity determinations; and • Do not discriminate against Medicaid enrollees, including providing services to individuals with disabilities in the most integrated setting appropriate to the needs of those individuals.	✓			
Attestation B-12. Applicant will 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.	✓			
Attestation B-13. Applicant will provide all services covered by Medicaid and comply with OHA coverage determinations.	✓			
Attestation B-14. Applicant, Applicant staff and its affiliated companies, subsidiaries or subcontractors (first tier, downstream, and related entities), and subcontractor staff will 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	✓			

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
tier, downstream, and related entities).				
Attestation B-15. 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 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.	✓			

Medicaid Assurances for Appendix B – Provider Participation and Operations Questionnaire

Assurance B-1. Emergency and Urgent Care Services. Applicant will have written policies and procedures and monitoring systems that provide for emergency and urgent services for all Members on a 24-hour, 7-days-a-week 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 438.114 and OAR 410-141-3140]	✓			
Assurance B-2. Continuity of Care. Applicant will have 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. 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 438.208 and OAR 410-141-3160]	✓			
Assurance B-3. Applicant will have 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. Applicants will 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. Applicants will document all monitoring and Corrective Action activities. 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]				
Assurance B-4. Applicant will have an ongoing quality performance improvement program for the services it furnishes to its Members. The program will 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 42 CFR 438.200 and 438.240; OAR 410-141-0200]			✓	Currently, PacificSource Community Solutions has a robust QI program and will incorporate race, ethnicity, and language demographics into outcomes tracking.
Assurance B-5. Applicant will make Coordinated Care Services accessible to enrolled Members. The Applicant will not discriminate between Members and non-Members as it relates to benefits to which they are both entitled. 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 438.206 to 438.210; and OAR 410-141-3220]	✓			
Assurance B-6. Applicant will 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 G "Core Contract". 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 438.228, 438.400 – 438.424; and OAR 410-141-3260 to 410-141-3266]	✓			
Assurance B-7. Applicant will develop and distribute informational materials to potential Members that meet the language and alternative format	✓			

requirements of potential Members. 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 438.10; OAR 410-141-3280]				
Assurance B-8. Applicant will have an on-going process of Member education and information sharing that includes appropriate orientation to the Applicant, Member handbook, health education, availability of intensive care coordination for Members who are aged, blind and/or disabled and appropriate use of emergency facilities and urgent care. 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 438.10; and OAR 410-141-3300]	✓			
Assurance B-9. Applicant will 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 Attachment 4, Core Contract. 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 438.100, ORS 414.635 and OAR 410-141-3320]	✓			
Assurance B-10. Applicants will provide Intensive Care Coordination (otherwise known as Exceptional Needs Care Coordination or ENCC) to Members who are Aged, Blind or Disabled. 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 438.208 and OAR 410-141-3405]	✓			
Assurance B-11. Applicant will 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. The Applicant and its providers will not hold Members responsible for the Applicants or providers debt if the entity becomes insolvent. The Applicant will 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 and OAR 410-141-0420]	✓			

Assurance B-12. Applicant will 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. Applicant has 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. The Applicant will 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 45 CFR Part 162; OAR 943-120-0100 to 943-120-0200]	✓			
Assurance B-13. Applicant will maintain an efficient and accurate system for capturing encounter data, timely reporting the encounter data to OHA, and validating 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. The Applicant will 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 438.242; and the Contract]	✓			
Assurance B-14. Applicant will 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. The Applicant will 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 438.242 and 438.604; and Contract]	✓			

Informational Representations for Appendix B – Provider Participation and Operations Questionnaire

Informational Representation	Yes	No	Yes, Qualified	Explanation
Representation B-1. 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.	✓			PacificSource Community Solutions will have contracts with related entities, contractors, and subcontractors to perform, implement or operate any aspect of the CCO operations for the CCO. As the CCO fully develops, appropriate entities will be identified to contract with for appropriate delegated functions.
Representation B-2. Applicant has an administrative or management contract with a delegated entity to manage/handle all staffing needs with regards to the operation of all or a portion of the CCO program.		✓		PacificSource Community Solutions will not delegate the management of staffing needs with regards to the operation of all or a portion of the CCO program. PacificSource Community Solutions, Inc. has an Administrative Services Agreement with PacificSource Health Plans, which includes a leasing of employees.

Informational Representation	Yes	No	Yes, Qualified	Explanation
Representation B-3. Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the systems or information technology to operate the CCO program for Applicant.			✓	PacificSource Community Solutions may delegate all or a portion of the systems or information technology to operate the CCO program. It is the expectation of PacificSource Community Solutions that the IT systems for those CCO functions that are delegated to outside entities will be maintained by the entity that is delegated. All other IT systems and supports that are relevant to the functions that PacificSource Community Solutions has not delegated will be performed by PacificSource Community Solutions.
Representation B-4. Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the claims administration, processing and/or adjudication functions.	✓			PacificSource Community Solutions will contract with a delegated entity to perform claims administration, processing, and/or adjudication functions.
Representation B-5. Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the Enrollment, Disenrollment and membership functions.	✓			PacificSource Community Solutions will contract with a delegated entity to perform Enrollment, Disenrollment, and membership functions.

Informational Representation	Yes	No	Yes, Qualified	Explanation
Representation B-6. Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the credentialing functions.	✓			PacificSource Community Solutions will contract with a delegated entity to perform a portion of the credentialing functions. PacificSource Community Solutions, Inc. has an Administrative Services Agreement with PacificSource Health Plans, which includes a leasing of employees.
Representation B-7. Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the utilization operations management.	✓			PacificSource Community Solutions will contract with a delegated entity to perform a portion of the utilization operations management in relation to mental health and chemical dependency. PacificSource Community Solutions, Inc. has an Administrative Services Agreement with PacificSource Health Plans, which includes a leasing of employees.

Informational Representation	Yes	No	Yes, Qualified	Explanation
Representation B-8. Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the Quality Improvement operations.		✓		PacificSource will not be delegating any of the QI Operations related to the CCO. PacificSource Community Solutions, Inc. has an Administrative Services Agreement with PacificSource Health Plans, which includes a leasing of employees.
Representation B-9. Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of its call center operations.	✓			PacificSource Community Solutions will contract with a delegated entity to perform call center operations.
Representation B-10. Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the financial services.		✓		PacificSource Community Solutions will not delegate any financial functions. PacificSource Community Solutions, Inc. has an Administrative Services Agreement with PacificSource Health Plans, which includes a leasing of employees.

Informational Representation	Yes	No	Yes, Qualified	Explanation
Representation B-11. Applicant will have an administrative or management contract with a delegated entity to delegate all or a portion of other services that are not listed.			✓	PacificSource Community Solutions will contract with related entities, contractors, and subcontractors to perform, implement or operate any aspect of the CCO Operations of the CCO Contract as they are identified and as appropriate.

(Applicant Authorized Officer)
Signature: _____ Title: President/CEO Date: 4/30/12

ATTACHMENT 7 –APPLICATION CHECKLISTS

The checklist presented in this Attachment 7 is provided to assist Applicants in ensuring that Applicant submits a complete Technical Application and Financial Application that will satisfy the pass/fail requirements for an Application submission in accordance with RFA section 6.1.2.

1. Technical Application, Mandatory Submission Materials

☒ **a.** Application Cover Sheet (Attachment 1)

☒ **b.** Attestations, Assurances and Representations (Attachment 6).

☒ **c.** This Technical Application Checklist

☒ **d.** Letters of Support from Key Community Stakeholders.

☒ **e.** Résumés for Key Leadership Personnel.

☒ **f.** Organizational Chart.

☒ **g.** Services Area Request (Appendix B).

h. Questionnaires

☒ **(1)** CCO Criteria Questionnaire (Appendix A).

☒ **(2)** Provider Participation and Operations Questionnaire (Appendix B).

☒ **(3)** Accountability Questionnaire (Appendix C)

☒ • Services Area Table.

☒ • Publicly Funded Health Care and Service Programs Table

☒ **(4)** Medicare/Medicaid Alignment Demonstration Questionnaire (Appendix D).[§]

2. Technical Application, Optional Submission Materials

If Applicant elects to submit the following optional Application materials, the materials must be submitted with the Technical Proposal:

☒ **a.** Transformation Scope Elements (Appendix H).

☐ **b.** Applicant's Designation of Confidential Materials (Attachment 2).

[§] For the 1st Application date, Appendix D responses are not due until May 14, 2012.

3. **Financial Application, Mandatory Submission Materials**

APPENDIX E

- ☐ **a.** Certified copy of the Applicant's articles of incorporation.
- ☐ **b.** Listing of ownership or sponsorship.
- ☐ **c.** Chart or listing presenting the identities of and interrelationships between the parent, the Applicant.
- ☐ **d.** Current financial statements.
- ☐ **e.** Contractual verification of all owners of entity.
- ☐ **f.** Guarantee documents.
- ☐ **g.** Developmental budget.
- **h.** Operational budget.
- ☐ **i.** Monthly staffing plan.
- ☐ **j.** Pro Forma Projections for the First Five Years.
- ☐ **k.** Quarterly developmental budget.
- ☐ **l.** Quarterly operational expenses.
- ☐ **m.** Reinsurance policy.

APPENDIX F

- ☐ **a.** Base Cost Template

From: Cheryl Hukill
To: Rhonda Busek
Subject: copy of letter that was mailed to you yesterday
Date: Friday, April 27, 2012 8:49:07 AM
Attachments: image001.png

Here is the copy of the lette

Klamath County Commissioners

Al Switzer, *Commissioner* Position One | Dennis Linthicum, *Commissioner* Position Two | Cheryl Hukill, *Commissioner* Position Three

April 26, 2012

Pacific Source Community Health Plans, Inc.
Rhonda Busek
110 International Way
Springfield, Oregon 97477

Dear Ms. Busek:

The Klamath County Board of Commissioners have approved a Letter of Support for:

- Pacific Source
- Cascade Comprehensive Care
- Greater Oregon Behavioral Health Inc.

We support these organizations and their applications for becoming Coordinated Care Organizations in Klamath County.

Enclosed with this letter is this link to the public meetings where this issue was discussed and then voted on during a work session on April 25, 2012. (http://www.viddler.com/v/253fa7ad)

Other public meetings are online (http://www.viddler.com/profile/klamathcounty) and were held on April 6, 2012 and April 24, 2012 . However, video titles do not necessarily reflect the content with regard to special topics covering CCO's.

We thank these organizations for their devotion in continuing to care for Klamath County.

Sincerely,

Dennis Linthicum,
Chair

Cheryl Hukill,
Vice-Chair

Al Switzer,
Commissioner

305 Main Street, Klamath Falls, Oregon 97601
Phone: (541) 883-5100 | Fax: (541) 883-5103 | Email: bocc@co.klamath.or.us

r of support that was mailed to you yesterday.

JEFFERSON COUNTY

COMMISSION ON CHILDREN AND FAMILIES

715 SW 4th Street, Suite A • Madras, Oregon 97741 • Ph: (541)-325-5040 • Fax: (541) 475-4878

April 30, 2012

Tammy L. Hurst, Contract Specialist
Office of Contracts and Procurement
Sole Point of Contact, RFA 3402
250 Winter Street NE, 3rd Floor
Salem, Oregon 97301

RE: Letter of support for PacificSource Community Solutions Coordinated Care Organization for Central Oregon

Dear Ms. Hurst:

The Jefferson County Commission on Children and Families supports PacificSource Community Solution's application for a Coordinated Care Organization in Central Oregon which would include Deschutes County, Crook County, Jefferson County, and specific zip codes in Klamath County. It is anticipated that other organizations may be added after additional discussion including Grant County and Harney County, and specific zip codes in Lake County and Wheeler County. These discussions are pending as of the date of this application.

Our endorsement also comes with recognition and understanding that this development in Central Oregon must include collaboration through the Central Oregon Health Board and with our counties as local mental health and public health authorities. We fully expect these roles will continue throughout the next six years of CCO operation, working in partnership with the Health Council and PacificSource as our regional named CCO. We are confident that this continued collaborative work, bridging the involvement of all interest groups, will yield health benefits to our region's resident.

PacificSource Community Solutions has a strong community presence and commitment to improving health care outcomes in the communities it serves. PacificSource is an active community partner with a focus on provision of care that improves health outcomes and reduces medical costs that align with the objectives of HB 3650 and SB 1580.

In its varied experience as a health services contractor for commercial products, Medicaid products, and Medicare products, PacificSource is ideally suited to be the primary agent of Health System Transformation through integration and coordination of health care for the community including physical health, addictions and mental health services, and oral health care with a focus on prevention.

The Jefferson County Commission on Children and Families expects that the development of a local community health care system through the PacificSource Community Solutions Coordinated Care

Organization will bring significant value and improvement to the overall population health of Central Oregon.

The proposed application is aligned with the needs of our community and we expect a positive impact on the following;

- ✓ Improvement in health outcomes leading to improved population health.
- ✓ Improvement in health outcomes for those members experiencing health disparities.
- ✓ Accountability for the provision of integrated care.
- ✓ Improvement in quality of care within the community.
- ✓ Delivery of cost-effective care that will reduce health care costs overall.

Please accept this letter as formal recognition of the value of this application in helping Central Oregon improve population health, increase member satisfaction, and reduce the cost of health care.

Sincerely,

Ron Mulke,
Jefferson County CCF Board Chair

BESTCARE
TREATMENT SERVICES

541-504-9577 • Fax 541-504-2361
P. O Box 1710 • 676 Negus Way • Redmond, OR 97756

April 30, 2012

Tammy L. Hurst, Contract Specialist
Office of Contracts and Procurement
Sole Point of Contact, RFA 3402
250 Winter Street NE, 3rd Floor
Salem, Oregon 97301

RE: Letter of support for PacificSource Community Solutions Coordinated Care Organization for Central Oregon

Dear Ms. Hurst:

BestCare Treatment Services, Inc. would like to indicate our support of PacificSource Community Solution's application for a Coordinated Care Organization in Central Oregon which would include Deschutes County, Crook County, Jefferson County, and specific zip codes in Klamath County. It is anticipated that other organizations may be added after additional discussion including Grant County and Harney County, and specific zip codes in Lake County and Wheeler County. These discussions are pending as of the date of this application.

PacificSource Community Solutions has a strong community presence and commitment to improving health care outcomes in the communities it serves. PacificSource is an active community partner with a focus on provision of care that improves health outcomes and reduces medical costs that align with the objectives of HB 3650 and SB 1580.

In its varied experience as a health services contractor for commercial products, Medicaid products, and Medicare products, PacificSource is ideally suited to be the primary agent of Health System Transformation through integration and coordination of health care for the community including physical health, addictions and mental health services, and oral health care with a focus on prevention.

BestCare Treatment Services, Inc. expects that the development of a local community health care system through the PacificSource Community Solutions Coordinated Care Organization will bring significant value and improvement to the overall population health of Central Oregon.

The proposed application is aligned with the needs of our community and we expect a positive impact on the following;

- ✓ Improvement in health outcomes leading to improved population health.
- ✓ Improvement in health outcomes for those members experiencing health disparities.
- ✓ Accountability for the provision of integrated care.
- ✓ Improvement in quality of care within the community.
- ✓ Delivery of cost-effective care that will reduce health care costs overall.

Please accept this letter as formal recognition of the value of this application in helping Central Oregon improve population health, increase member satisfaction, and reduce the cost of health care.

Sincerely,

Rick Treleaven, LCSW
Executive Director

Central Oregon Health Council

April 30, 2012

Tammy L. Hurst, Contract Specialist
Office of Contracts and Procurement
Sole Point of Contact, RFA 3402
250 Winter Street NE, 3rd Floor
Salem, Oregon 97301

RE: Letter of support for PacificSource Community Solutions Coordinated Care Organization for Central Oregon

Dear Ms. Hurst:

The Central Oregon Health Council would like to indicate our support of PacificSource Community Solution's application for a Coordinated Care Organization in Central Oregon which would include Deschutes County, Crook County, Jefferson County, and specific zip codes in Klamath County. It is anticipated that other organizations may be added after additional discussion including Grant County and Harney County, and specific zip codes in Lake County and Wheeler County. These discussions are pending as of the date of this application.

Our endorsement also comes with recognition and understanding that this development in Central Oregon must include our collaboration as the Central Oregon Health Council and with our counties as local mental health and public health authorities. We fully expect to continue in these roles throughout the next six years of CCO operation, working in partnership with the Health Council and with PacificSource as our regional named CCO. We are confident our work together, bridging the involvement of all interest groups, will yield excellent health benefits to our region's residents.

PacificSource Community Solutions has a strong community presence and commitment to improving health care outcomes in the communities it serves. PacificSource is an active community partner with a focus on provision of care that improves health outcomes and reduces medical costs that align with the objectives of HB 3650 and SB 1580.

In its varied experience as a health services contractor for commercial products, Medicaid products, and Medicare products, PacificSource is ideally suited to be the primary agent of Health System Transformation through integration and coordination of health care for the community including physical health, addictions and mental

health services, and oral health care with a focus on prevention.

The Central Oregon Health Council expects that the development of a local community health care system through the PacificSource Community Solutions Coordinated Care Organization will bring significant value and improvement to the overall population health of Central Oregon.

The proposed application is aligned with the needs of our community and we expect a positive impact on the following;

- ✓ Improvement in health outcomes leading to improved population health.
- ✓ Improvement in health outcomes for those members experiencing health disparities.
- ✓ Accountability for the provision of integrated care.
- ✓ Improvement in quality of care within the community.
- ✓ Delivery of cost-effective care that will reduce health care costs overall.

Please accept this letter as formal recognition of the value of this application in helping Central Oregon improve population health, increase member satisfaction, and reduce the cost of health care.

Sincerely,
The Central Oregon Health Council

Tammy Baney, Commissioner Deschutes County

Jim Diegel, President and Chief Executive Officer
St. Charles Health System

Mike Ahern, Commissioner Jefferson County

Ken Fahlgren, Commissioner Crook County

Chuck Frazier, Citizen Representative

Linda McCoy, Citizen Representative

Stephen Mann, DO, COIPA

Dan Stevens, Senior VP of Government, Pacific Source Health Plans

CROOK COUNTY COMMISSION ON CHILDREN AND FAMILIES

April 26, 2012

Tammy L. Hurst, Contract Specialist
Office of Contracts and Procurement
Sole Point of Contact, RFA 3402
250 Winter Street NE, 3rd Floor
Salem, Oregon 97301

RE: Letter of support for PacificSource Community Health Plans Coordinated Care Organization for Central Oregon

Dear Ms. Hurst:

Crook County Commission on Children and Families would like to offer this letter of support for the PacificSource Community Health Plan's application to serve as a Coordinated Care Organization in Central Oregon, including service in a region that includes Deschutes County, Crook County, Jefferson County, and specific zip codes in Klamath County. It is anticipated that other counties may be added after additional discussion including Grant County, Harney County, and specific zip codes in Lake and Wheeler Counties. As Commission Director, I am actively involved in the Central Oregon Health Board, an affiliate to the Central Oregon Health Council and support the expectation that the Council will assure community governance and oversight for our CCO.

This endorsement also comes with recognition and understanding that CCO development in Central Oregon must include collaboration with county governments as local mental health and public health authorities. It is expected that these roles will be continued through the next six years of CCO operation, working in partnership with the Health Council and with PacificSource as our regional named CCO. We are confident our work together will yield excellent health benefits to our region's residents.

PacificSource Community Health Plans is ideally suited to serve as the CCO and to work with the Health Council as the primary agent of Central Oregon's Health System Transformation through integration and coordination of health care for the community including physical health, addictions and mental health services, and oral health care with a focus on prevention. They are an active community partner with a focus on provision of care that improves health outcomes and reduces medical costs that align with the objectives of HB 3650 and SB 1580.

The proposed application is aligned with the needs of our community. We expect a positive impact on:

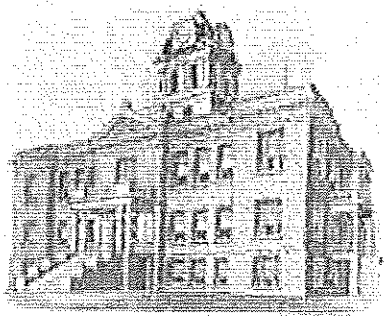
- Improvement in health outcomes leading to improved population health.
- Improvement in health outcomes for those members experiencing health disparities.
- Accountability for the provision of integrated care.
- Improvement in quality of care within the community.
- Delivery of cost-effective care that will reduce health care costs overall.

The Crook County Commission on Children and Families expects that the development of a local community health care system through the work of the Central Oregon Health Board, Central Oregon Health Council and the PacificSource Community Health Plan Coordinated Care Organization will bring significant value and improvement to the overall population health of Central Oregon.

Please accept this letter as formal recognition of the value of this application in helping Central Oregon improve population health, increase member satisfaction, and reduce the cost of health care.

Sincerely,

Brenda Comini,
Director



Crook County

300 N.E. 3rd Street • Prineville, Oregon 97754
Phone (541) 447-6555 • FAX (541) 416-3891

April 30, 2012

Tammy L. Hurst, Contract Specialist
Office of Contracts and Procurement
Sole Point of Contact, RFA 3402
250 Winter Street NE, 3rd Floor
Salem, Oregon 97301

RE: Letter of support for PacificSource Community Solutions Coordinated Care Organization for Central Oregon

Dear Ms. Hurst:

The Crook County Court would like to indicate our support of PacificSource Community Solution's application for a Coordinated Care Organization in Central Oregon which would include Deschutes County, Crook County, Jefferson County, and specific zip codes in Klamath County. It is anticipated that other organizations may be added after additional discussion including Grant County and Harney County, and specific zip codes in Lake County and Wheeler County. These discussions are pending as of the date of this application.

PacificSource Community Solutions has a strong community presence and commitment to improving health care outcomes in the communities it serves. PacificSource is an active community partner with a focus on provision of care that improves health outcomes and reduces medical costs that align with the objectives of HB 3650 and SB 1580.

In its varied experience as a health services contractor for commercial products, Medicaid products, and Medicare products, PacificSource is ideally suited to be the primary agent of Health System Transformation through integration and coordination of health care for the community including physical health, addictions and mental health services, and oral health care with a focus on prevention.

The Crook County Court expects that the development of a local community health care system through the PacificSource Community Solutions Coordinated Care Organization will bring significant value and improvement to the overall population health of Central Oregon.

The proposed application is aligned with the needs of our community and we expect a positive impact on the following;

- ✓ Improvement in health outcomes leading to improved population health.
- ✓ Improvement in health outcomes for those members experiencing health disparities.
- ✓ Accountability for the provision of integrated care.
- ✓ Improvement in quality of care within the community.
- ✓ Delivery of cost-effective care that will reduce health care costs overall.

Please accept this letter as formal recognition of the value of this application in helping Central Oregon improve population health, increase member satisfaction, and reduce the cost of health care.

Sincerely,

Mike McCabe
Crook County Judge

DESCHUTES COUNTY
CHILDREN & FAMILIES
COMMISSION

TOGETHER WE FIND SOLUTIONS

1130 NW Harriman
Suite A
Bend, OR 97701
ph: 541 385-1717
www.deschutes.org/ccf

April 30, 2012

Tammy L. Hurst, Contract Specialist
Office of Contracts and Procurement
Sole Point of Contact, RFA 3402
250 Winter Street NE, 3rd Floor
Salem, Oregon 97301

RE: Letter of support for PacificSource Community Solutions Coordinated Care Organization for Central Oregon

Dear Ms. Hurst:

On behalf of the Deschutes County Children and Families Commission, we are writing this letter in full support of PacificSource Community Solution's application for a Coordinated Care Organization in Central Oregon which would include Deschutes County, Crook County, Jefferson County, and specific zip codes in Klamath County. It is anticipated that other organizations will be added after additional discussion including Grant County and Harney County, and specific zip codes in Lake County and Wheeler County. These discussions are pending as of the date of this application.

PacificSource Community Solutions has a strong community presence and commitment to improving health care outcomes in the communities it serves. PacificSource is an active community partner with a focus on provision of care that improves health outcomes and reduces medical costs that align with the objectives of HB 3650 and SB 1580.

In its varied experience as a health services contractor for commercial products, Medicaid products, and Medicare products, the PacificSource is ideally suited to be the primary agent of Health System Transformation through integration and coordination of health care for the community including physical health, addictions, and mental health services, and oral health care with a focus on prevention.

The Deschutes County Children and Families Commission expects that the development of a local community health care system through the PacificSource Community Solutions Coordinated Care Organization will bring significant value and improvement to the overall population health of Central Oregon.

The proposed application is aligned with the needs of our community and we expect a positive impact on the following.

- Improvement in health outcomes leading to improved population health.
- Improvement in health outcomes for those experiencing health disparities.
- Accountability for the provision of integrated care.
- Improvement in quality of care within the community.
- Delivery of cost-effective care that will reduce health costs.

DESCHUTES COUNTY
CHILDREN & FAMILIES
COMMISSION

TOGETHER WE FIND SOLUTIONS

1130 NW Harriman
Suite A
Bend, OR 97701
ph: 541 385-1717
www.deschutes.org/ccf

Please accept this letter as formal support and recognition of the value of this application in helping Central Oregon to improve health outcomes, to increase satisfaction among those receiving care, and to reduce the overall cost of health care in our region.

Sincerely,

William H. Davidson, CFC Chair

Hillary Saraceno, CFC Director

DESCHUTES COUNTY

HEALTH SERVICES

2577 NE Courtney Drive • Bend, Oregon 97701
Public Health (541) 322-7400 • FAX (541) 322-7465
Behavioral Health (541) 322-7500 • FAX (541) 322-7565
www.deschutes.org

April 25, 2012

Tammy L. Hurst, Contract Specialist
Office of Contracts and Procurement
Sole Point of Contact, RFA 3402
250 Winter Street NE, 3rd Floor
Salem, Oregon 97301

RE: Letter of support for PacificSource Community Solutions Coordinated Care Organization for Central Oregon

Dear Ms. Hurst:

Deschutes County Health Services would like to indicate our support of PacificSource Community Solution's application for a Coordinated Care Organization in Central Oregon which would include Deschutes County, Crook County, Jefferson County, and specific zip codes in Klamath County. It is anticipated that other organizations may be added after additional discussion including Grant County and Harney County, and specific zip codes in Lake County and Wheeler County. These discussions are pending as of the date of this application.

PacificSource Community Solutions has a strong community presence and commitment to improving health care outcomes in the communities it serves. PacificSource is an active community partner with a focus on provision of care that improves health outcomes and reduces medical costs that align with the objectives of HB 3650 and SB 1580.

In its varied experience as a health services contractor for commercial products, Medicaid products, and Medicare products, PacificSource is ideally suited to be the primary agent of Health System Transformation through integration and coordination of health care for the community including physical health, addictions and mental health services, and oral health care with a focus on prevention.

Deschutes County Health Services expects that the development of a local community health care system through the Central Oregon Health Council as the community governance entity working in partnership will the PacificSource Community Solutions as our Coordinated Care Organization will bring significant value and improvement to the overall population health of Central Oregon. The proposed application is aligned with the needs of our community and we expect a positive impact on the following;

- Improvement in health outcomes leading to improved population health.
- Improvement in health outcomes for those members experiencing health disparities.
- Accountability for the provision of integrated care.
- Improvement in quality of care within the community.
- Delivery of cost-effective care that will reduce health care costs overall.

Please accept this letter as formal recognition of the value of this application in helping Central Oregon improve population health, increase member satisfaction, and reduce the cost of health care.

Sincerely,

Scott Johnson
Director

\\ZEUS\katheh\MY DOCUMENTS\CORRESPONDENCE\2011-2012\LoS of PacificSource for CCO App.doc

JEFFERSON COUNTY
PUBLIC HEALTH DEPARTMENT

715 SW 4TH Street, Suite C • Madras, Oregon 97741 • Ph: (541) 475-4456 • FAX: (541) 475-0132

Dare: April 18, 2012

To: Tammy L. Hurst, Contract Specialist
Office of Contracts and Procurement
Sole Point of Contact, RFA 3402
250 Winter Street NE, 3rd Floor
Salem, Oregon 97301

From: Tom Machala, MPH, RN - Director

RE: Letter of support for PacificSource Community Solutions Coordinated Care Organization for Central Oregon

Dear Ms. Hurst:

Please be advised the Jefferson County Public Health Department supports PacificSource Community Solution's application for a Coordinated Care Organization in Central Oregon which would include Deschutes County, Crook County, Jefferson County, and specific zip codes in Klamath County. It is anticipated that other organizations may be added after additional discussion including Grant County and Harney County, and specific zip codes in Lake County and Wheeler County. These discussions are pending as of the date of this application.

This support comes through our active involvement in the development of the Central Oregon Health Board and Central Oregon Health Council and with the expectation that the Council will assure community governance and oversight for our CCO. We believe this program will help Central Oregon improve population health, increase member satisfaction and reduce the cost of health care.

Our endorsement also comes with recognition and understanding that this development in Central Oregon must include our collaboration as the Jefferson County Public Health Authority. We fully expect to continue in this role throughout the next six years of CCO operation, working in partnership with the Health Council and with PacificSource as our regional named CCO. We are confident our work together, bridging the involvement of all interest groups, will yield excellent health benefits to our region's residents.

PacificSource Community Solutions has a strong community presence and commitment to improving health care outcomes in the communities it serves. PacificSource is an active community partner with a focus on provision of care that improves health outcomes and reduces medical costs that align with the objectives of HB 3650 and SB 1580.

In its varied experience as a health services contractor for commercial products, Medicaid products, and Medicare products, PacificSource is ideally suited to be the primary agent of Health System Transformation through integration and coordination of health care for the community including physical health, addictions and mental health services, and oral health care with a focus on prevention.

Jefferson County Public Health expects that the development of a local community health care system through the PacificSource Community Solutions Coordinated Care Organization will bring significant value and improvement to the overall population health of Central Oregon.

The proposed application is aligned with the needs of our community and we expect a positive impact on the following;

- ✓ Improvement in health outcomes leading to improved population health.
- ✓ Improvement in health outcomes for those members experiencing health disparities.
- ✓ Accountability for the provision of integrated care.
- ✓ Improvement in quality of care within the community.
- ✓ Delivery of cost-effective care that will reduce health care costs overall.

The Jefferson County Public Health Department expects the development of a local community health care system through the work of the local community in conjunction with the PacificSource Community Solutions will bring significant value and improvement to the overall population health of Central Oregon.

April 30, 2012

Tammy L. Hurst, Contract Specialist
Office of Contracts and Procurement
Sole Point of Contact, RFA 3402
250 Winter Street NE, 3rd Floor
Salem, Oregon 97301

LET'S TALK DIVERSITY
coalition
Building Community Strength Through Diversity

RE: Letter of support for PacificSource Community Solutions Coordinated Care Organization for Central Oregon

Dear Ms. Hurst:

The Let's Talk Diversity Coalition of Jefferson County and the Confederated Tribes of Warm Springs would like to indicate our support of PacificSource Community Solution's application for a Coordinated Care Organization in Central Oregon which would include Deschutes County, Crook County, Jefferson County, and specific zip codes in Klamath County. It is anticipated that other organizations may be added after additional discussion including Grant County and Harney County, and specific zip codes in Lake County and Wheeler County. These discussions are pending as of the date of this application.

PacificSource Community Solutions has a strong community presence and commitment to improving health care outcomes in the communities it serves. PacificSource is an active community partner with a focus on provision of care that improves health outcomes and reduces medical costs that align with the objectives of HB 3650 and SB 1580.

In its varied experience as a health services contractor for commercial products, Medicaid products, and Medicare products, PacificSource is ideally suited to be the primary agent of Health System Transformation through integration and coordination of health care for the community including physical health, addictions and mental health services, and oral health care with a focus on prevention.

The Let's Talk Diversity Coalition expects that the development of a local community health care system through the PacificSource Community Solutions Coordinated Care Organization will bring significant value and improvement to the overall population health of Central Oregon.

The proposed application is aligned with the needs of our community and we expect a positive impact on the following;

- ✓ Improvement in health outcomes leading to improved population health.
- ✓ Improvement in health outcomes for those members experiencing health disparities.
- ✓ Accountability for the provision of integrated care.
- ✓ Improvement in quality of care within the community.
- ✓ Delivery of cost-effective care that will reduce health care costs overall.

Please accept this letter as formal recognition of the value of this application in helping Central Oregon improve population health, increase member satisfaction, and reduce the cost of health care.

Sincerely,

Sonya Littledeer-Evans

Sonya Littledeer-Evans
Chair - Let's Talk Diversity Coalition

Lutheran Community Services
NORTHWEST
Health • Justice • Hope

365 NE Court Street
Prineville, OR 97754

Mental Health Counseling
Phone: 541/323-5330
Fax: 541/447-6694

Adult Alcohol & Drug Services
Phone: 541/323-5330
Fax: 541/416-0991

Developmental Disabilities Case Management
Phone: 541/323-5330
Fax: 541/447-6694

Web site: www.lcsnw.org

April 30, 2012

Tammy L. Hurst, Contract Specialist
Office of Contracts and Procurement
Sole Point of Contact, RFA 3402
250 Winter Street NE, 3rd Floor
Salem, Oregon 97301

RE: Letter of support for PacificSource Community Solutions Coordinated Care Organization for Central Oregon

Dear Ms. Hurst:

Crook County Mental Health would like to indicate our support of PacificSource Community Solution's application for a Coordinated Care Organization in Central Oregon which would include Deschutes County, Crook County, Jefferson County, and specific zip codes in Klamath County. It is anticipated that other organizations may be added after additional discussion including Grant County and Harney County, and specific zip codes in Lake County and Wheeler County. These discussions are pending as of the date of this application. This support comes with our active involvement in the Advisory Council and expectation that the Council will assure community governance and oversight for our CCO.

Our endorsement also comes with recognition and understanding that this development in Central Oregon must include our collaboration as the Crook County Mental Health agency and with our counties as local mental health and public health authorities. We fully expect to continue in this role throughout the next six years of CCO operation, working in partnership with the Health Council and with PacificSource as our regional named CCO. We are confident our work together, bridging the involvement of all interest groups, will yield excellent health benefits to our region's residents.

PacificSource Community Solutions has a strong community presence and commitment to improving health care outcomes in the communities it serves. PacificSource is an active community partner with a focus on provision of care that improves health outcomes and reduces medical costs that align with the objectives of HB 3650 and SB 1580.

A United Way Agency

COA

In its varied experience as a health services contractor for commercial products, Medicaid products, and Medicare products, PacificSource is ideally suited to be the primary agent of Health System Transformation through integration and coordination of health care for the community including physical health, addictions and mental health services, and oral health care with a focus on prevention.

Crook County Mental Health expects that the development of a local community health care system through the PacificSource Community Solutions Coordinated Care Organization will bring significant value and improvement to the overall population health of Central Oregon.

The proposed application is aligned with the needs of our community and we expect a positive impact on the following;

- Improvement in health outcomes leading to improved population health.
- Improvement in health outcomes for those members experiencing health disparities.
- Accountability for the provision of integrated care.
- Improvement in quality of care within the community.
- Delivery of cost-effective care that will reduce health care costs overall.

Please accept this letter as formal recognition of the value of this application in helping Central Oregon improve population health, increase member satisfaction, and reduce the cost of health care.

Sincerely,

Scott Willard
Area Director

MosaicMedical
Real People, Real Care.

www.mosaicmedical.org

April 30, 2012

Tammy L. Hurst, Contract Specialist
Office of Contracts and Procurement
Sole Point of Contact, RFA 3402
250 Winter Street NE, 3rd Floor
Salem, Oregon 97301

RE: Letter of support for PacificSource Community Solutions Coordinated Care Organization for Central Oregon

Dear Ms. Hurst:

Mosaic Medical would like to indicate our support of PacificSource Community Solution's application for a Coordinated Care Organization in Central Oregon which would include Deschutes County, Crook County, Jefferson County, and specific zip codes in Klamath County. It is anticipated that other organizations may be added after additional discussion including Grant County and Harney County, and specific zip codes in Lake County and Wheeler County. These discussions are pending as of the date of this application.

PacificSource Community Solutions has a strong community presence and commitment to improving health care outcomes in the communities it serves. PacificSource is an active community partner with a focus on provision of care that improves health outcomes and reduces medical costs that align with the objectives of HB 3650 and SB 1580.

In its varied experience as a health services contractor for commercial products, Medicaid products, and Medicare products, PacificSource is ideally suited to be the primary agent of Health System Transformation through integration and coordination of health care for the community including physical health, addictions and mental health services, and oral health care with a focus on prevention.

Mosaic Medical expects that the development of a local community health care system through the PacificSource Community Solutions Coordinated Care Organization will bring significant value and improvement to the overall population health of Central Oregon.

The proposed application is aligned with the needs of our community and we expect a positive impact on the following;

- ✓ Improvement in health outcomes leading to improved population health.
- ✓ Improvement in health outcomes for those members experiencing health disparities.

Prineville
375 NW Beaver Street, Suit. 101
Prineville, Oregon 97754
541-447-0707 PHONE

Bend
409 NE Greenwood Avenue, Suite 101
Bend, Oregon 97701
541-383-3005 PHONE

Madras
910 SW Hwy 97, Suite 101
Madras, Oregon 97741
541-475-7800 PHONE

- ✓ Accountability for the provision of integrated care.
- ✓ Improvement in quality of care within the community.
- ✓ Delivery of cost-effective care that will reduce health care costs overall.

Please accept this letter as formal recognition of the value of this application in helping Central Oregon improve population health, increase member satisfaction, and reduce the cost of health care.

Sincerely,

Megan Haase
CEO

St. Charles
HEALTH SYSTEM

2500 NE Neff Road
Bend, Oregon 97701
541.382.4321
www.stcharleshealthcare.org

April 30, 2012

Tammy L. Hurst, Contract Specialist
Office of Contracts and Procurement
Sole Point of Contact, RFA 3402
250 Winter Street NE
3rd Floor
Salem OR 97301

RE: Letter of support for PacificSource Community Solutions Coordinated Care Organization for Central Oregon

Dear Ms. Hurst:

St Charles Health System would like to offer our support of PacificSource Community Solution's application for a Coordinated Care Organization in Central Oregon which would include Deschutes County, Crook County, Jefferson County, and specific zip codes in Klamath County. It is anticipated that other organizations may be added after additional discussion including Grant County and Harney County, and specific zip codes in Lake County and Wheeler County. These discussions are pending as of the date of this application. As part of the Central Oregon Health Council, St Charles Health System supports this application in concert with the development of a Joint Management Agreement between PacificSource and the Central Oregon Health Council to manage the CCO in this region.

PacificSource Community Solutions has a strong community presence and commitment to improving health care outcomes in the communities it serves. PacificSource is an active community partner with a focus on provision of care that improves health outcomes and reduces medical costs that align with the objectives of HB 3650 and SB 1580 and has been an active member of the Central Oregon Health Council since its inception.

In its varied experience as a health services contractor for commercial products, Medicaid products, and Medicare products PacificSource Community Solutions is ideally suited to join with the Central Oregon Health Council and be part of Health System Transformation through integration and coordination of health care for the community including physical health, addictions and mental health services, and oral health care with a focus on prevention. St Charles Health System expects

that the development of a local community health care system through the Central Oregon Health Council's Joint Management Agreement with the PacificSource Community Solutions Coordinated Care Organization will bring significant value and improvement to the overall population health of Central Oregon.

The proposed application is aligned with the needs of our community and we expect a positive impact on the following;

- ✓ Improvement in health outcomes leading to improved population health.
- ✓ Improvement in health outcomes for those members experiencing health disparities.
- ✓ Accountability for the provision of integrated care.
- ✓ Improvement in quality of care within the community.
- ✓ Delivery of cost-effective care that will reduce health care costs overall.

Please accept this letter as formal recognition of the value of this application in helping Central Oregon improve population health, increase member satisfaction, and reduce the cost of health care.

Sincerely,

James A. Diegel, FACHE
President and CEO

Central Oregon Health Board

April 30, 2012

Tammy L. Hurst, Contract Specialist
Office of Contracts and Procurement
Sole Point of Contact, RFA 3402
250 Winter Street NE, 3rd Floor
Salem, Oregon 97301

RE: Letter of support for PacificSource Community Solutions Coordinated Care Organization for Central Oregon

Dear Ms. Hurst:

The Central Oregon Health Board would like to indicate our support of PacificSource Community Solution's application for a Coordinated Care Organization in Central Oregon which would include Deschutes County, Crook County, Jefferson County, and specific zip codes in Klamath County. It is anticipated that other organizations may be added after additional discussion including Grant County and Harney County, and specific zip codes in Lake County and Wheeler County. These discussions are pending as of the date of this application.

Our endorsement also comes with recognition and understanding that this development in Central Oregon must include our collaboration as the Central Oregon Health Board and with our counties as local mental health and public health authorities. We fully expect to continue in these roles throughout the next six years of CCO operation, working in partnership with the Health Board and with PacificSource as our regional named CCO. We are confident our work together, bridging the involvement of all interest groups, will yield excellent health benefits to our region's residents.

PacificSource Community Solutions has a strong community presence and commitment to improving health care outcomes in the communities it serves. PacificSource is an active community partner with a focus on provision of care that improves health outcomes and reduces medical costs that align with the objectives of HB 3650 and SB 1580.

In its varied experience as a health services contractor for commercial products, Medicaid products, and Medicare products, PacificSource is ideally suited to be the primary agent of Health System Transformation through integration and coordination of health care for the community including physical health, addictions and mental health services, and oral health with a focus on prevention.

The Central Oregon Health Board expects that the development of a local community health care system through the PacificSource Community Solutions Coordinated Care Organization will bring significant value and improvement to the overall population health of Central Oregon.

The proposed application is aligned with the needs of our community and we expect a positive impact on the following;

- ✓ Improvement in health outcomes leading to improved population health.
- ✓ Improvement in health outcomes for those members experiencing health disparities.
- ✓ Accountability for the provision of integrated care.
- ✓ Improvement in quality of care within the community.
- ✓ Delivery of cost-effective care that will reduce health care costs overall.

Please accept this letter as formal recognition of the value of this application in helping Central Oregon improve population health, increase member satisfaction, and reduce the cost of health care.

Sincerely,

The Central Oregon Health Board

Ken Fahlgren, Commissioner Crook County

Tammy Baney, Commissioner Deschutes County

Mike Ahern, Commissioner Jefferson County

cc: Crook County Court
Deschutes County Board of Commissioners
Jefferson County Board of Commissioners

CROOK COUNTY HEALTH DEPARTMENT
A Healthier Future for the People of Crook County
375 NW Beaver St., Suite 100 Prineville, OR 97754
Telephone: (541) 447-5165 Fax (541) 447-3093

DIVISIONS: Immunizations · Vital Statistics · Community Health Nursing · Maternal-Child Health · Family Planning · WIC · HIV/STD Communicable Disease · Public Health Preparedness · Healthy Start · Health Promotion Programs · School Based Health

April 30, 2012

Tammy L. Hurst, Contract Specialist
Office of Contracts and Procurement
Sole Point of Contact, RFA 3402
250 Winter Street NE, 3rd Floor
Salem, Oregon 97301

RE: Letter of Support for PacificSource Community Solutions Coordinated Care Organization for Central Oregon

Dear Ms. Hurst:

On behalf of the Crook County Health Department, I are writing this letter in full support of PacificSource Community Solution's application for a Coordinated Care Organization in Central Oregon which would include Deschutes County, Crook County, Jefferson County, and specific zip codes in Klamath County. It is anticipated that other organizations maybe added after additional discussion including Grant County and Harney County, and specific zip codes in Lake County and Wheeler County. These discussions are pending as of the date of this application.

This support comes with our active involvement in the Central Oregon Health Council and Central Oregon Health Board. It is our expectation that the Health Council will assure community governance and oversight for our CCO and that our CCO will in turn continue to develop a strong and mutually supportive planning, program development and contractual relationship with COHB and our participating counties.

Our endorsement also comes with recognition and understanding that this development in Central Oregon must include our collaboration as the Crook County Board of Commissioners and the CO Health Board and with our counties as local mental health and public health authorities. We fully expect to continue in these roles throughout the next six years of CCO operation, working in partnership with the Health Council and with PacificSource as our

regionally named CCO. We are confident our work together, bridging the involvement of all interest groups, will yield excellent health benefits to our region's residents.

PacificSource Community Solutions has a strong community presence and commitment to improving health care outcomes in the communities it serves. PacificSource is an active community partner with a focus on provision of care that improves health outcomes and reduces medical costs that align with the objectives of HB 3650 and SB 1580.

In its varied experience as a health services contractor for commercial products, Medicaid products, and Medicare products, PacificSource is ideally suited to serve as the CCO and to work with the Health Council as the primary agent of Central Oregon's Health System Transformation through integration and coordination of health care for the community including physical health, addictions and mental health services, and oral health care with a focus on prevention.

Crook County Health Department expects that the development of a local community health system through PacificSource Community Solutions Coordinated Care Organization will bring significant value, strong partnerships and coordination with our strong population based public health programs including tobacco prevention, WIC, reproductive health, immunizations, and community health nurses serving CaCoon children, pregnant women and children.

The proposed application is aligned with our region's needs. We expect a positive impact on the following:

- Improvement in health outcomes leading to improved population health.
- Improvement in health outcomes for those members experiencing health disparities.
- Accountability for the provision of integrated care.
- Improvement in quality of care within the community.
- Delivery of cost-effective care that will reduce health care costs overall.

Please accept this letter as formal recognition of the value of this application in helping Central Oregon improve population health, increase member satisfaction, and reduce the cost of health care.

Sincerely,

Muriel DeLaVergne-Brown, RN, MPHc, Public Health Director
Crook County Health Department
375 NW Beaver St., Suite 100
Prineville, Oregon 97754
541-447-5165

KENNETH P. PROVENCHER

2471 NW Michelle Drive
Corvallis, Oregon 97330
(541) 745-2069
kprovencher@pacificsource.com

EXPERIENCE

PACIFICSOURCE HEALTH PLANS, Eugene, OR
1995- Present

President & CEO (2001 - Present). Chief Executive for 280,000 member regional, not-for-profit health plan with 650 employees, revenues in excess of $1billion, and net worth of $160 million. The company provides Commercial, Medicare and Medicaid coverage and administration in Oregon, Idaho, Montana and Washington. Since 2001, the company has experienced considerable growth, change and expansion including six acquisitions and increases of 150% in members, 250% in net worth and 350% in revenues. During this period, the company has been an industry leader in service, innovation, public policy and community collaboration and has launched a progressive provider partnership model.

Also serve as CEO and President of PacificSource Administrators Inc, PacificSource Community Health Plans, Inc., PacificSource Community Solutions, Inc. and President of the PacificSource Charitable Foundation.

Acting President & CEO (2000 – 2001). Served as acting CEO for six months prior to being named CEO in March, 2001.

Vice President of Operations (1996 - 2000). Responsible for administration, direction and coordination of all aspects of operations. Major duties and accomplishments included:

- Administration and direction of claims, customer service, provider network management, and billing/membership departments.
- Coordination of all plan activities to ensure smooth and efficient operations and achievement of financial, growth and quality objectives. PacificSource consistently outperformed all major Oregon health plans in terms of profitability and growth.
- Direction of development and implementation of all new products, provider contracts, operational enhancements and market expansion. Successfully directed expansion efforts throughout the state of Oregon.
- Assisting Chief Executive Officer in the direction and coordination of strategic planning process and in investigating, evaluating, negotiating and implementing new business, acquisition and merger opportunities.

Provider Contracting Director (1995-1996). Responsibilities included:

- Provider network development, contracting and management to support both HMO and PPO products. Negotiated discounted fee-for-service, per diem, case rates, capitation and other risk-sharing arrangements.
- Direction of Provider Affairs Department responsible for provider relations, credentialing, profiling, electronic linkages, and provider database and fee schedule maintenance.

OREGON STATE UNIVERSITY, Corvallis, OR
1997 – 2005

Adjunct Instructor. Teach "Reimbursement Mechanisms" and "Contracting and Negotiations" courses in graduate and undergraduate Health Administration program.

VHA UPSTATE NEW YORK, East Syracuse, NY
1988 - 1994

Vice President (1990 - 1994) for a 15 hospital regional health care system.
Responsibilities and accomplishments included:

- Direction of regional managed care and hospital-physician integration initiatives. Responsible for planning and implementation of regional strategy, development of workshops and educational programs and providing contract negotiation support.
- Development and implementation of a business plan to establish document imaging company providing centralized, computer-driven imaging technology to assist hospitals in the management, storage, and retrieval of medical and other records. Responsible for oversight and direction of all aspects of the company's operations consisting of 40+ employees and $1.2 million budget.
- Management and coordination of regional productivity improvement and cost reduction initiatives including projects related to length of stay reduction, inventory management, and control of pharmaceutical and orthopedic implant costs.
- Development of a successful grant proposal that resulted in a 3-year $750,000 award to establish a clinical quality improvement resource center which provides CQI training, education, and support to member hospitals.
- Coordination and direction of regional educational and information sharing programs to assist hospitals in effectively meeting community health needs and reporting community benefits.

Director, Managed Care (1988 - 1990)
Responsible for all managed care activities for regional health care system.

UNITED HEALTH SERVICES, Binghamton, NY
1986 - 1988

Administrative Director for the UHS Network, a hospital/physician joint venture established to develop managed care contracts, joint marketing initiatives and physician practice support services. Responsible for planning, development and implementation, as well as day-to-day operational management. Specific accomplishments and responsibilities included:

- Development of business and marketing plans.
- Analysis of managed care options, development of managed care strategy and coordination of negotiations with managed care organizations.
- Development and implementation of physician service benefits including discount purchasing program, answering service, patient newsletter, physician referral service and physician marketing package.

BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA, Durham, NC
1985 - 1986

Director of Finance and Operations for HMO of North Carolina, a Blue Cross and Blue Shield hospital-based HMO. As a key member of the HMO development team, was responsible for:

- Preparation of budgets and financial projections.
- Development of provider capitation payments and negotiation of provider agreements.
- Identification of information system requirements.
- Marketing of program to targeted hospitals and physicians.
- Negotiation of provider agreements.
- Completion of application for state certification.

KAISER PERMANENTE, Portland, OR
Summer, 1984

Summer Intern. Exposed to all aspects of HMO operations. Performed financial and market analyses for assigned projects.

CENTRE COMMUNITY HOSPITAL, State College, PA
1980 - 1983

Psychiatric Assistant on inpatient psychiatric unit in 193-bed community hospital. Additional responsibilities included development of procedures for collecting and summarizing patient outcome and quality data, and preparation of quality assurance reports.

EDUCATIONAL TESTING SERVICE, Princeton, NJ
1979 - 1980

Research Assistant for longitudinal research projects. Conducted statistical analyses and set up and managed databases.

EDUCATION

THE WHARTON SCHOOL, UNIVERSITY OF PENNSYLVANIA
MBA, Health Care Management, 1985

COLLEGE OF WILLIAM AND MARY
Graduate Study, Psychology, 1977 - 1979

PROVIDENCE COLLEGE, Providence, RI
BA, Psychology, magna cum laude, 1977

CURRENT PROFESSIONAL, CIVIC AND VOLUNTEER ACTIVITIES

Board Member, United Way of Lane County – Served as President 2010
Member, United Way of Lane County 100% Access Coalition – Served as Chair 2007-2009
Board Member, The Foundation for Medical Excellence
Board Member, Oregon Medical Insurance Pool – Served as Chair 2009-2011
Co-Chair, Oregon Health Leadership Council
Board Member, Oregon Urology Foundation
Youth Baseball and Basketball Coach
Board Member, Corvallis Little League

PAST PROFESSIONAL, CIVIC AND VOLUNTEER ACTIVITIES

Chair, Oregon Health Care Safety Net Advisory Council
Board Member, Health Matters of Central Oregon
Member, Oregon Health Information and Privacy Collaboration Steering Committee
Member, Archimedes Design Team
Member, Oregon Health Policy Commission Delivery System Advisory Board
Member, Oregon Health Fund Delivery Systems Committee

Erick Doolen

4036 NW Live Oak Place • Corvallis OR 97330

(541)758-8476 • erick.doolen@gmail.com

PROFESSIONAL EXPERIENCE:

PacificSource Health Plans, Springfield, OR (September 2005 to present)

Senior Vice President of Operations and Chief Information Officer: May 2010 – present
Responsible for information technology, claims, customer service, membership, and billing across PacificSource's Commercial, Medicare, and Medicaid lines of business. Serving over 280,000 members in Oregon, Idaho, and Montana responsibilities include managing distributed Operations and IT teams to deliver extraordinary service while ensuring standardized and efficient processes that meet regulatory and compliance guidelines.

- Responsible for the integration of Operations and IT when PacificSource acquired a company in Central Oregon with new lines of business including Medicare and Medicaid. Integration included the conversion of the Medicare business onto PacificSource systems with Operations in the Bend office. Additionally, IT was integrated across the company with a functional structure to support all lines of business.

Chief Information Officer: September, 2005 – April 2010
Responsible for strategic technology investments and delivery of information technology to the company. Led 5 IT teams with over 50 IT professionals for the implementation of new capability and the ongoing operations of the existing portfolio of IT applications and services. As the Security Officer responsible for all aspects of IT security including ensuring appropriate investment in security capability and fulfilling HIPAA security duties.

- Successfully completed conversion from legacy claims system to Facets core system for claims processing, eligibility, billing, and customer service. In phases over 28 months the individual, small group, and large group business was moved to the new system. Implementation included building over 300 reports and 75 data interfaces. Project required coordination of multiple vendors and a cross-functional team within PacificSource of over 80 people.
- Completed significant upgrade of infrastructure in support of PacificSource expanding locations and becoming more distributed. Investments to support distributed collaboration and increased travel included wireless network in all facilities, VOIP phone system, teleconference / web conference system, and video conferencing.
- Implemented improvements in core data center capability including the addition of backup generator and UPS, implementation of VMWare and blade servers to create a virtualized server environment, and implementation of enterprise-level SAN.

Hewlett-Packard Company, Corvallis, OR (May 1994 to August 2005)

Imaging and Printing Group Americas IT Director: January 2005 – August 2005
Responsible for information systems for the customer facing processes in the Americas. Worked with partner organizations to provide end-to-end IT solutions for customer support, supply chain, marketing, and sales. Managed over 90 people with $30+M budget.

Worldwide Inkjet Supplies Factory Systems Director: February 2000 – December 2004
Responsible for factory control and information systems across 5 inkjet supplies manufacturing factories in the United States, Asia, and Europe. This organization consisted of 290 engineers with an annual budget in excess of $32M. Delivered on operational commitments including aggressive yield improvements, productivity improvements, and other cost reductions. Started organization with 'virtual' community across all factories by building a governance structure and supporting strategy. Successfully transitioned from the virtual team to a completely integrated, global organization.

Manufacturing Engineering Manager: April 1996 –December 1997
Managed team of process, software and tooling engineers responsible for a modular manufacturing tool set, and associated information systems used to manufacture inkjet cartridge components. Provided leadership in preparation for process startup of a factory in Ireland including engineering training, manufacturing equipment purchase or transfer, and cross training of process and software engineers. Startup was successful in all schedule, cost, and quality goals.

Manufacturing Systems Engineer May 1994 - March 1996
Responsible for control systems on custom manufacturing equipment used to produce new inkjet cartridge components. Worked with vendors during equipment build and checkout of control systems. Partnered with process engineers and production to qualify new tools, implement statistical process control, improve cycle time, and increase automation.

GTE Government Systems, Mountain View, CA (October 1987 to May 1994)

Technical Manager October 1991 - May 1994
Led a team of systems, software, hardware, mechanical, and RF engineers to successfully design, build, and deploy a mobile radio research laboratory. Worked closely with the customer to determine mission requirements and translate into system requirements, design, and implementation.

Systems Engineer October 1987 -September 1991
Worked in three positions with increasing levels of responsibility developing experiments for a classified signal processing system. Led team of five systems engineers responsible for the requirements definition and subsequent debug, integration and formal testing of the system.

PROFESSIONAL VOLUNTEERING:

Oregon Health Leadership Council's Administrative Simplification Executive Committee Co-Chair *(January 2010 - present)*
In support of the overall OHLC goal of controlling healthcare costs, the Administrative Simplification efforts have developed standards for electronic transactions, implemented a single sign-on solution for providers accessing health plan portals, and identified provider portal best practices. Efforts currently underway include establishing a central repository for credentialing and development of additional standards for electronic transactions.

Oregon Administrative Simplification Work Group member *(March 2010 – June 2010)*
This stakeholder work group was created by the Office of Oregon Health Policy and Research as a result of HB 2009 to develop recommendations for standardizing administrative transactions between health plans and healthcare providers.

Health Information Technology Oversight (HITOC) Council member *(April 2012 – present)*
Appointed by the Oregon Governor to serve on HITOC. This council is responsible for setting goals and developing a strategic health information technology plan and monitoring progress in achieving those goals. HITOC is currently coordinating Oregon's public and private statewide efforts in electronic health records adoption and the eventual development of a statewide system for electronic health information exchange.

HITOC Finance Workgroup member (*February 2011 – present*)
Workgroup is responsible for developing and recommending finance models to HITOC for funding of the Health Information Exchange services within Oregon.

EDUCATION: Bachelor of Science in Electrical Engineering and Bachelor of Science in Computer Science, Washington University, St. Louis, 1987

ACTIVITIES: Golf, soccer coach (1998 – 2003), Childcare Committee member (1998 – 2002), Organizer for fund raising golf tournaments (2007-2012)

Peter F. Davidson, CPA

110 International Way,
Springfield, OR 97477

Business: 541 684-5212
Cell: 541 554-1734
Email: Pdavidson@pacificsource.com

Management Experience

PacificSource Health Plans — **Springfield, OR**
Executive Vice President and Chief Financial Officer — **2008 – Present**

CFO of a not-for-profit community health insurance plan that covers 265,000 commercial, Medicare and Medicaid members. PacificSource Health Plans, and its subsidiaries, deliver healthcare solutions to businesses and individuals in Oregon, Idaho, Washington and Montana. PacificSource is a 78 year-old company that values partnership, service excellence, and community solutions for improving the healthcare delivery system. Responsibilities include oversight of the organization's financial, investment, provider network, actuarial, legal and HR departments. Key duties involve long range planning and strategic growth.

Oregon Medical Group — **Eugene, OR**
Chief Executive Officer — **1998 – 2008**

CEO of a primary care based multi-specialty group that included a 105-provider medical practice, laboratory, imaging department and investment in a local hospital system. Responsibilities included focus on clinical and service excellence, strategic planning, development of the management team and physician recruiting.

Joseph J. Bean Associates — **Portland, ME**
Partner — **1995 – 1998**

Vice President and partner in a management and development firm specializing in the operation of healthcare companies. Noteworthy activities included the development of a Breast Health Center, consulting on financial and strategic issues for the largest independent physician association in Maine and the management of various integrated medical groups.

Certified Public Accounting — **1987 – 1994**

Managed tax, consulting and compensation services for a base of clients in the field of healthcare and technology.

Peter F. Davidson, CPA

110 International Way,
Springfield, OR 97477

Business: 541 684-5212
Cell: 541 554-1734
Email: Pdavidson@pacificsource.com

Professional License / Affiliations

Certified Public Accountant- CPA
Certified by the State of California Board of Accountancy August 1986,
Current license to practice held in Maine #CP 1667 and Oregon #13213

State Affiliations
Oregon Health Policy Board Subcommittee – CCO Global Budget Methodology, 2011
Oregon Health Authority Senate Bill 204, 2011

Current Affiliations
Direction Service, a non-profit multi-program family support agency - Board of Directors
Lane Transit District - Budget Committee Member
AICPA – Member
PacificSource Charitable Foundation - Advisor

Former Affiliations
Cascade Health Solutions, a community-based non-profit health services organization - Board of Directors
Lane Community College Foundation - Board Member
Agate Resources (LIPA, OHP MCO) – Board Member and Treasurer
Trillium Community Health Plans, Medicare Advantage Plan – Board Member
Lane County 100% Access – Executive Committee and Board Member
American Diabetes Association Walk – Chair, Eugene Region 1999 and 2000
Maine State Music Theatre –Board Member
Brighton Medical Center Foundation Board of Trustees – Board Member
Maine Employee Benefits Council – Board member

Education

Bowdoin College **Brunswick, ME**
B.A. Biology 1981; Honors: Cum Laude, James Bowdoin Scholar.

Personal Information
Age 52. Married with 2 children.
Gardening, running and cooking

Sujata S. Sanghvi, FSA, MAAA

110 International Way, Springfield, Oregon 97477 ssanghvi@pacificsource.com

Oregon Health Care Experience

September 2002 to Present
PacificSource Health Plans, Springfield, OR

Executive Vice President and Chief Operating Officer. June 2004 – Present Current responsibilities include all Sales, Marketing, Operations, and Information Technology (IT) functions including all commercial and government lines of business. Prior to taking on responsibility for Sales, Marketing, and IT functions in 2010, responsibilities also included provider contracting and network administration and actuarial, underwriting, and analytics.

- Active participant in Central Oregon Opportunity Conference and Lane County Opportunity Conference including supervision and review of analytic support related to both Opportunity Conferences and presentation of data at the Lane County Opportunity Conference.
- Member of Oregon Health Policy Board's Health Incentives and Outcomes Committee.
- Active participant in State Exchange Carrier workgroups for SHOP and Individual Exchanges.
- Member of workgroup on Value Based Benefits for the Oregon Health Leadership Council.

Vice President, Actuarial Services. September 2002 to May 2004. Responsible for rating, underwriting, and reserving. Products include individual and group medical plans and group dental.

January 2008 to Present
United Way of Lane County, Springfield, OR

Board Member and Chair of Research and Evaluation Committee. The Research and Evaluation Committee is responsible for periodic assessment of community needs through survey and use of public data. Through the 100% Access Healthcare Coalition, I was also active in bringing together community emergency room data to provide insight regarding use of emergency room by uninsured, Medicaid, and commercial insurance status.

Other Professional Experience

August 1999 to June 2002
Harvard Pilgrim Health Care, Wellesley, MA

Acting Chief Financial Officer and Chief Actuary. June 1, 2001- January 2, 2002. Managed Accounting, Financial Planning and Analysis, and Treasury Functions, along with Chief Actuary functions. Oversaw completion of development and implementation of new Oracle-based Financial Management System, including consolidation to a single general ledger, as well as accounts payable, purchasing, budgeting, and HR/payroll functionality. Managed Accounting,

Financial Planning and Analysis, and Treasury Functions, along with Chief Actuary functions. Total staff under management approximately 120. Actively participated in investor meetings regarding sale and leaseback of major real estate holdings.

Senior Vice President & Chief Actuary. Responsible for Actuarial Services, Underwriting, and Reporting & Analysis functions, with a staff of forty. Hired as part of turnaround management team as company's first actuary. Plan results improved from $227 million loss in 1999, to eight consecutive profitable quarters as of June, 2002. Promoted from Vice President to Senior Vice President in October 2000 in recognition of key strategic role in planning both product and network strategies.

- Board Member of Neighborhood Health Plan, an HMO with primarily Medicaid membership, owned by HPHC, until May 2002, when the plans de-affiliated.

June 1997 to July 1999
Prudential Health Care, Roseland, NJ

Vice President and Pricing Actuary. Responsible for commercial pricing for health insurance products across thirteen states. Challenges included re-assessing central control of pricing and underwriting in a decentralized, matrix environment. Designed, developed, and implemented single rate calculation system for proposal and mid-market renewal business for all medical products. System integrated claims and loss ratio experience for renewal business and allowed for data collection and reporting on both prospect and renewal quotes and a unified rating engine for 35 networks across thirteen states. Oversaw development of pricing models and trend assumptions for medical products including HMO, Point-of Service, PPO and indemnity products. Developed stop loss rating and pooling factors. Reviewed administrative pricing guides for administrative services only products. Integrated reserving process and assumptions into experience rating methodologies.

April 1995 – May 1997
Coopers & Lybrand, LLP, Boston, MA

Senior Consultant. Managed care consultant with engagements ranging from employee benefits consulting, provider contracting, and strategic planning. Representative projects include in-depth risk adjustment analysis of multiple plan experience for large public employer with 100, 000 members and analysis of existing and proposed managed care contracts for major physician-hospital organization. Proposed changes to terms create potential savings of $2 million.

October 1988 to March 1995
Blue Cross and Blue Shield of Massachusetts, Boston, MA

Started as entry level actuarial analyst progressing to Director of Actuarial Services, Managed Care Programs in less than five years, while attaining ASA and MAAA. In final position, managed staff of 12 people to develop management reporting, pricing, rate filings, reserving, and financial planning for all managed care products, including HMO Blue, Bay State, and Blue

Choice. Experience included pricing for all group products, including HMO, PPO, indemnity, and dental plans as well as Medicaid plans.

Education and Professional Designations

Harvard College
Cambridge, MA Bachelor of Arts in Mathematics and Religion, 1988

Actuarial Designations

- Fellow in the Society of Actuaries, 1997
- Member of the American Academy of Actuaries, 1995

Other

- Certified in Basic Mediation, Southern Oregon University, June 2003

Thomas N. Ewing, M.D.
2795 Emerald Street
Eugene, Oregon 97403
(541) 683-5897
tewing@peacehealth.org

CURRICULUM VITAE

EDUCATION

Intermountain Health Care, Advanced Training Program in Health Care Delivery Improvement, 1998

The American College of Physician Executives, Physician in Management Series I & II, 1998

Medical University of South Carolina, Charleston South Carolina, Family Medicine Residency, 1986

Washington University School of Medicine, St. Louis Missouri, M.D., 1983

Illinois Wesleyan University, Summa cum laude, National Merit Scholarship Finalist, B.A., 1978

EMPLOYMENT HISTORY

EVP and Chief Medical Officer, PacificSource Health Plans, Springfield, Oregon, 2012-Present

Chief Medical Officer, PeaceHealth Medical Group, Eugene, Oregon, 2007-2012

Medical Director, 4J Wellness Clinic, Eugene, Oregon, 1995-present

Practicing Family Physician, PeaceHealth Medical Group, Eugene, Oregon, 1995-present

Medical Director, PeaceHealth Medical Group, Eugene, Oregon, 2002-2007

Medical Director, PeaceHealth Internet Services, Eugene, Oregon, 1999-2003

Acting Medical Director, Peace Health Medical Group, Eugene, Oregon, 2001-2002

Medical Director, Quality and Informatics, Peace Health Medical Group, Eugene, Oregon, 2000-2001

Director of Informatics, PeaceHealth Medical Group, Eugene, Oregon, 1998-2000

Practicing Family Physician and Partner, Eugene Clinic, 1989-1995

Clinical Assistant Professor, Medical University of South Carolina, Charleston, South Carolina, 1988-1989

Practicing Family Physician, Fetter Family Health Center, Charleston, South Carolina, 1986-1988

Emergency Medicine, Attending Physician, Charleston Memorial Hospital, Charleston, South Carolina, 1986-1987

Emergency Medicine, Bamberg Memorial Hospital, Bamberg, South Carolina, 1984-1985

LEADERSHIP & GOVERNANCE POSITIONS

Board Member, Oregon Health Care Quality Corporation, Eugene, Oregon, 2009-present

Member, Quality Council, PeaceHealth Medical Group, Eugene, Oregon, 1995-present

Clinical Faculty, Oregon Health Sciences University, Portland, Oregon, 1993-present

Board Member, Oregon Imaging Center, Eugene, Oregon, 2007-2009

Chairman, Professional Liability Committee, Eugene, Oregon, 2002-2008

Chairman, Quality Council, PeaceHealth Medical Group, Eugene, Oregon, 1999-2004

Member, Operations Council, PeaceHealth Oregon Region, Eugene, Oregon, 1995-1999

Board Member, Eugene Clinic Board of Directors, Eugene, Oregon, 1994-1995

Board Member, Board of Directors, HIV Alliance, Eugene, Oregon, 1990-1994

Program Director, Perinatal, Fetter Family Health Center, Charleston, South Carolina, 1986-1988

CERTIFICATIONS & LICENSURE

Board Certified, American Board of Family Practice, 1986-present

Oregon License, MD 15926, 1989-present

GRANT SUPPORT

Executive Sponsor, PeaceHealth Medical Group High Value Medical Home Innovation, Eugene, Oregon, 2010-present

Executive Sponsor, PacificSource, Enhancing Wellness Project, Eugene, Oregon, 2010-present

Executive Sponsorship, Regence Blue Cross Blue Shield, Planned Care Medical Home Pilot, Peace Health Medical Group, Eugene, Oregon, 2008-2010

"Prevention of Low Birth Weight andPreterm Labor for Women at Risk", Co-authored with Sally J. Frenkel RN ACCE and Janna Ellings CNM. March of Dimes granted 10/87.

PUBLICATIONS

"Temperature as a controller of Microvascular Activity in Rat skeletal muscle activity". BIOS 1, 4; 12/79

liMy Bookmarks", eMD Information Technology for Physicians, McGraw-Hill, May 2000

"Development and Implementation of an Information Management and Information Technology Strategy for Improving Healthcare Services: A Case Study", Journal of Health Information Management, vol.1S, no. 3, fall 2001

"The Risks and Rewards", Health Data Management, vol.II, no. 2, February 2003

MEMBERSHIPS

Oregon Academy of Family Physicians

American Academy of Family Physicians

Diplomat, American Board of Family Physicians

American Medical Association

Lane County Medical Society

PROFESSIONAL AFFILIATIONS

Provider communication and education on Community Health Plan strategy

Developed and lead a county wide consortium of Primary Care Leaders focused on evolving new care models in close collaboration

Involved with PacificSource Health Plans and PacificSource Community Health Plans across all product lines

Presentations and lectures available upon request

DAN A. STEVENS

2965 NE CONNERS AVENUE
BEND, OR 97701

EDUCATION

• Master of Business Administration	Portland State University	Portland, OR	2000
• Master of Public Health	Oregon Health and Science University	Portland, OR	1997
• Bachelor of Arts	Bowdoin College	Brunswick, ME	1991

PROFESSIONAL & COMMUNITY AFFILIATIONS

• Central Oregon Health Council	Member (2011-present)
• Healthmatters of Central Oregon	Board Member (2010-present)
• United Way of Deschutes County	Board Member and Managed Programs Committee Member (2011-present)
• Central Oregon Center on Aging	Senior Center Volunteer/Meals on Wheels (2011-present)

PROFESSIONAL EXPERIENCE

PacificSource Health Plans **2010 – present**
Senior Vice President, Government Programs
Chief Operating Officer, PacificSource Community Health Plans
PacificSource Health Plans is a not-for-profit community health plan, serving nearly 300,000 members in the Pacific Northwest through Commercial, Medicare, and Medicaid programs.

- Administrative leader for PacificSource's federal and state programs serving 17,000 Medicare and 40,000 Medicaid beneficiaries
- Responsible for development of benefit designs and provider/member engagement strategies to enable accountable care models
- Appointed to the Governor's work group to help formulate criteria for Coordinated Care Organizations (Fall/2011)

Regional Director, Provider Network Development, Providence Health Plans **2007 – 2010**
Administrator, Providence Preferred Oregon
Provider network executive reporting to the Chief Executive, with accountability for all provider services in Commercial and Government Programs products. Major responsibilities included leading and executing the provider contracting strategy, risk model development, and payment innovation programs aimed at promoting new care models. P&L responsibility for Providence Preferred, Oregon's largest PPO network serving over 250,000 enrollees.

- Oversee provider contracting and provider engagement strategies for network of over 16,000 providers.
- Led the planning and deployment of tools to achieve greater adoption of electronic transactions between health plan and its provider partners, resulting in $1.1 million savings in the first year
- Appointed to State Administrative Simplification task force, to develop strategies to enable transactional efficiencies between providers and payers.

Assistant Administrator, Providence Portland Medical Center, Portland, OR **2002 – 2006**
480 bed tertiary medical center with an active medical staff of >1,500 physicians; $400 million in revenue

Served as key member of the senior executive team, reporting to the CEO. With continued responsibility for service line administration from previous role, added P&L accountability for 3 operating divisions comprising 725 FTEs. Additional duties included strategic and capital planning, multiple site medical group administration, clinical integration across a three-hospital delivery system, facility planning, and customer satisfaction initiatives.

- Guided hospital-based employed physician division through period of rapid growth from 7 to 50 employees in three years

- Developed and deployed focused initiatives to improve customer satisfaction, resulting in scores exceeding the 90th percentile nationally
- Led cross functional teams to enhance capital planning decision making; guided negotiations and due diligence in annual capital budgeting process

Administrator, Medicine Service Lines, Providence Portland Service Area **1997-2002**

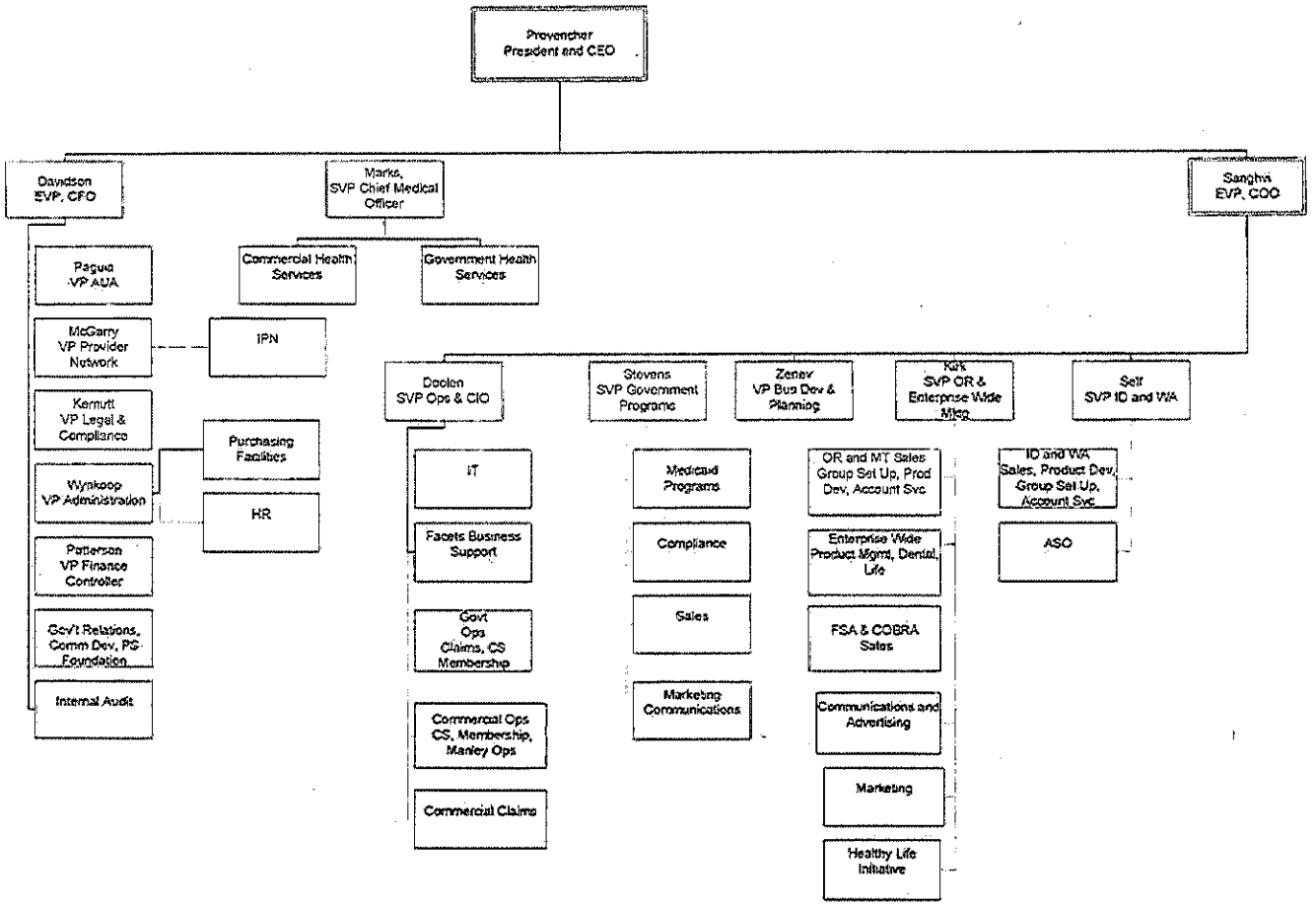
The Portland Service Area of Providence is the metropolitan area's market share leading healthcare delivery system with 16,000 employees, 1,100 acute care beds, 3,560 active medical staff, and >65,000 annual acute admissions.

Responsible for business development, capital planning, operations redesign, physician recruitment, and care model enhancement for clinical service lines representing annual revenues of $225 million.

- Collaborated with physician leaders to improve clinical performance reporting systems and conduct comparative effectiveness studies
- As a Six Sigma trained Change Facilitator, engaged clinical and operational leadership teams to drive productivity enhancements and reduce clinical defects

Senior Research Analyst, Providence Portland Service Area **1995-1997**

- Authored grant applications for externally funded research; conducted population-based outcomes research studies and presented findings to regional and national audiences
- Conducted the state's first comprehensive study evaluating the impact of Oregon Health Plan's expansion on the health outcomes of previously uninsured Oregonians


Provencher
President and CEO
Davidson
EVP, CFO
Marks,
SVP Chief Medical Officer
Sanghvi
EVP, COO
Pague
VP AUA
McGarry
VP Provider Network
Kernutt
VP Legal & Compliance
Wynkoop
VP Administration
Patterson
VP Finance Controller
Gov't Relations, Comm Dev, PS Foundation
Internal Audit
Commercial Health Services
Government Health Services
IPN
Purchasing Facilities
HR
Doolen
SVP Ops & CIO
Stevens
SVP Government Programs
Zenev
VP Bus Dev & Planning
Kirk
SVP OR & Enterprise Wide Mktg
Self
SVP ID and WA
IT
Facets Business Support
Govt Ops Claims, CS Membership
Commercial Ops CS, Membership, Manley Ops
Commercial Claims
Medicaid Programs
Compliance
Sales
Marketing Communications
OR and MT Sales Group Set Up, Prod Dev, Account Svc
Enterprise Wide Product Mgmt, Dental, Life
FSA & COBRA Sales
Communications and Advertising
Marketing
Healthy Life Initiative
ID and WA Sales, Product Dev, Group Set Up, Account Svc
ASO

Service Area Description County	Zip Code	Maximum Number of Members-Capacity Level
Crook	97751, 97752, 97753, 97754, 97760	3800
Deschutes	97701, 97702, 97707, 97708, 97709, 97712, 97739, 97756, 97759, 97760	28000
Jefferson	97730, 97734, 97741, 97760, 97761, 97711	5500
Klamath (Members in these four zip codes access care in Deschutes County)	97731, 97733, 97737, 97739	250

Pending Counties:

Grant	97817, 97820, 97825, 97845, 97848, 97856, 97864, 97865, 97869, 97873, 97877	1100
Harney	97710, 97720, 97721, 97722, 97732, 97736, 97738, 97758, 97904, 97911	1250
Lake (Members in Lake County seek care in Deschutes County)	97638, 97640, 97641, 97735, 97739	1300
Wheeler	97750, 97825, 97830, 97874	250

APPENDIX A – CCO Criteria Questionnaire

A.1: Background Information about the Applicant:

a. PacificSource Community Solutions, Inc. (PSCS) is a corporation domiciled in the State of Oregon.
b. PSCS Applicants and affiliates include the following: Central Oregon Health Council, Deschutes County, Jefferson County, Crook County, Klamath County, St. Charles Health System, Blue Mountain Hospital, Central Oregon Independent Practice Association, and Mosaic Medical. It is anticipated that other organizations will be added after additional discussion including Wheeler County, Lake County, Grant County, and Harney County. These discussions are pending as of the date of this application.
c. PSCS's effective date for serving Medicaid populations would be August 1, 2012.
d. PSCS is not invoking alternative dispute resolution with respect to any provider at the time of this application.
e. At this time, PSCS is not requesting any changes or negotiating any terms or conditions in the Core Contract. PSCS recognizes that there are parts of the contract mandated by Medicaid or Medicare. As the PSCS CCO evolves, PSCS respectfully requests the opportunity to revisit the contract if necessary to negotiate any terms or conditions outside of those portions mandated by Medicaid or Medicare. It is during this evolution that the applicability of requirements such as the ISSRs within the new delivery system can be evaluated and discussed in terms of future applicability.
f. The proposed service area by zip code 97751, 97752, 97753, 97754, 97760, 97701, 97702, 97707, 97708, 97709, 97712, 97739, 97756, 97759, 97760, 97711, 97730, 97734, 97741, 97760, 97761, 97731, 97733, 97737, and 97739 (Klamath). Pending zip codes for Grant County, Harney County, Wheeler County, and Lake County include: 97750, 97817, 97820, 97825, 97845, 97848, 97856, 97864, 97865, 97869, 97873, 97877, 97710, 97720, 97721, 97722, 97732, 97736, 97738, 97758, 97904, 97911, 97825, 97830, 97874, 97638, 97640, 97641, 97735, and 97739 (Lake),
g. The primary address for the proposed service area for Pacific Source Community Solutions is 2965 NE Conners, Bend OR.
h. The service area will include Deschutes County, Crook County, Jefferson County, and specific zips in Klamath County. Discussions are currently occurring regarding inclusion of Wheeler County, Harney County, Grant County, and Lake County (specific zips). Once decisions are made, it is PSCS's goal to move forth accordingly. PSCS has contracts with counties and county health departments to provide covered services for Medicaid members. As the CCO develops, PSCS will expand its agreements to coordinate the public health care services as listed in ORS 414.153 with county health departments, other publicly supported programs, and other providers contracted with PSCS.
i. PSCS has a contract with OHA as a Fully Capitated Health Plan and a Mental Health Organization. PSCS had these contracts as of October 1, 2011.

j. PSCS is the identical organization with the current MCO contract and has not undergone any legal status change since October 1, 2011.

k. PSCS currently includes a Fully Capitated Health Plan (FCHP) and a Mental Health Organization (MHO).

l. PSCS is completing this application for the counties listed above. The counties listed above are currently included in the FCHP service area that is the subject of the current PSCS FCHP contract with OHA. The counties listed on this application are not inclusive of all the counties covered by PSCS currently. Crook County, Deschutes County, Jefferson County, and the specific zips listed for Klamath County are currently included in the MHO Service area that is the subject of the current PSCS MHO contract with OHA. This application would expand the service area to include Wheeler County, Harney County, Grant County, and specific zips in Lake County.

m. PSCS is a wholly owned subsidiary of PacificSource Community Health Plans, Inc. (PCHP). PCHP is a wholly owned subsidiary of PacificSource Health Plans. PacificSource Health Plans either directly or through its subsidiaries participates in Healthy Kids Connect and Public Employees Benefit Board. PSCS participates in the Adult Mental Health Initiative as included in its MHO Contract. (Please see attached Attachment A.1.m ~ PacificSource Health Plans Corporate Chart).

n. As indicated on the organization chart referenced above, PacificSource Community Health Plans (PCHP), the parent company of PSCS, currently has a contract with Medicare as a Medicare Advantage Plan. The service area for PCHP MA-PD Plan is Crook County, Deschutes County, Grant County, Hood River County, Jefferson County, Klamath County*, Lake County*, Sherman County, Wasco County, Wheeler County, and Lane County. Klamath County and Lake County are partial counties as indicated by "*".

o. PSCS does not hold a current certificate of insurance from the State of Oregon Department of Consumer and Business Services, Insurance Division.

p. (1) PSCS has developed an OHP capitation methodology as a part of its contracting model with providers for its OHP population. This OHP capitation methodology removes volume-of-service based on financial incentives and replaces it with incentives that reward primary care (including those that have successfully applied for Patient Centered Primary Care Home (PCPCH) recognition status) and for providing "the right care at the right time at the right place". This new agreement further provides shared savings incentives for PCPCH primary care providers as well as specialty providers for appropriate management of care as measured by performance in a specialty care fund, a hospital fund, and a prescription drug fund. In addition, PSCS has existing payment methodologies including these Medical Home Incentive Payments which align quality and best practice metrics that are designed to promote high quality care alongside cost efficient care. PSCS has partnered with Central Oregon IPA (COIPA) who is investing in new informational capabilities which are anticipated to lead to community-wide evidence-based best practices, and will provide a data-based solution to variations in care in the PSCS Medicaid population.

(2) PSCS will demonstrate the experience and capacity for the coordination of the delivery of physical health care, mental health and chemical dependency services, oral health care and covered DHS Medicaid-funded LTC services. This experience will be further demonstrated in other sections in the application.

(3) PSCS will engage 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 the entity's enrollees and in the entity's community. This engagement is described in various sections following this section.

q. Please see resumes for the following individuals listed below attached.

- Chief Executive Officer ~ Kenneth Provencher
- Chief Financial Officer ~ Peter Davidson
- Chief Medical Officer ~ Tom Ewing, MD
- Chief Administrative Officer ~ Sujata Sanghvi

Chief Information Officer ~ Erick Doolen

- Chief Operations Officer ~ Dan Stevens

r. Please see organizational chart which shows the relationships of the various departments. (Please see attached, PacificSource Community Solutions Organizational Chart).

s. PSCS is deferring submission of the following documents until PSCS's readiness review under Section 6.7.1.

- Joint Management Agreement.
- Regional Health Assessment ~ "2012-2015 Central Oregon Health Improvement Plan" full report.
- Plain language narrative of members' rights and responsibilities.
- Hospital agreements.

A.II. Community Engagement in Development of Application

The PSCS CCO application effort is supported by the community it represents as is evidenced by the governance description provided in Section 1. Multiple community partners have been involved with PSCS staff to develop the CCO application, participate on the CCO workgroup, and have authored sections of the application. In addition, the Central Oregon Health Council (COHC) provided specific input in relation to "Governance" for the CCO application process with PSCS. Deschutes County, Crook County, and Jefferson County Public Health completed the Community Health Assessment and Health Improvement Plan for the region with input from numerous stakeholders.

Relevant History: PSCS and other community partners convened a group of thought leaders to begin discussions in 2008 to discuss health reform beginning with the integration of public health, behavioral health and physical health. These discussions and partnerships led to the development of a regional health transition board with the initial charge of integrating the physical health and behavioral health needs of Central Oregon residents. As a result of this work, PSCS became both the FCHP and MHO for Deschutes County, Crook County, Jefferson County and 4 zip codes in Klamath

County in January 2011. This project included the placement of behavioral health staff in primary care provider offices such as Mosaic Medical.

The Central Oregon leadership group led to the creation of the Central Oregon Health Council (COHC). In July 2011, the Governor signed legislation that officially recognized the Central Oregon Health Council through SB 204. The COHC responsibility included development and implementation of a regional health improvement plan due to the State of Oregon in March of 2012. The COHC has lead various initiatives and taken different forms during the last two years. Over these last two years, the COHC has initiated projects including:

- Formation of the Central Oregon Health Board, an Inter-Governmental Agency that consolidates administrative services provided by Deschutes, Jefferson and Crook Counties.
- Development of an Emergency Department Diversion program.
- Integration of MHO (behavioral health) and FCHP (physical health) services.
- Development of the Program for Evaluation of Development and Learning clinic at St. Charles Medical Center.
- Co-location of Behavioral Health Consultants in Primary Care Settings.
- Development of a Regional Health Improvement Project.
- Partner in the passage of SB1506 which improves data transparency for mental health medications prescribed to Medicaid members.

In addition, PSCS has also taken the role of a neutral convener in Central Oregon, bringing providers and systems to a common table to focus on making Central Oregon one of the healthiest regions in the country. Through a series of meetings called Opportunity Conferences, leaders from the following organizations were brought together:

- St. Charles Health System,
- Bend Memorial Clinic,
- High Lakes Health Care,
- Central Oregon Independent Practice Association,
- Mosaic Medical,
- Public Health Agencies in all three counties including County Public Health Directors,
- Mental Health Agencies in all three counties including County Mental Health Directors, and
- Chemical Dependency organizations.

The Opportunity Conferences resulted in a shared community focus on four strategic areas that will improve the health of the PSCS community.

1. Complex Care Strategy.
2. Improving Primary Care Access.
3. Community Health Information Exchange platform.
4. Enhancing Preventive Services.

It is these initiatives and the collaborative work done by Central Oregon Health Council over the last two years that has resulted in a common vision for the community. This shared vision and invited participation has greatly informed the development of the Central Oregon CCO application. In the development of the CCO delivery system model and the completion of the CCO application, PSCS has relied on the same partners involved in developing the shared vision for Central Oregon, both in a consultative fashion and in drafting certain elements of the application. PSCS is currently working to engage the leadership in Wheeler, Grant, Lake and Harney Counties which have expressed interest in becoming a part of the Central Oregon CCO.

Section 1 – Governance and Organizational Relationships

A.1.1. Governance

Description of CCO Governance

The Central Oregon CCO will utilize Central Oregon Health Council (COHC) as its governance structure. COHC has a three year history of bringing public and private healthcare stakeholders together to develop and implement collaborative community health initiatives in Central Oregon. COHC's role was formalized in 2011 with the passage of SB 204, which obligates COHC to oversee a Regional Health Assessment and implement a robust Health Improvement Plan for the region.

Membership in the COHC will be evolving over the next 2 months, to fulfill the governance role specified in ORS 414.625 and SB 1580. Current COHC membership consists of:

- County Commissioner from Jefferson County
- County Commissioner from Crook County
- County Commissioner from Deschutes County
- President of Central Oregon IPA (COIPA)
- CEO of St Charles Health System
- COO of PacificSource Community Solutions (PSCS)
- Consumer representative from Jefferson County
- Consumer representative from Deschutes County

Additional membership being considered includes, minimally, representation from behavioral health, oral health, specialty care and a regional Federally Qualified Health Center (FQHC).

Although PacificSource Health Plan's Board of Directors cannot delegate full fiscal authority to a community governing board, COHC governance functions of the CCO and the relationship between the two organizations will be robust. COHC is currently forming as a legal entity for the purpose of providing full community accountability and oversight to both the CCO and to regional population health initiatives including initiatives that address the needs of members with severe and persistent mental illness and members receiving DHS Medicaid-funded service and supports. Prior to the CCO Readiness Review, COHC and PSCS will enter into a Joint Management Agreement (JMA) to delineate CCO governance and operations roles. It is the intention of both COHC and PSCS that PSCS's CCO contract with OHA be contingent on the successful execution and ongoing maintenance

of the JMA between PSCS and COHC. It is anticipated that the JMA will be available at the Readiness Review. (Please find attached, Attachment 1.1.1. Governance Visio).

Under the Joint Management Agreement with PSCS, Governance functions to be fulfilled by COHC include:

- Oversight of CCO strategic plan and annual work plan.
- Establishment CCO performance metrics.
- Creation of principles and framework for annual CCO budget, principles around global budget management, and shared savings/community reinvestment principles.
- Endorsement and enforcement of the CCO quality plan, and community standards of care for CCO enrollees in concert with the CCO Clinical Advisory Council.
- Accountability for Community Needs Assessment, Community Health Improvement Plan, and plans to address significant health disparities in the region including the needs of members with severe and persistent mental illness and members receiving DHS Medicaid-funded LTC services in concert with the CCO Community Advisory Council.
- Accountability for healthcare transformation including care model innovation, and strategies to enable meaningful integration of behavioral health, physical health, oral health, and the long term care delivery system.
- Evaluation of PSCS in its role of CCO legal entity.
- Resolving disputes among CCO contractors, providers, and other stakeholder organizations.
- Assurance of transparency and accountability to the local community and to CCO members.

Under the Joint Management Agreement with COHC, CCO legal entity functions to be fulfilled by PacificSource Community Solutions include:

- Fulfill CCO fiscal entity and legal entity functions including maintenance of required reserve levels, appropriate licensure, and financial risk bearing.
- Be lead CCO operating entity. Includes provision of managed care and Third Party Administrator functions including provider network maintenance and contracting, eligibility, claims, customer service, member communications, compliance, member appeals, care coordination and utilization management.
- Ensuring CCO annual work plan and priorities are carried out effectively on behalf of members in concert with COHC, appropriate Advisory Councils, and providers.
- Provision of robust analytics and supporting data to develop global budget, alternative payment methodologies, and performance metrics.
- Develop and maintain contracts with any downstream entities deemed necessary for the CCO to efficiently fulfill the above obligations.

Community Advisory Council

PacificSource is working with COHC and its community partners to develop a Community Advisory Council (CAC) to meet the requirements of ORS 414.625. The CAC will be broad based, and its Chair will be a voting member of the COHC governing body. There will be consistent communication between the COHC governing body and the CAC to ensure transparency and

accountability for the governing body's consideration of recommendations from the CAC. The Community Advisory Council will be seated and chartered prior to the CCO effective date.

A.1.2. Clinical Advisory Panel

PSCS will establish a Clinical Advisory Panel (CAP) as a means of assuring best clinical practices. The CAP will serve as a subcommittee of the Central Oregon Health Council (COHC). The role of the CAP will be to provide clinical oversight and leadership to community clinical integration efforts, clinical quality improvements projects and improvements in the local health care system and delivery. The CAP will also serve a central role in coordination of the quality committees of the health plan, Central Oregon Health Board (COHB) and the Central Oregon IPA (COIPA). The CAP will consist of 15-17 members. Members will include a COHC member, Operating Council member and Community Advisory Council member as liaisons. Additional members will include representatives of behavioral health, oral health, the local FQHC, the hospital system, health plan, COIPA, public health, clinical pharmacy, Long Term Care, Alcohol & Drug, Alternative Medicine, Obstetrics, and other Specialty Care. The committee chair will be a clinical member of the governing body of the CCO. The representatives from COIPA, PSCS and behavior health will be members of their respective organizations quality committees. Through all CAP members, PSCS will also obtain representation from each of the following regions: Bend, LaPine, Sisters, Redmond, Prineville, Madras and Warm Springs. The CAP will also include members that provide representation of underserved populations. At least two positions each will be for members presenting Jefferson & Crook Counties. (Please find attached Attachment A.1.2 – CAP Visio).

A.1.3. Agreements with Type B Area Agencies on Aging and DHS local offices for APD (APD)

PSCS is working directly with DHS local APD office in obtaining the initial MOU. These conversations have been expanded to include identification of current processes, intersects, and areas of collaboration.

A.1.4. Agreements with Local Mental Health Authorities and Community Mental Health Programs

Representatives of the Central Oregon Counties including Crook County, Deschutes County and Jefferson County have been working closely with representatives of PSCS to create a formal, administrative, programmatic and financial framework that will assure the Local Mental Health Authority's (LMHA) role and Community Mental Health Program's (CMHP) role will be accomplished successfully throughout the region. There is agreement in principal to create both a legally binding letter of agreement and a contractual global payment by PSCS for LMHA/CMHP responsibilities. A comprehensive program contract, including a global payment methodology and reporting framework will be signed between PSCS and the Central Oregon Health Board (COHB) in summer 2012. This contract will be based on a matrix of assigned responsibilities between the Central Oregon Health Council (COHC), PSCS as CCO fiscal agent, the COHB, and the participating counties. Within the next six months, all behavioral health responsibilities currently

managed by PSCS MHO through its subcontractor Accountable Behavioral Health Alliance (ABHA) will be assumed by the COHB, its participating counties, and/or PSCS.

The parties agree that all resources needed to sustain current CMHP services, particularly for people requiring intensive services, will be provided to the COHB, and then through the COHB to the participating counties. This includes but is not limited to such essential services as EASA, acute care, AMHI, assertive community treatment, children's wraparound services, 24/7 crisis services, residential and employment programs, and other programs and services for people requiring more intensive services and support. It is further agreed that the CMHP will participate actively in the transformation process, in complex care models, in outcome based investments, in the movement to improve care coordination and integration, in the development of person centered primary care homes and in the shared services that require both OHP and State General Fund resources to be successful.

A.1.4.a. As outlined above, intensive negotiations have resulted in a framework and matrix for these working relationships. At the time of application, these roles and responsibilities are being priced and a financial model is being created. In addition, work has begun on the global payment framework that will assure that PSCS invests in COHB services for OHP members requiring intensive services and supports. The participating counties, through the County Commissioners represented on the COHB, have reviewed this framework and authorized budget and personnel development in anticipation of a signed contract and payment plan within the next 60-90 days. It is expected that the COHB may assume many of the duties currently assigned to ABHA on or close to the PSCS CCO start date.

A.1.4.b. Central Oregon Counties have a long history of working with St. Charles Health System, public safety and social service organizations, and residential programs in the local area to serve and support people transitioning for extended or long-term psychiatric care programs. Deschutes County, in particular, has invested in residential development with a significant increase in SRTF, RTH and supported housing options in the last 18 months. The region's Central Oregon Regional Acute Care Council (CORACC) will be reconstituted through the COHB to assure acute care and residential resources are in place and responsive to the needs of OHP members in a timely manner. It is agreed that representatives of PSCS will participate actively in the work of COHB's CORAC Council.

A.1.4.c. PSCS will coordinate with Community Emergency Service Agencies to promote an appropriate response to members experiencing a mental health crisis. PSCS will work with and through Local Public Safety Coordinating Councils and their participating members. In addition, the work of the Crisis Intervention Coalition in Deschutes Council will be sustained as additional officers throughout the region and will be trained in and serve as extensions of a CIT model in Central Oregon. This forum in each County and collectively throughout the region, will promote an appropriate response to members experiencing a mental health crisis. .

A.1.5. Social and support services in the service area

A.1.5.a. PSCS is in the process of identifying key agencies and individuals within the offices listed below. As these agencies and individuals are identified, PSCS will meet to discuss how to partner with each agency so that the services they offer are incorporated into the work being done within the CCO. These key agencies and offices are:

- DHS Children's Adults and Families 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;
- Community-based family and peer support organization;
- Other social and support services important to communities served.

Connections to these resources for members of the CCO will happen directly through connections of Community Health Workers, public health staff, and other consumer advocates in the health care system and their community services networks. Connections will also happen through the networks and relationships of the COHB and COHC Membership to existing advisory boards. These connections will include: County Local Alcohol and Drug Planning Committees, Mental Health Advisory Boards, Commissions on Children and Families, Local Public Safety Coordinating Councils, Emergency Food and Shelter Advisory Boards, Family Court Advisory Boards, and local hospital boards to name a few. The COHB Membership to Central Oregon Intergovernmental Council, Regional Housing Authority, and Regional Community Action Agency will provide additional connections.

A.1.6. Community Health Assessment and Community Health Improvement Plan

Community Health Assessment: PSCS through the COHC has begun work on a community health assessment and a community health improvement plan. In 2011, collaboration began to conduct one region-wide assessment through shared work with schools, public health agencies, health care organizations, United Way and other community partners. By collaborating in this manner, it is expected that there will be increased efficiencies in the work to conduct the assessment, but more importantly, involved organizations will share the workload, involve their stakeholders, learn together and work together to act accordingly for the advancement of the community.

The assessment as currently structured involves:

- Identifying key indicators, definitions, and sources
- Gathering existing objective data
- Gathering new subjective data (surveys, focus groups, etc.)
- Analyzing the information
- Informing through a cohesive story
- Formatting the document
- Developing and implementing a marketing plan
- Coordinating interventions from each organization to begin addressing the identified gaps
- Evaluating the interventions to determine impact on key indicators

PSCS will work with the OHA, including the Office of Equity and Inclusion, to further identify the components of the community health assessment. Currently, PSCS partners with the local public health authority, hospital system, and local mental health authority. PSCS will be discussing the status of the current community health assessment with local APD offices to identify areas of partnership and collaboration. The assessment will be analyzed in accordance with OHA's race, ethnicity and language data policy once the policy is made available.

As a part of the community assessment discussions that have occurred, plans for a Regional Health Database – Healthy Communities Institute have started to develop. Community partners have agreed that rather than having multiple agencies searching multiple (and often similar) sources for data and information year after year, the creation of a common database that would evolve over time to become a single source of data with automated feeds from disparate sources, standard reports and customizable mining capabilities would be useful. PSCS and its community partners will collaborate with other regions and the state to ensure standard definitions and design. The work is expected to occur in four main phases:

- Planning and quick wins.
- Approving of Healthy Communities Institute Website and funding decisions.
- Designing of the database infrastructure through Healthy Communities Institute and core data feeds and reports available to the public on a shared website.
- Enhancing and automating, possible merging with other regions into a state-wide database.

In addition, a smaller group of data stakeholders from Crook County, Jefferson County, and Deschutes County began working with Sarah Kingston, MPH, data analyst for Deschutes County to analyze the data from the three counties to create a comprehensive health report including information on disparities, race and ethnicities, and language needs in the three counties.

PSCS was included in the assessment through the opportunity conferences sponsored by PacificSource Health Plans. This regional community health assessment will be an ongoing process led by the Central Oregon Health Board Public Health Departments yearly. There will be quarterly strategic planning sessions with tri-county partners to analyze the data and assess strategies. Data from public sector and private sector is also being used to identify the needs in the community. An

effort will be made to continue to add partners to the table who did not participate in the initial process such as the AAA system.

Deschutes County, Crook County, and Jefferson County will continue to assist PSCS in the engagement of diverse populations including but not limited to individuals receiving DHS Medicaid Funded LTC and individuals with severe and persistent mental illness in the community health assessment process through consultation focus groups, surveys, and contracted services as needed to gather data from specific populations.

The Central Oregon Health Report 2012 Executive Summary is attached. (Please see attached Attachment A.1.6 – Central Oregon Health Report 2012 Executive Summary). The full Central Oregon Health Report will be available at Readiness Review.

Stakeholders in support of this regional effort include: St. Charles Health System, Mosaic Medical, HealthMatters, United Way, Deschutes County Health Department, Jefferson County Health Department, Crook County Health Department, Deschutes County Commission on Children and Families, Crook County Commission on Children and Families, Jefferson County Community Health Improvement Plan, High Desert Education Service District, FivePine Lodge, St. Charles Health System ~ Behavioral Health, St. Charles Health System ~ Performance Management, St. Charles Health System ~ Self-Care, St. Charles Health System ~ Kids@ Heart, PacificSource Community Solutions, Warm Springs Tribal Council, Bend Memorial Council, Central Oregon Independent Practice Association, Les Schwab, City of Bend, City of Redmond, City of Prineville, City of Sisters, City of Madras, AAA, St. Charles Health System ~ Redmond; St. Charles Health System ~ Bend, St. Charles Health System ~ Prineville, Mountainview Hospital ~ Madras, Partnership to End Poverty, and Kids Center.

Health Improvement Plan: A data/assessment workgroup composed of community partners met January 3, 2012. Available data was reviewed and discussed incorporating experiential and professional knowledge. From that meeting, nine priorities for the Central Oregon Region were identified; sub-categories of interest were called out and listed where appropriate. The areas chosen for the Health Improvement Plan were then vetted through the COHB and COHC and Healthy Environments was added as an additional area. The ten areas chosen were:

- Disparity and Inequality
- Access and Isolation
- Early Childhood Wellness
- Food Insecurity
- Oral Health
- Safety, Crime, and Violence
- Chronic Disease
- Alcohol, Drug, and Tobacco
- Behavioral Health, Suicide
- Healthy Environments

Staff from the counties worked with a contractor to write the Health Improvement Plan for the region which has been submitted to the State of Oregon as required by SB204. The workgroup created the plan based on the ten areas with engagement of multiple community partners to complete the work. The Health Improvement Plan was approved by the COHB and the COHC. The plan provides the guidance for developing coordinated care plans in the region while focusing on prevention and the Triple Aim and aligns with the care strategies being developed by PSCS.

Section 2 – Member Engagement and Activation

A.2.1. Member and Family Partnerships

PSCS will actively engage partners in the design and implementation of treatment and care plans being inclusive of cultural preferences and goals for health maintenance and improvement. Whenever possible, PSCS will engage members in a way that the member's choices will be reflected in provider selection and treatment plans.

A.2.1.a. PSCS and its subcontractors understand that the brief period of time when a member is newly enrolling on the plan is critical for building a strong and lasting relationship. Currently, PSCS members are sent identification cards, member handbooks, provider directories and an automatic assignment of a primary care provider (if an existing primary care provider isn't assigned). These resources allow the member to engage in managing their health by connecting them to not only PSCS but also a community provider who is actively interested in taking care of the member.

Members new to the plan and who call PSCS Customer Service for the first time are identifiable in the system so that the customer service staff can allocate additional time to walk the member through accessing their benefits. Customer service staff has the opportunity to spend time with the member which can include conferencing in local provider offices to help setup initial consultations. If the member already has an established primary care provider identified in the system, the customer service agent will ensure that they are properly assigned within the system. Customer service staff will also send the member or their guardians a disclosure form to allow for others to actively participate in managing their care.

Currently, the customer service department maintains a list of quality activities that are being offered by the PSCS and educate staff members on their benefits relevant to the members' situations. Additionally the customer service department maintains a list of community resources that the member might be interested in accessing outside of the standard benefit package. It is the main goal of PSCS customer service staff to build a relationship of trust and integrity with each member that can help guide the member through the health delivery system. Through policy and program designs that are coordinated with community partners, a consistent method for facilitation of meaningful member engagement will occur.

PSCS will work with its partners to develop community terms of engagement that can be consistently applied across providers, services and settings. Member engagement will be

fostered through shared decision-making within the clinical advisory committee and the community advisory committee. Tools will be developed along with population based clinical guidelines to improve the members care and to help the member evaluate health care decisions. The following methods based on research and best practice will be supported through the program when possible.

- Employ individuals when possible whose cultures and language match the populations.
- Provide training in coordination with providers regarding cultural norms and practices that effect care and outcomes.
- Engage interpreters.
- Provide targeted member materials for identified populations.
- Provide translation of materials for members upon request.
- Develop partnerships with public health, community and faith based organizations serving minority populations to increase trust, access, and education.
- Collect data and analyze data to identify and address disparities and social injustice issues within the community.
- Utilize peer navigators, community health workers, community public health nurses, and public health programs such as WIC to access members and improve client care.
- Provide reports to the Community Advisory Committee to aid in the improvement of care.
- Develop written care plans and offer training to providers on the use of the care plans.
- Develop a variety of materials and training tools for member engagement.
- Initiate specific focus groups coordinated with public health for high need clients to determine gaps in care and needs. Development of surveys to better assess needs will be considered as well.
- Document outreach to and case management of members to allow for better tracking coordination and facilitation of care between partners.
- Develop health literacy programs. Multiple providers including St. Charles Health System, Mosaic, and the counties are currently engaged in this process.

A.2.1.b. PSCS and its subcontractors approach each interaction with a member as a chance to educate and empower. PSCS believes that members can be hindered and disadvantaged in managing their care due to a lack of knowledge and confidence and lack of empathy from their health care organization. PSCS places a focus on understanding and actively supports each member in overcoming barriers. PSCS ensures that each member is educated on the PSCS's quality initiatives and other community resource available to the member. The claim and authorization system can be used to measure member activation rates. The time is measured from the first day of enrollment to the first date of service on a

claim, first call to Customer Service or the first referral to a provider. The claim and authorization system has the ability to flag members with certain chronic diseases or complex needs based on both claims and referral data. Any staff member who interacts with a member with a chronic disease or complex need can be notified of the condition so they can ensure the member's needs are addressed appropriately. This notification allows staff the opportunity to provide members with focused instruction or education.

PSCS will further analyze opportunities to encourage member engagement teams in provider practices. PSCS will work with community partners to:

- Develop training programs by public health on the social determinants of health and the effect on health.
- Identify and address transportation barriers.
- Identify situations leading to lack of access to healthy food.
- Encourage walking paths and other opportunities for physical activities for all populations in communities.
- Provide education and information for members regarding prevention programs such as Oregon Quit Line, Living Well and other programs.
- Provide engagement materials for members.

PSCS will engage members in culturally and linguistically appropriate ways. The enrollment system has the ability to track a member's race, ethnicity and primary language. This allows PSCS to ensure all materials sent to the members are provided in the members' primary language. It also allows customer service staff to route calls from a member to a native speaker or to prepare a language line interpreter. The customer service department will employ native Spanish speakers and utilize a language line service for all other languages.

PSCS will educate members on how to navigate the coordinated care system and will ensure access to peer wellness and other non-traditional healthcare worker resources. PSCS will provide education to staff on the nuances of navigating the new coordinated care approach. Customer service staff will go through extensive training on the local community's available resources. Because the customer service staff is one of the most readily available resources to a member, it is critical that they understand the new delivery model and are able to guide the members through the process.

PSCS will encourage members to use effective wellness and prevention resources and to make healthy lifestyle choices in a manner that is culturally and linguistically appropriate. PSCS will maintain a list of quality programs and alternative benefits that are being offered and educate members on benefits of making healthy lifestyle choices.

PSCS will provide plain language narrative that informs members about what they should expect from the PSCS with regard to their rights and responsibilities. As conversations continue in the development of the CCO, this narrative will evolve. A draft of the narrative will be available upon readiness review. Once the Community Advisory Committee (CAC) is activated, it is expected that the CAC will monitor and measure member activation. The

process of how this is to be accomplished will be determined by the CAC with assistance from PSCS staff and community partners.

Section 3 – Transforming Models of Care

A.3.1. Patient-Centered Primary Care Homes (PCPCH)

A.3.1.a. PSCS will support provider networks through the provision of technical assistance, tools for coordination, management of provider concerns, relevant member data, and training tools necessary to communicate in a linguistically and culturally appropriate fashion as explained below.

- **Technical assistance:** PSCS will provide assistance, resources, and supportive services for clinics who are working to become "PCPCH Recognized", clinics that have already received PCPCH recognition, and clinics who are working toward advancement of tiers. In addition, PSCS will offer assistance, resources, and supportive services for clinics who are implementing other quality improvement efforts in collaboration with PSCS. This assistance can include practice facilitation and/or coaching, participation in learning collaborative, online learning modules, and other resources that support practice transformation and result in better health, better care, lower costs and enhanced member experience. Presently, several clinics in the Central Oregon area have already achieved PCPCH Recognition. These clinics are able to collaborate with one another as well as with practices who have not yet applied in order to provide technical assistance and share best practices for application, advancement of tier level, and practice transformation.
  Sharing of information among provider practices is currently being facilitated by the Central Oregon Independent Practice Association (COIPA) and other community partners including PSCS. The Oregon Health Authority has partnered with Northwest Health Foundation and HRSA to fund a PCPCH Center (Center) which intends to provide technical assistance and opportunities for providers to participate in a learning collaborative, learning networks, and online learning to support practice transformation. It is expected that the Center will provide assistance with strategic planning and financial coordination. COIPA and PSCS are in the process of setting up a PCPCH community forum in Bend with the potential of a second community forum in the Gorge with speakers from Oregon Health Policy and Research. The tentative date for Bend is set for May 22nd. The agenda is being developed, and potential topics include:

- Overview of PCPCH Program.
- Application Process.
- Additional PMPM funds available for recognized clinics.
- Reporting.
- Payment timelines and structures (MCO vs. FFS OHP members, and Q&A opportunities).

The intention is to also make discussion available remotely to clinics out of the area with use of "Go to Meeting".

- **Tools for coordination:** In coordination with traditional case management services PSCS currently provides and will continue to provide, PSCS case managers are well trained and are currently taking on "co-management" tasks and communications with coaching and transitions in collaboration with clinic-based case managers. PSCS intends to further build upon these relationships and collaboration further through the PSCS/PCPCH model. PSCS encourages care coordination through the use of Exceptional Needs Care Coordinators (ENCCs), PSCS case managers, and an electronic referral system to keep primary care managers involved with and well-informed about the specialty care being received by their members. Data analysis is being used to identify and support opportunities to improve quality/coordination of care.

- **Management of provider concerns.** When concerns are brought to PSCS Provider Network Department, the appropriate team researches the issue and contacts the provider. Often, PSCS Provider Network will work with multiple departments within the company to research and address the providers concern. During the research process, the provider is kept informed of the progress/status. In addition, PSCS's community partner, COIPA, currently provides support for provider members and serves as a liaison between providers and various community resources, including other providers, payers, the hospital system, etc.
- **Relevant Member data.** For PCPCH clinics, PSCS is currently providing a list of clinic assigned members and identifying which members have ACA qualified condition eligible claims. This activity will assist clinics in identifying members that may be ACA qualified. In addition to that information, PSCS is providing some additional information about the member such as Ingenix ERG prospective risk score, total medical and pharmacy costs of the member for the past 12 months, date of most recent ER visits, total ER visits in the last year, date of most recent inpatient stay and count of inpatient stays in the last year, and the DRG for the most recent stay to help assist clinics

with managing PSCS members. PSCS is also a data supplier to Quality Corp and has worked with them to add PSCS's Medicaid lines of business to the reporting of quality improvement measures which include member specific results that providers can access through an online portal. Currently, an agreement between COIPA, TransUnion, and PSCS allows data reports to be developed using OHP member claims. These reports identify and track quality initiatives and give providers an additional resource for population management and tracking of utilization. Three local provider offices are expected to participate in a pilot with Q-Corp which will provide opportunities to analyze EMR data in an effort to begin looking at consolidating claims and clinical data.

- **Training and tools necessary to communicate in a linguistically and culturally appropriate fashion with Members and their families.** Provider Directories noting the provider's languages will be provided to members to ensure members can choose a Primary Care Provider that is fluent in the member's primary language. Materials will be written in 6th grade reading level and will also be translated into Spanish, since the thresholds as identified by OHA are met for this need in Central Oregon. If members need other informational materials in another form, PSCS will provide them with the pertinent information. Examples include:
    - Other Languages
    - Large Print
    - Computer Disk
    - Audio Tape
    - Oral Presentation
    - Braille

  PSCS also provides interpreter services, including sign language, for members. Members can request an interpreter to assist at their doctor office visits. These services are available in person or by phone. For members who have cultural or physical challenges deterring them from receiving the appropriate care due to transportation, PSCS will assist in providing transportation services to and from healthcare appointments. PSCS will continue to work with community partners in the service area to provide these services to ensure members get the needed care.

  PSCS will provide members with newsletters that include pertinent benefit information, resources, access to care, and other important information about their health. These newsletters will be available in Spanish and other formats noted above. PSCS has a website for members where they can access information 24 hours a day, 7 days a

week. The website is Section 508 compliant and is written at a 6th grade reading level.

A.3.1.b. PSCS will continue to engage its members though a number of outreach initiatives. Contact will be made via print materials, member access via the PSCS website, direct outreach to the member either through clinical or non-clinical staff at PSCS, and through initiatives that are communicated in conjunction with PSCS provider partners. Through these vehicles, members will be made aware of program changes and transformation activities and their impact on provider capabilities. PSCS will assist its providers in developing methods of member engagements. Currently, new members at one PSCS provider office have an initial hour-long appointment with a patient navigator who explains what it means to be in a PCPCH, what the member should expect with regard to access to care, what he/she should expect in relation to quality and customer service-from the provider staff, and what is expected of the member with regard to keeping appointments, communicating with the clinic and his/her PCP, and appropriate ER utilization, etc. PSCS considers this to be a best practice model for providing member education, achieving member engagement, and setting expectations. It has strong potential for being implemented in other PSCS provider offices.

A.3.1.c. PSCS will partner with the provider community to implement a network of PCPCHs that will include a plan to encourage use of PCPCHs by members and a plan to encourage providers to move toward higher tiers. PSCS is in full support and alignment when working with clinics currently tiered for PCPCH and is also assisting those clinics who are currently working to apply for recognition. Currently in the Central Oregon area, 12 clinics have been awarded PCPCH recognition. These clinics are located in all areas that have the highest member saturations throughout this geographic area. For clinics that are attempting to apply but may fall short of the "must haves", PSCS is willing and able to support requests for assistance to ensure these clinics have the capabilities to meet standards required for PCPCH recognition. PSCS has internal resources well versed in PCPCH standards and requirements at all tiers and are ready and able to engage with clinics regardless of their current readiness and level of engagement in PCPCH. For those clinics that have applied and been recognized for Tier 1, 2 or 3, PSCS is able to supply rosters of Medicaid members in their area that are attributed to their clinic as well as indicators of what ACA qualifiers these members/patients may meet these criteria to be able to assist them with the appropriate identification. PSCS is able to identify member saturation and will reach out to clinics in areas of high member concentration to promote and support PCPCH recognition. For those not yet recognized, PSCS is ready to work with them to ensure they are capable of applying and becoming recognized. This will ensure that clinics serving these populations are engaged and are collaborating with PCPCH standards and expectations. As the number of PCPCH recognized clinics increase, PSCS and its partners can begin to work with each network to ensure that the needs of each member population's needs are addressed appropriately and across all aspects of care to ensure that targets and benchmarks are obtainable and reached within 5 years and beyond.

PSCS will require two-way communication and coordination between the PCPCH and other contracting health and service providers in a timely manner for comprehensive case management. Once PCPCH clinics are tiered and members are attributed, PSCS will set up an introduction of a communication requirement/outline between PSCS case management team and the clinic. This requirement/outline will be created to ensure communication is open and utilized to its fullest capacity. These relationships will be built from the beginning and will be a top priority to ensure collaboration is enhanced with communication that is effective and timely. PSCS has the ability to communicate with clinics in various ways including: Phone, In Person, Fax and Email. One PSCS provider is already using Relay Health to electronically communicate lab orders and results with the local hospital system. The electronic OHP Referral system utilized by PSCS allows for e-submission and review of referrals. Through this system, many referral responses are received same day. The system allows for specialty providers to route additional referral requests back to PCPs for approval, or PCPs can delegate sub-referral authority to a specialist.

A.3.1.d. PSCS's PCPCH delivery system will coordinate PCPCH providers and services with DHS Medicaid-funded LTC providers and services. In coordination with traditional case management services PSCS currently provides and will continue to provide, case managers who are coordinating tasks and communications and are well trained in providing coaching in transitions and assistance for LTC providers. PSCS intends to build upon these relationships and collaboration further through the CCO/PCPCH model. PSCS will identify local LTC providers in the service area of application and assist with coordination and communications if PSCS members require LTC outside their immediate service area. In addition, an Advanced Illness Management committee with representatives from the hospital, palliative care, home health, in-home care, hospice, and primary care is working to develop evidence-based guidelines for advanced illness management, with the intention of educating providers and improving coordination of member care and communication between PCPs, Specialists, and ER providers.

A.3.1.e. PSCS will encourage the use of federally qualified health centers, rural health clinics, school-based health clinics and other safety net providers such as family planning programs that qualify as patient centered primary care homes. PSCS currently partners with Federally Qualified Health Centers (FQHCs) Rural Health Centers (RHCs), school-based health clinics, and other safety net providers for the comprehensive provision of care for OHP enrollees. These safety net providers are highly-engaged participating members of the Central Oregon Independent Practice Association (COIPA) which is the main physician-led organization in central Oregon, which works to align the safety-net physician community with all community providers through activities such as:

- Committees on quality, appropriate utilization, transitional care, end-of-life care, and disease management.
- Community Health Information assessments to assess cost and utilization with a goal of reductions in variations of care.

- Alignment of provider incentives, through new reimbursement models which reduce the reliance on per service, volume based reimbursement, and increase payment methodologies which provide investment for high quality, cost-effective care.

In addition, these safety net providers are core participants in the PCPCH initiative, and have further participated in grant funding and other shared savings from PSCS for initiatives which support both medical home development and increased capability for integration of dental and behavioral health capabilities. Through the co-promotion of safety net provider's increased capability, PSCS has and will continue to encourage and expand the use of these providers by the communities they serve.

A.3.2. Other models of patient-centered primary health care

A.3.2.a. Considering a long-term strategy as the CCO evolves, PSCS may consider the use of other models of patient-centered primary health care that align with other PacificSource plan models. PacificSource through PSCS has adopted the model of PCPCH throughout all its Medicaid medical home endeavors (See Medicaid Line of Business below) and had agreements prior to the PCPCH standards being formed. A multiyear agreement was adopted and agreed to and included measurements very similar to PCPCH measurements. Upon renewal of each medical home agreement currently in place, PSCS will ensure that it completely and entirely represents PCPCH standards and requirements to ensure full collaboration with this model.

Commercial/Medicaid Lines of Business: PacificSource is engaged in a statewide initiative that coordinates and collaborates with multiple payers and clinics across the state of Oregon. This patient-centered model coordinates all the individuals responsible for treating members with chronic conditions. Under this pilot project, a specially trained nurse acts as a navigator, developing a personal relationship with a member to understand exactly how best to care for them. This nurse then coordinates between other partners on the team, including the member's primary care physician, medical specialists, hospitals and health plans. Potential initiatives have been identified that could help improve quality while reducing the $20,000 per person in annual health care costs for this segment of the population is anticipated.
Medicare Advantage HMO Line of Business: PacificSource is engaged with a large clinic in Bend, Oregon. This patient-centered model embeds a Care Manager (RN) in their clinic to manage and coordinate the individuals responsible for treating members with chronic conditions. Similar to the pilot above, the embedded Nurse Care Manager acts as a navigator, developing a personal relationship

with a member to understand exactly how best to care for them. This nurse then coordinates between other partners on the team, including the member's primary care physician, medical specialists, hospitals and health plans.

Medicaid Line of Business: PSCS is engaged with the local IPA in Bend, Oregon (Central Oregon Independent Practice Association-COIPA) in a patient-centered model. This patient-centered model embeds a Care Manager (RN) in the FQHC to manage and coordinate the individuals responsible for treating members with chronic conditions. This Nurse Care Manager (NCM) is employed by COIPA and PSCS supports the salary for this nurse to be embedded in the clinic. Similar to the pilots above, this embedded NCM acts as a navigator, developing a personal relationship with a member to understand exactly how best to care for them. This nurse then coordinates between other partners on the team, including the member's primary care physician, medical specialists, hospitals and health plans.

Grant Funding for Medical Home and PCPCH: In addition, the safety net providers are core participants in the PCPCH initiative, and have further participated in grant funding and other shared savings from PacificSource for initiatives which support medical home development and increased capability for integration of dental and behavioral health capabilities. Through the co-promotion of safety net provider's increased capability, PacificSource has and will continue to encourage and expand the use of these providers by the communities they serve.

A.3.2.b. PacificSource and its associated health plans recognize that one essential element in the achievement of the Triple Aim in the communities it serves will be the positive transformation of primary care. Through collaboration and partnership, PacificSource seeks to foster and align with that change. PacificSource believes that aligning internal goals and strategies to incorporate PCPCH standards within a medical home network is the best path in achieving Health System Transformation.

A.3.2.c. PacificSource will require timely two-way communication and coordination between its patient-centered primary health care providers and other contracting health and services providers for comprehensive care management. Once PCPCH clinics are tiered and members are attributed, PacificSource will set up an introduction of a communication requirement/outline between the care management team and the clinics. This requirement will ensure communication is open and utilized to its fullest capacity between all entities. Whenever possible, PacificSource will facilitate coordination between clinics EHR/EMR systems to most efficiently

transfer information as well. These relationships will be built from the beginning and will be a top priority to ensure collaboration is enhanced with communication that is effective and timely. PacificSource has the ability to communicate with clinics through their methods of preference which maybe a combination or one of the following: Phone, In Person, Fax and Email. In addition, one of PacificSource's providers is already using Relay Health to electronically communicate lab orders and results with a local hospital system. PacificSource's electronic referral system allows for e-submission and review of referrals. Through this system, many referral responses re received same day. The system also allows for specialty providers to route additional referral requests back to PCPs for approval.

A.3.2.d. PacificSource's patient centered primary health care delivery system will coordinate with PCPCH providers and services with DHS Medicaid-funded LTC providers and services. In coordination with traditional case management services and PCPCH case management PacificSource currently provides and will continue to provide, case managers are well trained and are currently capable of coordinating tasks and communications with coaching in transitions and assistance for LTC providers. PacificSource intends to build these relationships and collaboration further through the CCO/PCPCH model. PacificSource is capable of assisting with coordination and communications if members require care in an LTC facility in service area or outside this service area.

A.3.3. Access

A.3.3.a. PSCS will take steps to assure that coordinated care services are geographically located in settings that are as close to where members reside as possible, are available in non-traditional settings and ensure culturally-appropriate services, including outreach, engagement, and re-engagement of diverse communities and under-served populations (e.g., members with severe and persistent mental illness) and the delivery of a service array and mix is comparable to the majority population. PSCS assures network adequacy via regular assessments of providers who are open to new members, as well as monitoring wait times for members to get access to their designated provider. Members have the choice of who they want as their dedicated primary care provider, but if a member does make a selection, PSCS ensures geographic proximity for assignment to a primary care home.

In addition, PSCS is able to identify member saturation and reach out to clinics in those areas of high concentration to determine level of PCPCH recognition. For those offices that may not be recognized, PSCS is ready to work with them to ensure they are able and capable of applying and becoming recognized. This will ensure that clinics serving these populations are engaged and are collaborating with PCPCH standards and expectations. Once this has been identified and clinics are in compliance, PSCS can begin to work with each network to assure that the specific area member population's needs are address appropriately and across all aspects of

care to ensure that targets and benchmarks are obtainable and reached within 5 years and beyond.

In terms of non-traditional care, PSCS has been involved in a cross-community collaboration to develop, fund and encourage Community Health Workers (CHWs) within the provider community, as well as within the safety net providers in the PSCS provider network. In addition, PSCS has provided grant funding to enable a community health assessment to determine to what extent and in what domains non-traditional care workers are best deployed in a community where those providers have not yet been deployed. This assessment also identifies geographical locations of services and cultural appropriate services to provide outreach, engagement, and re-engagement of diverse communities and underserved populations including those members who have severe and persistent mental illnesses. CHWs engage with the members both in the inpatient as well as outpatient setting, to ensure members have the most benefit from these engagements and have access across the continuum of care. In terms of Personal Health Navigators, PSCS employs Transitional Care Coordinators who function in a member advocate/navigator role in helping members with medical system question/navigation, transportation, primary care assignment, and other forms of personal assistance. Interpreters are available both within PSCS and in conjunction with customer service staff via a contract with interpretation services vendors, as well as in the provider community, particularly within the safety net providers. This will assist in making sure members get culturally-appropriate care reflective of the diverse community both PSCS and PSCS provider partners serve. Members with severe/persistent mental illness and who otherwise are regarded as underserved, benefit from exceptional needs care coordination services made available to them, with PSCS staff and Community Health Workers dedicated to making sure they receive personalized/coordinated care for their care needs. There are no referral requirements for such members. Many of the PCPCH also have integrated Behavioral Health Consultants, mental health professionals, who are trained in providing brief therapeutic interventions in primary care settings for those who may have mental conditions secondary to a primary medical illness and whose symptoms are impacting their healthcare. These Behavioral Consultants have also worked with individuals with complex and chronic conditions who are part of the Emergency Department Diversion project, resulting in more appropriate utilization of the healthcare system.

PSCS is working to identify populations and demographics of the populations needs to be able to identify local resources that are appropriately qualified and ready to provide patient centered levels of care. This provides opportunities for members/patients to receive services at the most effective level of care. PSCS is currently working in several areas that are incorporating FQHC's, RHC's, Safety Net and also school-based clinics with Primary Care and ensuring these members have

access to these resources and communications are open and utilized between these qualified clinics.

A.3.3.b. PSCS does not anticipate any barriers at this time.

A.3.3.c. PSCS will engage members of all covered populations to be fully informed partners in transitioning to this model of care. PSCS will engage its members though a number of outreach initiatives. Contact is made via print materials, member access via PSCS website, direct outreach to the member either through clinical or non-clinical staff at PSCS, and through initiatives that are communicated in conjunction with PSCS provider partners. Through these vehicles, members can become aware of program changes and their impact on provider capabilities, through the medium where they most effectively get their information.

PacificSource as an organization of multiple products is currently researching different member engagement models and strategies such as Insignia Health that will provide assistance across multiple and diverse populations.

A.3.4. Provider Network Development and Contracts

A.3.4.a. PSCS will build on existing provider networks that deliver coordinated care and a team based approach, including providers external to the Central Oregon service area, to ensure access to a full range of services to accommodate member needs. PSCS is able to identify member saturation and reach out to clinics in these areas of high concentration. PSCS will work with each network to ensure that the specific area member populations' needs are address appropriately and across all aspects of care to ensure that targets and benchmarks are obtainable and reached within 5 years and beyond. PSCS Staff is knowledgeable in regards to requirements related to utilization of appropriate community resources and are ready to coordinate. PSCS is currently working in several areas including some outside Central Oregon that are incorporating FQHC's, RHC's, Safety Net and also school-based clinics with Primary Care and ensuring these members have access to these resources and communications are open and utilized between these qualified clinics.

A.3.4.b. PSCS will develop mental health and chemical dependency service alternatives to unnecessary inpatient utilization for children and adults, including those with addictive disorders. PSCS will work with community partner organizations to identify resources specific to mental health and chemical dependency that can be provided in an outpatient setting.

PSCS has developed strategies to divert members with non-medically necessary inpatient care, decrease length of stay, and prevent readmissions. As a part of the strategy, PSCS receives hospital census data from the major hospital system in Central Oregon, St. Charles Health System. PSCS has also embedded a Nurse Case Manager (NCM) in St. Charles Health System. The census data, along with the

embedded NCM, are part of a robust hospital case management system to reduce hospital readmissions. All PSCS members admitted to the St. Charles Health System are screened and, when appropriate, actively case managed during their inpatient stay. PSCS's embedded NCM works with the system and providers to ensure appropriate inpatient lengths of stay based on disease severity and co-morbid conditions. PSCS members who transition out of the hospital and require additional services will be assigned to a centralized NCM or Care Coordinator for ongoing clinical follow up. The case management and care coordination interventions are focused on improving areas that are known to cause hospital readmissions and improve overall quality of care (follow-up PCP appointment, medication adherence, fall risk, etc). In addition, PSCS is developing a post-hospital discharge program to call every member discharged from the hospital. This process will be facilitated by the dedicated Transitional Care Coordinators and a structured workflow that is built on the St. Charles Health System census data. This program will focus on telephonic care coordination and follow up to reduce readmissions.

PSCS is actively pursuing census data from other inpatient facilities in the proposed service area. In addition, PSCS utilizes a robust reporting system (Thompson Reuters) that utilizes claims experience to identify members at risk for readmission and targeted care coordination, disease management and case management services. Using this data, PSCS care coordination team will provide telephonic care coordination and follow up to reduce readmissions. Where appropriate, members will be enrolled in case management including case management of mental health and chemical dependency conditions.

Reporting of readmissions, urgent care and ED visits using claims history is utilized to report on each Primary Care Medical Home contracted with PSCS. This data is used to inform process improvement and quality improvement opportunities with the PSCS provider network. In one example, PSCS providers review the time of day their members visited the Emergency Department and Urgent Care. If the visit occurred during the PCP hours, the clinic reaches out to the member for re-education about the availability of same-day appointments.

A.3.4.c. PSCS will develop a behavioral health provider network that supports members in the most appropriate and independent setting, including their own home or independent supported living. PSCS has contracted with a robust network of mental health & chemical dependency providers to ensure that PSCS members have access to these services. This network is further addressed in RFA 3402 Application Appendix B. All PSCS Nurse Case Managers receive regular training on the availability of these services in the community to ensure that inpatients who are identified with mental health & chemical dependency needs are connected with the appropriate clinicians and do not have to rely on intensive inpatient services for their care. PSCS assures network adequacy via regular assessments of providers who are

open to new members, as well as monitoring wait times for members to get access to their designated provider.

In terms of non-traditional care, PSCS has been involved in a cross-community collaboration to develop, fund and promote Community Health Workers (CHWs) within the provider community, as well as within the safety net providers in PSCS provider network. In addition, PSCS has provided grant funding to enable a community health assessment to determine to what extent and in what domains non-traditional care workers are best deployed in a community where those providers have not yet been deployed. These CHWs engage with the members both in the inpatient as well as outpatient setting, to ensure members that most benefit from these engagements have access across the continuum of care. In terms of Personal Health Navigators, PSCS employs Transitional Care Coordinators who function in a member advocate/navigator role in helping members with medical system and behavioral system question/navigation, transportation, primary care assignment, and other forms of personal assistance. Interpreters are available both within PSCS and in conjunction with customer service staff via a contract with interpretation services vendors, as well as in the provider community, particularly within the safety net providers, to assist in making sure members get culturally-appropriate care reflective of the diverse community both PSCS and PSCS's provider partners serve. Members with severe/persistent mental illness and who otherwise are regarded as underserved, benefit from exceptional needs care coordination services made available to them, with PSCS staff, peer support specialists and Community Health Workers dedicated to making sure they receive personalized/coordinated care for their care needs. There are no referral requirements for such members.

A.3.5. Coordination, Transition and Care Management Care Coordination:

Care Coordination:

A.3.5.a. PSCS 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, in order to avoid duplication of services, medication errors and missed opportunities to provide effective preventive and primary care. PSCS maintains an electronic database for documenting member eligibility, claims payment, referral status, authorization status and any special eligibility categories that a member may qualify for. This database is a product of PSCS's claims & eligibility sub-contractor. Through a web-based portal, PSCS providers are able to view the current status and historical record of authorizations and referrals.

Services that are funded by agencies outside of PSCS can be more difficult to coordinate. In order to facilitate communication and information flow between LTC providers, mental health crisis services and providers of home and community based

services; the PSCS Medical Services staff receives periodic training on the contacts and availability of community resources. This includes in-person presentations by community partners to inform PSCS of services offered to members. The contact information for these providers is maintained on an internal Sharepoint site dedicated to the Medical Services staff. This is maintained by the Medical Services Manager. These resources are used to support case management and care coordination activities.

PSCS is also tightly coordinated with the Central Oregon Health Board (COHB). The COHB is an Inter-Governmental Agency that consolidates administrative services provided by Deschutes, Jefferson and Crook Counties. The PSCS Health Services staff will work closely with the COHB staff to ensure integration of services provided to the SPMI population. Recent coordinated efforts have included a Performance Improvement Project that brought physical health providers to a health fair at the Deschutes County Annex to provide preventive screenings to the SPMI population.

PSCS also maintains an integrated data warehouse that captures claims history and member eligibility records. The PSCS Actuarial Services Unit is responsible for generating reports out of the data warehouse to identify targeted areas for under and over-utilization. These reports are distributed to clinical, operational and contracting staffs who take any action necessary to ensure the proper level of services are provided.

The Integrated Care Management (ICM) team consists of PSCS case managers, PSCS care coordinators, physical health providers, behavioral health therapists and community health workers. The ICM team meets each week to coordinate care for high-needs members who have both behavioral health and physical health needs. This often includes members meeting the SPMI definition. These members are identified through data analysis that targets elevated risk scores, high claims experience and other clinical intelligence rules. The coordinated effort of this multi-disciplinary team is able to identify gaps in a member's care that can lead to poor health and quality of life outcomes. Often times the intervention of this group is to ensure that members get connected with community resources and/or a medical home. Since its inception in the 4th quarter of 2011, the ICM team has coordinated care for approximately 50 members. For those who have been in the program at least 6 months, the prospective risk scores have declined from an average of 11.2 to 7.9. PSCS is committed to building on this success by expanding the ICM team model to reach more members in 2012. This will include the following changes:

- adding new care coordinators,
- streamlining workflows,
- improving data aggregation,
- enhancing member engagement on the ICM team, and

- utilizing a distributed model that takes the team to the member and providers.

A.3.5.b. PSCS 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. PSCS is rooted in the community governance and the integration of physical health, behavioral health and public health. This is represented in the membership of the Central Oregon Health Council (COHC), the COHC Operations Council and the tight integration of the CCO, COHB and the Central Oregon IPA (COIPA). These community collaborations have allowed, and will continue to reinforce, partnerships between public health initiatives focused on community prevention and member self-management and physical and behavioral health initiatives. This is evidenced in the Regional Health Improvement Plan, published in April 2012 that was jointly developed by members of the COHC associated organization. Please see the Central Oregon Health Report information documented in Section A.1.6.

A.3.5.c. PSCS with community partners will develop a tool for provider to 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. This tool will be a result of the culmination of the Community Health Assessment and the Regional Health Plan. In addition, PSCS will work with the OHA, including the Office of Equity and Inclusion, to further identify the components of the community health assessment. The assessment will be analyzed in accordance with OHA's race, ethnicity and language data policy once the policy is made available.

A.3.5.d. PSCS will work with providers to implement uniform methods of identifying members with multiple diagnoses and who are served with multiple healthcare and service systems. PSCS will implement intensive care coordination and planning model in collaboration with member's primary care health home 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. PSCS will identify members with complex medical and social needs through the following uniform methods:

- Robust reporting software used to identify high-needs members. PSCS currently use a software engine purchased from Ingenix; however, this is being transitioned to a Thomson Reuters application during 2012. These reporting systems integrate member demographics, disease burden and claims history to identify members who are likely to require high resource levels in the near future. This data is overlaid with Clinical Intelligence

Rules which help to identify members with interveneable conditions.

- Members may also be identified through the ENCC program. All newly eligible ENCC members receive a wellness survey. Surveys are tabulated and scored for physical health and mental health needs based on national norms for responses to the standardized Short Form 12 survey. High need ENCC members are prioritized for referral and enrollment into the programs below. ENCC member rosters are provided to contracted medical homes each month by the Quality Improvement Coordinator in Health Services.

  Identified members are then connected with appropriate community and health plan resources by the PSCS Care Coordinators. These resources may include:

  - Patient Centered Medical Home.
  - Complex Care Clinic which resulted from the previously documented Opportunity Conference.
  - Integrated Care Management team (previously documented above).
  - Community Health Workers
    - Currently contracted through Mosaic Medical and St. Charles Health System.
  - Referrals to other community-based resources as necessary.

A.3.5.e. PSCS 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. PSCS is working closely with the COHB to ensure comprehensive coordination of care for the SPMI population. The COHB will be delegated responsibility for coordinating care for this population. PSCS will provide the COHB with a capitated budget to manage this population and all contract requirements of the CCO contract that could be delegated will be evaluated and potentially transferred to the COHB, with oversight & monitoring maintained by PSCS. The COHB is contracted with the County Mental Health Programs for the direct provision of care. The compliance with all contractual requirements for the SPMI population will be monitored by the PSCS Compliance Department in coordination with the Behavioral Health Department. To ensure that services provided by the COHB to the SPMI population are closely coordinated with the physical health and mental health services provided by PSCS and their provider network, the PSCS Behavioral Health Manager (or

designee) and the COHB Executive Director (or designee) will maintain standing positions on each of the other's respective quality committees and other committees as appropriate.

A.3.5.f. PSCS will use evidence-based or innovative strategies within the delivery system network to ensure coordinated care, including the use of non-traditional health workers, especially for members with intensive care coordination needs, and those experiencing health disparities. PSCS currently contracts with Community Health Workers (CHWs) at Mosaic Medical and St. Charles Health System. CHWs are engaged as part of the Mosaic medical home model and reimbursed through the primary care capitated arrangement with the Central Oregon IPA (COIPA). Members who are not engaged with a Mosaic medical home and who are identified as good candidates for a CHW engagement, are referred to the St. Charles Community Health CHW program. These CHWs are reimbursed on a case-rate and the success of the program is closely monitored for process and outcome measures. Further description of the evidence-based and innovative strategies for care coordination is included in Section A.3.5.a.

A.3.5.g. PSCS will adhere to current industry 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. PSCS and its subcontractors approach each interaction with a member as a chance to educate and empower. PSCS has a belief that members can be hindered and disadvantaged in managing their care due to a lack of knowledge and confidence and lack of empathy from their health care organization. PSCS places a focus on understanding each member's situation and supporting each member in addressing it. PSCS ensures that each member is educated on the plans quality initiatives and any other community resource available to them. The claim and authorization system can be used to measure member activation rates. The time is measured from the first day of enrollment to the first date of service on a claim, first call to Customer Service or the first referral to a provider.

A.3.5.h. PSCS 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. PSCS will engage members in culturally and linguistically appropriate ways. The enrollment system has the ability to track a member's race, ethnicity and primary language. This allows PSCS to ensure all materials sent to the members are provided in the member's primary language. It also allows customer service staff to route calls from a member to a native speaker or to prepare a language line interpreter. The customer

service department will employ native Spanish speakers and utilize a language line service for all other languages.

Comprehensive transitional care:

A.3.5.i. PSCS will 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 chemical dependency or other care settings. PSCS will address 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. PSCS Medical Services team enforces evidence based Utilization Management policies for members admitted to the hospital, skilled nursing facilities and those receiving home health care. The Utilization Management process ensures that all members transitioning to or from these care settings are identified prospectively. As mentioned above, the PSCS Nurse Care Managers have dual roles for Utilization Management and Case Management for physical health conditions and serious behavioral health conditions. This model ensures that the members identified as requiring transition to a new care setting receive case management to ensure that all necessary services and support are in place prior to the members move. All case management activity is documented in a proprietary Sharepoint application that was built on NCQA case management standards. This ensures consistent case management occurs across nurses and clinical situations. In addition, a full-time embedded nurse care manager is located at St. Charles Health System, the largest hospital system in the PSCS referral region. The embedded nurse is responsible for screening all PSCS hospital admissions, providing intensive case management to the highest needs members and working closely with the hospital discharge planning team and the PSCS centralized nurse care managers to ensure optimal transitions of care. Members with severe/persistent mental illness and who otherwise are regarded as underserved, benefit from exceptional needs care coordination services made available to them, with PSCS staff and Community Health Workers dedicated to making sure they receive personalized/coordinated care for their care needs as they face discharge from residential treatment settings and the state hospital. There are no referral requirements for such members.

A.3.5.j. PSCS and local APD office will approach coordination and communication in a multi-layered fashion. The local APD office will provide a copy of the CA/PS assessment that is used with LTC members to PSCS. PSCS and local APD office will coordinate staffing when appropriate. PSCS will maintain contact with assigned APD case manager or diversion transition worker. Meetings between PSCS and the local APD office will occur on a

regular basis to assist in coordination of care for members. In coordination with traditional case management services PSCS currently provides and will continue to provide, case managers who are experienced in coordinating tasks and communications and well-trained in providing coaching in transitions and assistance with LTC providers. PSCS will identify local LTC providers in the service area of application and assist with coordination and communications if PSCS members require transitions of care in a LTC outside this service area. In addition, an Advanced Illness Management Committee with representatives from the hospital, palliative care, home health, in-home care, hospice, and primary care is working to develop evidence-based guidelines for advanced illness management, with the intention of educating and improving coordination of member care and communication between PCPs, Specialists, and ER providers.

A.3.5.k. PSCS will 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. As described above, all case management activity is monitored in a proprietary Sharepoint application that is built on NCQA Case Management standards. This structured Case Management platform ensures that all case managed care transitions are documented in one centralized system. This structure also prompts PSCS nurse case managers with structured questions to ensure that members have the proper level of social support for a safe transition. This may include engagement of other family members.

Individual Care Plans:

A.3.5.l. PSCS will create standards and procedures that ensure the development of individualized care plans, including any priorities that will be followed in establishing such plans for those with intensive care coordination needs, including members with severe and persistent mental illness receiving home and community based services covered under the State's 1915(i) SPA. The care plans of community partners will be integrated into the process. Already, PSCS's community partner, St. Charles Health System has developed individualized care plans for individuals who are high frequency utilizers of the Emergency Department. As described above, the Case Management and Care Coordination software application used by PSCS Medical Services staff ensures a structured workflow and standardized questions. Every member engaged in Case Management or Care Coordination receives a single record in the application, which includes an individualized care plan. This application ensures consistent documentation and enables reporting of process and outcomes. Members enrolled in case management can be tracked over time and have their treatment plan adjusted according to their current needs. (Please find attached screen shots of the Case

Management and Care Coordination software in Attachment A.3.5.1 Case Mgt Screens). PSCS will also address individualized care plans in provider contracts and educational materials.

A.3.5.m. PSCS will have a 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. In addition, the local APD office will provide a copy of the CA/PS assessment for LTC members. PSCS and the local APD staff will mutually identify critical risk factors as appropriate. All members qualified as Exceptional Needs Care Coordination members will receive a wellness survey within 30 days of enrollment with PSCS. The survey is based on the standardized Short Form 12. Upon completion, all surveys are scored and logged in an electronic database. Using national SF12 norms, members are ranked for severity of physical health and mental health needs. The PSCS Care Coordinators conduct telephonic screenings for high-risk members using a care coordination screening application built in Sharepoint. This care coordination screening assessment is based on NCQA standards. PSCS members who are interested in Case Management and have complex clinical needs, will be assigned to a Nurse Case Manager for longitudinal case management.

A.3.5.n. PSCS will communicate and coordinate with the local APD office and DHS Medicaid-funded LTC providers. In this coordination and communication, PSCS will factor in relevant referral, risk assessment and screening information. As a part of this coordination, it has been recognized that an integration of information from both PSCS and the local APD office will be needed for creation of service and care plans. Once the local APD office completes a CA/PS assessment, a copy of the assessment will be forwarded to PSCS and utilized in the coordination of care for that member. In coordination with traditional case management services PSCS currently provides and will continue to provide, case managers are well trained and currently capable of coordinating tasks and communications with coaching and transitions and assistance with LTC providers. PSCS intends to build these relationships and collaboration further through the CCO/PCPCH model. PSCS will identify local LTC providers in the service area of application and assist with coordination and communications.

A.3.5.o. PSCS 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. All members engaged in PSCS Case Management and Care Coordination services are entered into a proprietary application that tracks their plan of care longitudinally. The medical services staff

responsible for maintaining these care plans represents the same staff conducting utilization management. When members are identified through the Utilization Management process with new clinical needs, the medical services staff will update their care plan as appropriate. Additionally, the medical services staff maintains a close relationship with the local provider network and can update a plan of care based on physician referral if the member is not captured through the Utilization Management process.

A.3.5.p. PSCS individualized care plans will be jointly shared and coordinated with relevant staff from the local APD with and DHS Medicaid-funded LTC providers. In this coordination and communication, PSCS will share individualized care plans and CA/PS assessments will be shared by local APD staff. This information will be jointly coordinated with shared staff. In coordination with traditional case management services PSCS currently provides and will continue to provide, case managers are experienced in coordinating tasks and communications and well-trained in coaching and transitions and assistance with LTC providers. PSCS intends to build these relationships and collaboration further through the CCO/PCPCH model. PSCS will identify local LTC providers in the service area of application and assist with coordination and communications.

A.3.6. Care Integration

Mental Health and Chemical Dependency Services and Supports

A.3.6.a. PSCS will develop a sufficient provider network, including providers from culturally, linguistically and socially diverse backgrounds for members needing access to mental health and chemical dependency treatment and recovery management services. This network includes members in all age groups and all covered populations. PSCS is a unique health plan contractor in that it is a Fully Capitated Health Plan contractor and a Mental Health Organization contractor with the State of Oregon. PSCS is truly an integrated health plan. PSCS's plan ensures members have access to the full continuum of behavioral health care services and supports. PSCS has an established integrated provider network which spans both physical and behavioral health. PSCS's current integrated behavioral health provider network renders services that are culturally and linguistically relevant to the local community and PSCS membership demographics. The following information is an overview of PSCS behavioral provider network which demonstrates sufficiency to meet the needs of current membership. PSCS expects to make adjustments to PSCS behavioral health provider network as dictated by 3 factors; needs of PSCS membership, alternative service delivery strategies and alternative payment models. PSCS's current behavioral health provider network consists of 3 local Community Mental Health Programs (CMHPs)

and a large variety of private subcontractors to assist with volume and specialty care. The local CMHPs provide a wide array of mental health and chemical dependency treatment and recovery services and supports. In addition to the CMHP providers, PSCS regional behavioral health provider network consists of (intensity of services correlates to service intensity described in A.3.6.b):

- 18 outpatient mental health facility based subcontractors (low intensity).
- 11 outpatient mental health subcontracts with individual practitioners (low intensity).
- 6 acute mental health care facility based subcontractors (high intensity).
- 1 adult residential facility based subcontractor (the CMHPs hold other residential subcontracts).
- 6 children crisis respite subcontractors (high intensity).
- 11 psychiatric residential treatment facility based subcontractors for children (high intensity).
- 1 child day treatment facility based subcontractor (high intensity).
- 1 adult residential alcohol and other drug treatment co-occurring disorder facility subcontract (high intensity).
- 2 outpatient mental health and chemical dependency facility based subcontracts. One subcontract is with Mosaic Medical (an FQHC) which carries a State designation as a Person Centered Primary Care Home (PCPCH). The other is with a private organization (low to moderate intensity).

PSCS anticipates adding 2 more outpatient subcontracted providers who are the local CMHPs for Crook and Jefferson counties. These providers will add additional outpatient mental health service capacity for PSCS Deschutes county members. These providers could also provide outpatient chemical dependency treatment services if the need arises.

PSCS anticipates having the following contracts in place by August 1, 2012 (low to moderate intensity).

- 7 outpatient chemical dependency treatment facility based subcontracts which includes an opiate substitution treatment facility (low to moderate intensity).
- PSCS members have access to 3 adult and 1 adolescent Fee-For-Service residential alcohol and other drug treatment facilities in the region. PSCS would like to point out that 1 of the adult facilities is dedicated to serving only the Hispanic/Latino

population. Once the State moves to place residential alcohol and other drug treatment services under the CCO, PSCS is prepared to subcontract with these facilities (moderate to high intensity).

A driving principal of PSCS behavioral health provider network development strategy is that PSCS's provider network must be localized and the provider workforce should reflect the community and PSCS membership demographics. For example, in Central Oregon, Jefferson County population demographics indicate the County has the highest percentages of Hispanic/Latino and American Indian/Alaskan Native residing in their County[1]. The Jefferson County CMHP work force is diverse and bilingual. The CMHP works closely with the Confederated Tribes of Warm Springs Reservation in coordinating and delivering behavioral health services. In addition, the Latino/Hispanic residential alcohol and other drug treatment program is located in Jefferson County. The program is administered and operated by the entity delegated by the Local Mental Health Authority as the CMHP.

A.3.6.b. PSCS will provide care coordination, treatment engagement, preventive services, community-based services, behavioral health services, and follow-up services for members with serious mental health and chemical dependency conditions requiring medication-assisted therapies, residential and hospital levels of care including members with limited social support systems. PSCS will transition members out of hospital, including state hospitals and residential care settings into the most appropriate, independent and integrated community-based settings. PSCS's integrated approach to care management is iterative and in a continuous state of evolution. PSCS in partnership with COHB, CMHPs and other healthcare providers will work together to achieve optimal health care outcomes by "…. bridging the gap between the healthcare delivery system and public community health systems, because psychosocial and environmental factors contribute roughly 80 percent to an individual's overall health in ways the health care system is not designed to address. To this end, effective care coordination must integrate the efforts of healthcare organizations with those of the communities in which members live and work. Although the healthcare system can and should provide appropriate medical care, maximizing the use of community resources can offer critical support to individuals and families in the prevention and management of diseases[2]". PSCS's innovative integrated care management strategies and models describe below are built on the ideals describe above.

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[1] Central Oregon Health Report, 2012 Executive Summary. Demographics. pg.8. Jefferson County population demographics; Hispanic/Latino 19.3% (11.9% higher than Deschutes and 12.3% higher than Crook). American Indian/Alaska Native 16.9% (16% higher than Deschutes and 15.5% higher than Crook).

[2] Care Coordinating Convening Meeting Synthesis Report September 2010. National Priorities Partnership Convened by the National Quality Forum.

The COHB will coordinate employment programs, and other programs and services for members requiring more intensive services and support. The COHB will receive a global payment from PSCS to carry out these services. The COHB will be responsible and accountable to provide comprehensive care coordination for members receiving intensive services. Additionally, the COHB in collaboration with the CMHPs will create seamless transitional care pathways which move PSCS members from the state hospital-acute hospital and residential care settings into the least restrictive community based setting. The COHB in partnership with the CMHPs will be responsible and accountable to ensure PSCS members have access to and receive all medically necessary behavioral health services and supports to maintain their independence in the community.

PSCS will execute contracts and perform administrative oversight and clinical management of low intensity behavioral health outpatient services[3]. PSCS will be responsible and accountable for all of the care coordination and creating seamless transitional care pathways into and out of high intensity services. Low intensity services are rendered in outpatient care settings. Services are provided by PSCS's local network of providers and CMHPs. PSCS's current Care Management Team (CMT) consists of Nurse Case Managers (NCM) and Transitional Care Coordinators (TCC). The work is targeted at members with physical health care needs and chronic health conditions. The CMT assesses the members healthcare needs including their psychosocial needs. These members often have unmet psychosocial needs and behavioral health care needs or, they are currently receiving behavioral health treatment. Their healthcare is uncoordinated and their psychosocial needs are rarely addressed by the healthcare system. In an effort to improve care management for these members, PSCS has developed and implemented innovative models of care management which bridge the systemic gaps between the healthcare systems and needed psychosocial supports.

PSCS has developed the Integrated Care Management model (ICM). The model is community based approach to care management. The ICM team meets weekly and is composed of PSCS's CMT and community behavioral health providers. PSCS will add a Behavioral Health Utilization/Care Manager within 60-90 days and potentially add a Behavioral Health Transitional Care Coordinator to create a multidisciplinary integrated CMT within PSCS. Other examples of innovative community based care management strategies include the PSCS current Performance Improvement Project (PIP). In partnership with the Deschutes County CMPH, PSCS is using the CMHP's Peer Support (PSS) Specialist (who are also Certified Healthcare Workers) to engage and motivate individuals with Severe and Persistent Mental Illness (SPMI) to obtain a health screening. Based on the health screening results, the PSS helps the individual

[3]*See A.3.6.a. bullet points for a list of low intensity service contracts. These contracts will transition over to PacificSource by August 1, 2012. Residential alcohol and other drug treatment service providers are currently paid as fee for service through the Division of Medical Assistance Programs. A contracting approach and rates for these services will be developed by PacificSource in partnership with the COHB and the providers once the State includes these services in the CCO global budget.*

make follow-up preventative physical health and dental care appointments. The PSS helps the individual navigate the healthcare system and develop new healthcare pathways. The overall aim of the PIP is reduce healthcare disparities and improve the overall health statuses for members coping with SPMI. AMHI and Children's Wrap Around are other innovate care managements services provided to PSCS members through the COHB and CMHPs.

PSCS is developing a post-hospital discharge program to call every member discharged from the hospital. This process will be facilitated by the dedicated Transitional Care Coordinators and a structured workflow that is built on the St. Charles Health System census data. This program will focus on telephonic care coordination and follow up to reduce readmissions. PSCS is actively pursuing census data from other inpatient facilities in the proposed CCO service area. In addition, PSCS utilizes a robust reporting system (Thompson Reuters) that utilizes claims experience to identify members at risk for readmission and targeted care coordination. Using this data, the care coordination team will provide telephonic care coordination and follow up to reduce readmissions. Where appropriate, members will be enrolled in case management. PSCS will enter into a service contract with the Central Oregon Health Board (COHB) by August 1, 2012. PSCS will delegate the contracting, administrative oversight and clinical management of high intensity behavioral health services to the COHB[4]. High intensity services include but are not limited to EASA, acute care hospital, AMHI, assertive community treatment, Children's Wraparound (ICTS), 24/7 crisis services, residential and other services as appropriate.

A.3.6.c. PSCS will integrate care and service delivery to address mental health and chemical dependency issues by proactively screening for and identifying members with them, arranging and facilitating the provision of care, development of crisis intervention plans as appropriate, and coordinating care with related health services including DHS Medicaid-funded LTC services and other health services not funded by the Applicant. This includes members from all cultural, linguistic and social backgrounds at different ages and developmental stages. As described in A.3.6.a and A.3.6.b, PSCS and the COHB have a fully operational integrated service delivery system in place which addresses the physical, mental health and chemical dependency treatment needs of PSCS members. All behavioral health providers are either the local CMHPs or organizations certified by the State or local CMHPs. The network of behavioral health providers are governed by OAR 309-032-1500 (Integrated Services and Supports Rule [ISSR]). Specifically, OAR 309-032-1525(3)(d)(B)(C)(D)(F) requires comprehensive screening and the provision of appropriate services or referral to qualified professionals for the provision of care. Behavioral health provider contracts also mandate compliance with the ISSRs.

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[4] *See A.3.6.a. bullet points for a list of high intensity service contracts. These contracts will transition over to the COHB and CMHPs by August 1, 2012.*

If the CMT (e.g. TCC or NCM) identifies a behavioral health care need, a direct referral to the appropriate behavioral health provider is made. The CMT receives regular trainings and education on available community resources. Additionally, the TCCs perform data mining to identify members who present as high risk. Often, these members are in need of behavioral health services. The TCC will make direct referrals or they will bring the case to the ICM. The ICM ensures these members are connected to needed behavioral health services.

PSCS has been engaged in provider education and encouraging PCPCHs and the hospital EDs to implement the EBP Screening Intervention and Brief Treatment (SBIRT). PSCS will plan to increase efforts around implementation of SBIRT in these settings. PSCS on behalf of PSCS members will work through the COHB to gain access to critical services and supports which may not be funded through the PSCS plan. COHB will manage high intensity services. The COHB in collaboration with the CMHPs and PSCS will work together in the development of care plans and access to services and supports for DHS Medicaid-funded LTC services.

A.3.6.d. PSCS will organize a system of services and supports for mental health and chemical dependency. The 2012-2015 Central Oregon Regional Health Improvement Plan will be used as the framework to develop integrated preventative service. Under this framework, initiatives which target behavioral health prevention at the community and clinical level will be developed and implemented. Integration of behavioral healthcare into the primary care setting is underway. To date, Mosaic Medical, an FQHC and PCPCH, employs an embedded Behavioral Health Consultant. Mosaic will also hire a Psychiatric Mental Health Nurse Practitioner. Mosaic also provides embedded primary care services at Deschutes County Health Services (DCHS and is the CMHP) Annex location. The Annex location provides services to individuals who have a SPMI. DCHS and Mosaic are also planning to co-locate services in Redmond. All of the CMHPs are continuing to experiment with different models of integrative care with FQHCs. There are also models of integration being considered with PCPCHs that are not FQHCs. St. Charles Health System provides embedded Behavioral Health Consultants in other primary care settings throughout the PSCS region that serve PSCS clients.

As described in previous sections, PSCS has a robust provider network in place. The CMHPs currently provide behavioral health 24/7 crisis services which serves members of all ages. PSCS's behavioral health providers offer a variety of approved Addictions and Mental Health Division (AMH) Evidenced-Based Practices and Processes (EBPs). For a complete listing of AMH approved EBPs and practices please follow the link:

http://www.oregon.gov/OHA/amh/ebp/practices.shtml

The Central Oregon Health Council has developed a subcommittee called the Psychopharmacology workgroup. This workgroup is focused on providing

community education and resources to improve the utilization of pharmaceuticals for mental health conditions. In late 2011, the COHC brought renowned speaker Dr. Daniel Carlat to Central Oregon to conduct a day long educational seminar on the appropriate use of mental health medications. It is anticipated that this type of evidence based continuing education will bring clinical best practices and nationally recognized service models to Central Oregon. The Psychopharmacology workgroup's efforts continue with the integration of mental health prescription claims data from the State Fee-For-Service system with physical health prescription claims data from PSCS. This integration of claims data was enabled by the passing of SB1506 in the 2012 legislative session, which was initiated and lobbied by the Central Oregon Health Council. Integrated pharmacy claims data is a valuable tool in coordinating care for members and providing education to prescribers. The COHC in coordination with the National Alliance on Mental Illness (NAMI) will also be convening a Mental Health Advisory Group (MHAG) during the summer of 2012. The MHAG will consist of providers from a variety of behavioral health backgrounds, including psychiatrists, pharmacists, psychologists and LCSW's. This group will be charged with guiding future initiatives of the Psychopharmacology workgroup and reporting their findings to the 2013 Legislature.

Oral Health

A.3.6.e. PSCS will have a formal contractual relationship with Advantage Dental or other appropriate DCO who serves PSCS members in the Central Oregon service area by July 1, 2014. Discussions are currently occurring with Advantage Dental to define how dental care will be integrated and how roles will evolve. Potential elements of the plan moving forward will be: emergent/urgent access to dental; prevention; and general dental care screening in schools, HeadStart, and WIC programs. PSCS with its community partners will further develop a plan to coordinate dental care with behavior health, physical health and the hospitals to reduce the use of emergency rooms, operating rooms and medications by diverting members at the right time, to the right place, and for the right care.

A.3.6.f. PSCS and its community partners will coordinate care for members' oral health needs, prevention, and wellness as well as facilitating appropriate referrals to dental care. It will be critical to establish a 24 hour/ 7 days a week after-hours on-call system to meet the emergency and urgent needs of members and provide access that is local. Prevention and general oral health care provided by dental hygienists screening children in schools, the HeadStart, and Women Infants and Children (WIC) programs for cavities and by applying fluoride varnish to the children's teeth will be considered. In addition, coordination of care will occur between dental health, behavior health, and physical health and the hospitals to reduce the use of emergency rooms, operating rooms and medications by diverting members to appropriate care.

Hospital and Specialty Services

A.3.6.g. PSCS will have agreements with hospitals and specialty care providers to address coordination and referrals to PCPCHs and performance expectations as well as transition plans. Currently PSCS coordinates communications, including data sharing and transfer of admissions and coordination of notifications received by the hospital (St. Charles Health System) with PSCS nurse case managers and members' PCP care managers. PSCS communication agreements are put in place and routinely coordinated between the Hospital, PCP Clinics and PSCS case managers on a regular basis. With incorporation of PCPCHs, PSCS intends to continue to improve upon this process and will be facilitators, partners and supporters of this coordination of timely care and notifications. It is intended that the Hospital Agreements will be available at Readiness Review.

A.3.7. DHS Medicaid-funded Long Term Care Services

A.3.7.a. PSCS has begun discussions with the local APD office. Moving forward, PSCS and the local DHS APD office will begin communicating on a regular and interval basis to create a "multi-disciplinary" approach to coordination of member's care. It is anticipated that PSCS and the local APD office will participate in care conferences, hospital transition meetings, diversion/transition and case management efforts.

A.3.8. Utilization management

A.3.8.a. PSCS 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.

In performing UM activities, the authorization process differs between acute and ambulatory levels of care in that often acute episodes of care are classified as urgent or emergent and require analysis of the necessity, appropriateness, and efficiency of medical and dental services, procedures, facilities, and practitioners after service has been initiated. However, non urgent or ambulatory levels of care can be planned for and reviewed in a more proactive way. Requirement of preauthorization for non urgent care allows not only procedures and treatments to be reviewed for best practice but also to develop a holistic and member centered care plan. The authorization system has the ability to identify acute and ambulatory care and escalate their priority to the Health Services staff.

PSCS will use methodology and criteria for identifying over- and under-utilization of services. PSCS utilizes a robust reporting program to identify under and over-utilization of services. Various reports are generated by the PSCS Actuarial Services Unit and disseminated to the Health Services teams. These reports include

hospitalization rates, emergency room utilization rates, medication adherence, disease burden, various cost categories and clinically appropriate tests. These data are distributed to NCMs, pharmacists and Condition Support staff for member and provider intervention and education. PSCS is also engaging a new Fraud Waste & Abuse vendor in 2012 to target cases of overutilization. This vendor, Thomson Reuters, will provide monthly reports to a FWA team at PSCS who will be responsible for identifying legitimate FWA cases and reacting appropriately (contract termination, recoupment of payments, law enforcement referral, etc).

In addition, PSCS has created multiple data warehouses that integrate claims, enrollment and referral information. The data warehouse allows plan staff to actively identify over and under utilization of services. A key element of the data warehouse is the collection of all encounters between members and providers within the claims system. PSCS partners with its subcontractor Ph Tech to capture all viable encounters within a single unified system. These data sets incorporate the states own risk and rate member stratifications, revenue buckets and claims buckets. These data sets have been key in both the lowest cost and base cost estimate exercises performed at the request of OHA. The combination of those data elements allow PSCS to compare its funding to the expenses incurred by rate group for inpatient, outpatient, and other service types.

PSCS's approach to Utilization Management enables PSCS Medical Services staff to tailor all requests for services to a member's unique need. PSCS's model combines Utilization Management and Case Management functions into a single nursing position. This requires a Nurse Case Manager to focus on the whole member. All of NCMs who are dedicated to Medicaid business are expected to spend 2-4 hours daily providing telephonic case management to their population. Case Management cases may be initiated through the Utilization Management process, by data analysis or by referral. This consolidated model is at the core of PSCS's Medical Services team.

PSCS also has a dedicated Behavioral Health Department to ensure all of the behavioral health and physical health needs of PSCS members are met. This team is responsible for conducting UM & CM for high need mental health members and educating nurse case managers on the unique needs of those members with special health care needs. In addition, PSCS has the following programs to ensure that all UM activities are conducted in a manner consistent with the needs of each member:

- PSCS staffs a weekly Integrated Care Management (ICM) meeting for clinical staff and community providers. The ICM group is convened to identify the unique needs of a small subset of high-needs members and ensure that all barriers to optimal care are removed. This often includes providing members with an exception to the standard Utilization Management policies.

- The Exceptional Needs Care Coordination members (ENCC) are identified in the claims adjudication and authorization software to ensure that all NCMs conducting Utilization Management are aware of their intensive care needs. Through ENCC outreach, eligible members are assigned to Nurse Case Managers who are also responsible for their Utilization Management, ensuring a member-centered approach to both CM and UM.
- The PSCS Medical Services Manager conducts weekly training with all Medical Services staff. This training includes member centered topics such as Motivational Interviewing, long term care services, availability of community resources and program contact information. Additional topics include: Living Well with Chronic Conditions and other areas of focus on Behavioral Health. All Nurse Case Managers are expected to complete clinical training modules each month which often focus on the unique needs special populations.

The same Medical Services team members process acute inpatient and ambulatory care authorizations to ensure continuity of care and inter-rater reliability for PSCS members. However, no authorizations are required for Urgent or Emergent services and this is clearly communicated to members and providers through various channels (letters, newsletters, handbooks, website, and meetings). Inpatient hospital stays are reviewed concurrently for appropriateness of the member's level of care. Acute inpatient hospital stays are overseen by an embedded hospital case manager at St. Charles Health System. The embedded case manager is able to ensure all member needs are clearly communicated between the hospital staff and the nurse case managers at PSCS.

PSCS's utilization management system can be configured to flag members with specific conditions that require specific handling. These flags can be used in several areas:

Customer Service – Customer Service staff can be alerted that a member calling has special handling needs.

Benefit Package – The claims system can be configured to alter the members benefit package based on any special needs.

Authorization Requirements – The claims system can be configured to alter the member's authorization requirement based on any special needs.

Approval Rules – The authorization system can be configured to allow automatic/expedited approvals for members with special needs.

Provider Notification – Providers assigned to care for members with special needs are alerted of those special needs through the same system flags.

Health Services Notification – Health Services staff are notified during their workflow if any referral or prior authorization is for a member with special needs.

Section 4 - Health Equity and Eliminating Health Disparities

A.4.1. PSCS and its providers will work together to develop best practices of culturally appropriate care and service delivery to reduce health disparities and improve health and well-being of members. Currently, PSCS works closely with its providers in the area of providing the best possible culturally appropriate care. Partnerships with FQHCs, RHCs, and other provider entities skilled at the multiple cultures within their communities give PSCS a foundation to succeed in this area. PSCS uses culturally variable communication to members, and acts as a resource for identifying and providing access to the must culturally appropriate care in the community. PSCS has additionally collaborated in the community to invest in the development of additional capability of PSCS provider partners to increase access to those providers that provide such culturally-appropriate care. Examples of these investments include the creation of a new provider reimbursement model in the Central Oregon service area that no longer links higher reimbursement with providing more services. This new model allows primary care providers the opportunity to invest in the care that is culturally appropriate for the member population. Another investment example includes PSCS grant funding which is invested in those providers needing financial assistance in building new capabilities, as well as new and continuing shared savings models whereby new capability investments are paid for by cost reductions that result from the reduction of unnecessary/inefficient provision of care. PSCS also participates in a weekly Integrated Care Committee with local providers to share learnings on specific member care situations including dental and behavioral health care needs, in order to meet the needs of complex members and to eliminate health disparities. In addition, PSCS is partnering with community providers to create a new Complex Care model designated as the Medical Home to meet the needs of the complex members who receive least-optimal services by the current health care delivery system. The reduction of health disparities and improvement of the well-being of members will be conducted at a community level, and by engaging with local care providers and reviewing community care experiences formed by the many Community Health Assessments that have taken place in the Central Oregon Service Area. From these many point of analysis, a community

health improvement plan can be jointly created with the community providers that A) has community-wide buy-in and B) can assess if further community data should be assessed to identify further health improvement initiatives, and mutually craft strategies to achieve them.

A.4.2. PSCS will track and report on quality measures by these demographic factors that include race, ethnicity, primary language, mental health and substance abuse disorder data. PSCS has developed and implemented a written strategy and work plan for assessing and improving the quality of care to individual members. The work plan addresses eliminating health care disparities through access monitoring of appointment availability and provider capacity. The strategy describes systematic monitoring to identify special populations through enrollment demographic data and annual review of enrollment characteristics, including but not limited to race, language, and dual eligibility status to monitor relevance to health risk and utilization. Currently there is a significant population of members who speak Spanish so most materials are available in Spanish. PSCS has customer service representatives and grievance and appeals representatives available who speak Spanish. Member Safety is monitored through Adverse Events tracking. Tracking is currently reported for members with special health care needs and will need to be developed further to include information for race, ethnicity, and language.

Member satisfaction is evaluated through analysis of the CAHPS survey results. The CAHPS results reported for subpopulations are reported to the Quality Assurance Utilization Management Pharmacy and Therapeutics Committee (QAUMPT) for review and potential follow-up action.

PSCS monitors the utilization of available interpreter services annually. The intent of monitoring languages utilized is to identify early the need to make materials available in languages other than English and Spanish.

PSCS has some experience in the past year with reporting on members with mental health conditions. A current Performance Improvement Project is focused on improving preventive services to members with Serious Persistent Mental Illness. The population was identified through ICD 9 codes. ER and Hospital utilization as well as visits to PCPs and the use of preventive services were reviewed and compared to the general population. This analysis helped identify the need to focus the project on preventive services.

Client Process Monitoring System data (CPMS) is submitted by behavioral health providers to the state. This data includes demographic information and behavioral health utilization data. It is used for monitoring providers' utilization rates and calculating measures for Quality Improvement Report (outcome measures of clients). This data source is can be used to assess utilization and performance.

Epidemiological Data on Alcohol, Drugs, Mental Health and Gambling is available from the Addictions and Mental Health Division website. This site includes

information and data for 50 state measures and 41 county measures that can help local communities better understand substance use and mental health of their population.

Reporting quality measures by race, ethnicity, and language will involve ensuring that data is available in member enrollment tables used for reporting. The process to ensure the data is available has been initiated. Reporting specific quality measures for mental health and substance abuse may require using claims data queried for relevant ICD 9 and CPT codes to identify indicative diagnoses and services if the data is not available through CPMS or Oregon Addictions and Mental Health data. Survey data may also be used to identify these populations.

The claims and enrollment systems have the ability to capture and track race, ethnicity, primary language and any chronic disease state. These fields may be captured automatically if provided through the 834 enrollment feed from OHA, captured by plan staff passively during member interactions, or proactively by plan communication with members.

Chronic disease states such as mental health and substance abuse disorder can be identified within claims and referral data within PSCS systems. Once identified these disease states can be utilized for a variety of uses:

PCPCH – Members with a chronic disease can be encouraged to seek their care within a patient centered primary care home to receive the most complete care for their conditions.

Customer Service Interaction – Customer Service staff alerted by the system that a caller has a chronic condition can educate the member on the plans quality programs most beneficial to the member.

Case Management – Members with identified chronic conditions can be passively enrolled into a case management system.

Alternate Payment – Members with identified chronic conditions can be passively enrolled into an alternative payment program that creates incentives for providers delivering care to the chronically ill.

The inclusion of these chronic disease states and the enrollment status information directly in the claims system allows a unified data set to be maintained. The unified data set allows for easy reporting on expense, utilization and trend of race, ethnicity, language, mental health and substance abuse disorder data, and chronic disease states.

Section 5 - Payment Methodologies that Support the Triple Aim

A.5.1. PSCS's payment methodologies will support and promote the Triple Aim. PSCS will provide comprehensive coordination and create shared responsibility through alternative payment methodologies. PSCS implemented a new community-wide OHP capitation methodology which began February 2012. This new methodology removes volume-of-service based financial incentives and replaces them with incentives that reward primary care (including those who have applied for and received PCPCH status) for providing the right care at the right time. This same new agreement provides shared savings incentives for PCPCH primary care providers as well as specialty providers for appropriate management of care as measured by performance in a specialty care fund, a hospital fund, and a prescription drug fund.

PSCS will provide financial support that is differentially based. Financial support for certain PCPCH providers has been and will continue to be provided for different PCPCH-tiered providers based on PSCS agreement with COIPA. This agreement provides for special funding mechanisms (i.e. additional PMPM payments) for enhanced delivery of primary care. In addition, PSCS has provided grant-based funding to many of the PCPCH providers based on capability and the need for investment dollars for new innovative models.

PSCS will align financial incentives for evidence based and best emerging practices. PSCS's existing payment methodologies which include Medical Home incentive payments aligned with quality and best practice metrics, are designed to promote high quality care in tandem with cost-efficiencies. In addition, PacificSource has partnered with COIPA who is investing in new informational capabilities which will lead to community-wide evidence-based best practices and will provide a data-based solution to variations in care in the CCO population.

Section 6 - Health Information Technology

A.6.1. Health Information Technology (HIT), Electronic Health Record Systems (EHRs) and Health Information Exchange (HIE)

A.6.1.a. PSCS plans to improve HIT in the areas of data analytics, quality improvement, member engagement through HIT (using tools such as email, personal health records, etc.) and other HIT. PSCS actively applies data analytics in numerous areas with a goal of improving population health and engagement. PSCS has recently acquired significant analytical capability with the implementation of Thomson Reuters Advantage Suite which is an analytical tool specifically focused at the management of member health through the application of industry standard analytical models that have the ability to risk stratify members for management in our condition management programs. This application also has the ability to apply predictive

modeling with the goal of intervention prior to significant episodes occurring. This system can take numerous inputs including: Claims Data, Prescription Data, Lab value data, Vision data and EHR information. When combined, this information will provide a holistic view of member health and adherence to standardized treatment plans. This standardized data can be used to provide a feedback loop to our health system stakeholders on the quality and efficacy of care delivered. As described in more detail below, PSCS is also actively working with providers to encourage the adoption of EHRs and supporting the Central Oregon HIE efforts.

PSCS's community partner St. Charles Health System (SCHS) is currently providing EMR platforms for all community hospitals and subsidies to any provider implementing EMR in the community. SCHS is committed to substantial funding for a HIE that will ultimately include all providers in Central Oregon. There is a community Steering Committee which includes key stakeholders from provider groups (COIPA, BMC, SCMG, etc) to determine needs for data analytics, quality measures and a personal health record for members. Member engagement is critical for the success of the CCO and includes open access for any member through a member portal; the personal health record can be updated and will be available for the member's providers. Finally, PacificSource is currently in the process of implementing an enterprise system to facilitate secure and non-secure messaging via email and SMS/Text to our members and providers for the purposes of improved engagement and communication efficiency.

A.6.1.b. PSCS in working with community partners is developing strategies to track and increase adoption rates of federal ONC certified EHRs. PSCS currently tracks adoption of EHRs though frequent provider engagements with provider relations staff who regularly engage the providers on capability, technology interfaces between providers and PSCS, and technical capability growth/planning in the provider's offices. These engagements are supplemented by other workshops and surveys conducted by provider relations staff in which EHR and other technology planning on the part of the provider is discovered and assessed. In addition, nearly all the physical health professional providers in the CCO service area are affiliated with an independent practice association who tracks and makes available information on EHR adoption. The Central Oregon provider community is using certified ONC-certified EHRs, with a very high adoption rate running between 70-80%, possibly the highest in the State. SCHS is upgrading the Bend and Redmond hospital systems to achieve Stage 1 Meaningful Use status. The rural hospital areas, Madras and Prineville, are scheduled for 2013. In order to maintain high meaningful use standards, the SCHS subsidy applies only toward certified EHRs. OCHIN is under contract with SCHS to move EMRs out to the community, monitoring adoption is a part of their service terms. In terms of increasing adoption rates of EHRs, PSCS has and will continue to use various strategies. PSCS has already provided grant funding to some providers, including safety net providers, to enhance workflows and use of EHR within a

medical home expansion. This grant funding is available every year for provider enhancements to patient care through the robust use of EHR technology. PSCS will continue to monitor EHR adoption and identify methods to further increase usage that are consistent with our Triple Aim goals. Opportunities being explored include establishing eligibility criteria for funding of medical home development based on having an established and robustly-used EHR. PSCS may also consider future incentives for differential reimbursement for providers depending on those practices which have and robustly use their EHR.

A.6.1.c. PSCS with its community partners will facilitate meaningful use and HIE. The HIE company under contract with SCHS, Relay Health~ a subsidy of McKesson, is the partner designated as the connection point and ensures secure routing and identification. Providers are required to register with Relay Health for access to the information. Relay Health has access for external providers (after registration and validation), and those in-area providers without an EHR, to log in to a web portal. This configuration allows enrolled providers access to secure messaging, lab results and other platforms under development. Currently over 150 providers without an EHR are registered with Relay Health for these services. In addition, SCMG, Mosaic, COPA, Harney County, Mountainview Hospital and others have electronic lab results. SCMG (Redmond and Prineville Family Care) and Mosaic receive ED notifications through the HIE. PSCS has been working with various providers to fulfill meaningful use criteria through investments in grant funding to support capability, staff, and workflow development to achieve meaningful use standards, and will continue to do so in the future. PSCS may also consider future incentives for differential reimbursement for providers who provide information to, and robustly participate in community-based HIE, or an HIO, though those incentives are not currently established. PSCS is providing significant leadership and engagement with a newly formed group called the Central Oregon Health Information Exchange (COHIE). The focus of this group is to pool regional resources to support the Triple Aim through the use of HIT. This initiative is well supported by all of the primary stakeholders in the regional health system. The COHIE team is looking to implement best practices as learned from other successful HIE initiatives that have been implemented in other regions of Oregon and the country. Early goals are to leverage existing technologies and standardized interfaces to minimize time to market and maximize Triple Aim benefit to members and stakeholders. The initial focus will be to establish the infrastructure for the basic exchange of health information among stakeholders. Once this is in place, additional opportunities will exist for more sophisticated analytics and efforts to improve quality and patient engagement. PSCS has taken an early step along this path with the implementation of a daily patient census interface between SCHS Emergency Departments and PSCS with the goal of early detection of significant health episodes so that nurse case managers can develop intervention plans as needed.

APPENDIX B – Provider Participation and Operations Questionnaire

Section 1 - Service Area and Capacity

PacificSource Community Solutions is applying for the areas as listed in the Appendix B – Table B-1. Please note that 4 of the counties (Grant, Harney, Wheeler, and Lake) are pending due to current discussion. It is anticipated these 4 counties may join the PacificSource Community Solutions Central Oregon CCO. Please see attached, Appendix B - Table B-1 (Participating Provider Table).

Section 2 - Standards Related To Provider Participation

Standard #1 - Provision of Coordinated Care Services

PacificSource Community Solutions will have a comprehensive and integrated care management network and delivery system network servicing Medicaid and dually eligible members for the providers as noted below. PSCS will either contract directly with these providers or work collaboratively with community partners such as the COHB and Public Health to establish contracting mechanisms to allow the development of a comprehensive and integrated care management and delivery system network that will meet the needs of PSCS members. As the CCO evolves and the needs for other providers are identified, PSCS will work collaboratively with its community partners to facilitate access to these providers for PSCS members.

- Acute inpatient hospital psychiatric care
- Addiction treatment
- Ambulance and emergency medical transportation
- Assertive Community Treatment
- Chemical dependency treatment providers
- Community Health Workers
- Community prevention services
- Dialysis services
- Federally qualified health center
- Health Care Interpreters (qualified/certified)
- Health education, health promotion, health literacy
- Home Health
- Hospice
- Hospital
- Imaging
- Laboratories
- Mental Health Providers
- Navigators
- Oral Health Providers
- Palliative Care
- Patient Centered Primary Care Home
- Peer Specialists
- Pharmacies and Durable Medical Equipment
- Rural Health Centers
- School-Based Health Centers
- Specialty Physicians
- Supported Employment
- Tertiary Hospital Services
- Tribal and Urban Indian Services
- Urgent Care Centers

Please see Table B-1 (Participating Provider Table) attached.

ADDITIONAL QUESTIONS ABOUT SPECIFIED INTEGRATED CARE SYSTEM COMPONENTS

Standard #2 – Providers for Members with Special Health Care Needs

PSCS 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 chemical dependency 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) have access to primary care and referral providers with expertise to treat the full range of medical, mental health and chemical dependency conditions experienced by these Members. As PSCS develops a relationship with a DCO, dental will become part of this process. The providers and facilities identified in the Participating Provider Table or referral provider/facility (Standard #1 Table), will be identified by special skills or sub-specialties necessary to provide a comprehensive array of medical services to Members with Special Care Needs or Members who have high health care needs, multiple chronic conditions, mental illness or chemical dependency. In order to reduce costs to health care associated with chronic disease, PSCS will refer members to the Living Well Program and its Spanish-language equivalent, Tomando Control de su Salud, administered regionally by Deschutes County Health Services. Specially designed for people living with multiple chronic conditions, both mental and physical, Living Well is an evidence-based chronic disease self-management program that consists of six weekly two-hour workshops that teach tools for living a healthy life with chronic health conditions in a culturally and linguistically appropriate manner. The Living Well Program is an effective intervention for addressing the needs of PSCS members who incur the highest costs and use the most services, with significant return on investment. PSCS's collaboration with the Living Well Program will include:

- Covering workshops as a primary benefit for members with chronic mental or physical health conditions.
- Setting up referral systems from primary care medical homes and specialty clinics to Living Well.
- Providing incentives for plan members to participate.

Standard #3 – Publicly funded public health and community mental health services

PSCS has executed 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.

Publicly Funded Health Care and Service Programs Table

Please see Publicly Funded Health Care and Services Program Table attached.

(a) As members of the Central Oregon Health Board and Central Oregon Health Council; the three counties (Deschutes, Crook, and Jefferson) have been involved in the development of the CCO application. Each county has assisted in the writing of sections of the application and the Directors of Deschutes and Crook County have been active members in the CCO Workgroup Committee overseeing the process. The Public Health Directors will be in discussions with Pacific Source staff in the development of additional services that public health may provide to improve the health of the citizens of our three counties.

(b) Current contracts for public health services are in place for Deschutes, Jefferson, and Crook. Additional opportunities may develop as the CCO evolves which will be pursued.

(c) PSCS has agreements with these counties.

Standard #4 – Services for the American Indian/Alaska Native Population (AI/AN)

(a) PSCS has experience and ability in providing culturally relevant Coordinated Care Services for the AI/AN population. PSCS current Oregon Health Plan (OHP) membership includes the AI/AN population. As such, PSCS has developed policies and procedures specifically addressing responsibilities to this population. This includes providing AI/AN members with access to providers of their native culture and the processing of claims for this population based on AI/AN eligibility as reported on the 834 files received from the State. In addition, our nurse case managers work in collaboration with the tribal clinic case managers and providers to assist with any concerns or issues that arise within this population and to ensure they receive services that are culturally appropriate.

Standard #5 – Indian Health Services (IHS) and Tribal 638 facilities

(a) All PSCS members who are identified by OHA to be of Indian Heritage have the ability to be able to seek services with either a contracted provider or an Indian Health Service Facility. If the service or item is subject to Prior Authorization, the AI/AN provider must follow and comply with all Prior Approval (PA) requirements. It is the AI/AN providers' responsibility to contact PSCS prior to providing services. All services requiring prior authorization are provided on PSCS website at www.communitysolutions.pacificsource.com. Periodic updates to the prior authorization requirements are also communicated to contracted providers via electronic notice.

Standard #6 – Integrated Service Array (ISA) for children and adolescents

(a) PSCS will provide services as included in the Integrated Service Array. PSCS will enter into a service contract with the Central Oregon Health Board (COHB). Under the service contract, the COHB will further develop and administer the Central Oregon Integrated Service Array (ISA) in accordance with OAR 309-032-1500 (Integrated Services and Supports Rules). The COHB ensures that appropriate and needed health services including behavioral health and public health are provided to the residents of Central Oregon[1]. Currently, Central Oregon County Mental Health Programs (CMHPs) and PSCS, as the Central Oregon Mental Health Organization, contract with a number of agencies and individuals in order to provide the full continuum of care for individuals determined eligible for the ISA. The ISA contracts are currently executed by ABHA, a subcontractor of Pacific Source. The ISA provider network includes both traditional and non-traditional services and supports which are

[1] Draft COHB Governing Board By-Laws II. Roles and Responsibilities edited 4/6/12.

provided in variety of settings. Care Coordination for the ISA population will continue to be primarily performed by the local CMHPs in collaboration with other providers as appropriate.

(b) It is anticipated that COHB will administer the ISA as part of an agreement with PSCS in the manner consistent with the following approach. Central Oregon counties in partnership with ABHA have invested in training, coaching and monitoring to achieve full-fidelity wrap around services based on system of care principles, with a team creating a family-driven plan for each child in partnership with other child-serving systems. As a result, Central Oregon counties have reduced the percentage of children needing residential care, shortened the length of stay, and created a menu of community-based supports that enable children to be maintained in permanent homes in the community. Individuals and families served in Central Oregon, also receive services as part of the ISA with wrap around as the primary model used for team facilitation and care coordination. The local CMHPs for Central Oregon determine ISA eligibility and partner with all local child serving agencies through the wrap process and Community Care Coordination Committees. Trainings in wraparound and team facilitation have occurred and the services and supports are provided when documented as a need in the individual's wrap around Plan of care. Psychiatric Residential Treatment Services, Sub acute and Acute levels of care are utilized in a manner that best meets the needs of the individual and as medically necessary.

(c) PSCS's service delivery approach is family-driven, strength-based, culturally sensitive, and enhances community-based service delivery. PSCS expects its providers, community partners, COHB and local CMHPs to adopt similar practice guidelines currently being utilized and those that will be developed. The practice guidelines prescribe the elements needed to insure that the service delivery approach delivered to individuals who are determined eligible for the ISA meet the requirements for the Wraparound model, are family-driven, community-based and culturally competent.

Standard #7A– Mental Illness Services

(a) PSCS will provide community-based mental health services to Members, including Members receiving home and community-based services under the State's 1915(i) SPA. All services will be provided through PSCS's current community behavioral health (including mental health) provider network in partnership with the Central Oregon Health Board. Our current behavioral health provider network consists of 3 local Community Mental Health Programs (CMHPs). The local CMHPs provide a wide array of mental health and chemical dependency treatment and recovery services and supports. The CMHPs also provide most of the home and community-based mental health services to Members who qualify for these services under the State Plan 1915(i) wavier.

(b) PSCS will screen all eligible members for mental illness to promote prevention, early detection, intervention and referral to mental health treatment – especially at initial contact or physical exam, initial prenatal exam, when a Member shows evidence of mental illness, or when a Member over-utilizes services. The network of behavioral health providers is governed by OAR 309-032-1500 (Integrated Services and Supports Rule [ISSR]). Specifically, OAR 309-032-1525(3)(d)(B)(C)(D)(F) requires comprehensive screening and the provision of appropriate services or referral to qualified professionals for the provision of care. Behavioral health provider contracts also mandate compliance with the ISSR. PSCS has been engaged in provider education and encouraging PCPCHs and the hospital EDs to implement the EBP Screening Intervention and Brief Treatment (SBIRT). PSCS will plan to increase efforts around implementation of SBIRT in these settings. Additionally, PSCS will continue to emphasize and encourage screening for and early detection of behavioral health disorders in all primary care settings and at the initial prenatal exams. PSCS has a robust reporting software used to identify high-needs members (who maybe over utilizing certain services). These reporting systems, use predictive modeling algorithms to integrate member demographics, disease burden and claims history to identify members who are likely to require high resource levels in the near future. This data is overlaid with Clinical Intelligence Rules which help to identify members with interveneable conditions.

Standard #7B – Chemical Dependency Services

(a) PSCS will provide community-based chemical dependency services to members, including members receiving home and community-based services under the State's 1915(i) SPA. All services will be provided through PSCS's current community behavioral health (including chemical dependency) provider network in partnership with the Central Oregon Health Board. This network consists of 3 local Community Mental Health Programs (CMHPs). The local CMHPs provide a wide array of mental health and chemical dependency treatment and recovery services and supports. The CMHPs also provide most of the home and community-based mental health services to members who qualify for these services under the State Plan 1915(i) wavier. PSCS anticipates adding

2 more outpatient subcontracted providers who are the local CMHPs for Crook and Jefferson counties. These providers will add additional outpatient mental health service capacity for PSCS Deschutes county members and could also provide outpatient chemical dependency treatment services if the need arises.

(b) PSCS will screen all eligible members for chemical dependency to promote prevention, early detection, intervention and referral to chemical dependency treatment – especially at initial contact or physical exam, initial prenatal exam, when a Member shows evidence of mental illness, or when a Member over-utilizes services. The network of behavioral health providers are governed by OAR 309-032-1500 (Integrated Services and Supports Rule [ISSR]). Specifically, OAR 309-032-1525(3)(d)(B)(C)(D)(F) requires comprehensive screening and the provision of appropriate services or referral to qualified professionals for the provision of care. Behavioral health provider contracts also mandate compliance with the ISSR. As noted above, PSCS has robust reporting software used to identify high-needs members (who maybe over utilizing certain services).

Standard #8 – Pharmacy Services and Medication Management

(a) PSCS has experience and ability to provide a prescription drug benefit as a Covered Service for funded Condition/Treatment Pairs. PSCS, with its parent, PSCHP, Inc., currently manage a prescription drug benefit for ~40,000 OHP members and ~16,000 Medicare members. The organization has significant experience providing a prescription drug benefit that is consistent with OHP's Prioritized List of Covered Services. Through a customized benefit design algorithm, PSCS ensures payments for funded conditions, avoids payment for unfunded conditions, and provide exceptions to those members who would otherwise not receive certain medications. We propose using the current Medicaid formulary for the CCO population which contains over 18,000 different drug products every funded therapeutic class including prescription and OTC drugs.

(b) PSCS intends to offer a closed formulary to its CCO members. The proposed formulary restricts certain brand name medications as non-formulary, but maintains treatment options in all funded therapeutic classes as noted above. The Utilization Management process allows all members and providers the opportunity to request non-formulary medications through the Formulary Exception process. When formulary medications have been exhausted or are not clinically appropriate, exceptions to the formulary status are granted by our clinical pharmacist reviewers. The Quality Assurance Utilization Management Pharmacy & Therapeutics (QAUMPT) Committee is a clinical committee consisting of ~12 Medical Doctors, Nurses and Pharmacists from the PSCS service area. With the help of Pharmacy Services clinical staff, QAUMPT maintains a clinically appropriate, evidence-based formulary. The formulary is reviewed at least annually and new molecular entities are reviewed within 6 months of being FDA approved. The QAUMPT Committee reviews medications for clinical appropriateness and inclusion on the formulary while the Pharmacy Services clinical staff is responsible for ensuring that treatment options exist in all therapeutic categories, including OTC treatment options. The Pharmacy Services staff is also responsible for presenting community practice standards and requests for coverage policy changes to the QAUMPT on behalf of local providers to ensure the PSCS's clinical policies are reflective of local practice patterns. All medication related Coverage Policies are developed by the Pharmacy Services clinical staff after consultation with evidence-based literature, national treatment guidelines, FDA approved labeling and industry best practices. All coverage policies must be formally adopted by the QAUMPT Committee prior to enforcement. Coverage Policies are reviewed annually for updates to ensure current best practices are enforced. To ensure transparency and promote best practices, PSCS' policy is to post all coverage policies on the Member and Provider websites at www.communitysolutions.pacificsource.com. All formulary edits, utilization management restrictions and pharmacy messaging is decided by the Pharmacy Services staff, in consultation with the QAUMPT, and directed to the PBM for configuration.

(c) PSCP will provide an adequate pharmacy network to provide sufficient access to all enrollees and will communicate formulary choices and changes to the network and other medical professionals. PSCS contracts with a national Pharmacy Benefit Management (PBM) company to provide nationwide pharmacy access. The current PBM is Express Scripts, Inc. In 2013, PSCS will be contracted with CVS Caremark. Both PBMs offer nationwide pharmacy access with over 60,000 network pharmacies. The Pharmacy network information is available to members and providers on our website at www.communitysolutions.pacificsource.com. The Prior Authorization and Formulary Exception Request form is also available on our website and can be submitted by members or providers. In the case of formulary or network changes which adversely impact members or providers, PSCS will always provide advance notice of at least 30 days in written or electronic format. PSCS contracts directly with a mail order pharmacy, Wellpartner Mail Order, to provide our Medicaid members with up to a 60 day supply of covered medications, delivered through the mail.

(d) PSCS has the ability 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. PSCS outsources pharmacy claims adjudication to a Pharmacy Benefit Management (PBM) company. As mentioned above, the contracted PBM will be changing on 1/1/2013. Both PBM's process all pharmacy transactions from network pharmacies in real-time. Payment is guaranteed at the point-of-sale when a network pharmacy submits an electronic claim to the PBM. Since 2006, PSCS has coordinated benefits for dual eligible members to ensure that both primary and secondary pharmacy claims are paid in real-time at point-of-sale. In the case of Medicare & Medicaid dual eligible status, two enrollment segments are established in the pharmacy adjudication software. One enrollment segment is set to pay as primary and the other to pay as secondary. The PSCS Enrollment & Billing team, in partnership with a subcontractor, Performance Health Technology, LTD, (PH Tech) and the State of Oregon, are responsible for designating primary and secondary pharmacy eligibility in the primary eligibility database, called CIM. An eligibility extract is pulled from CIM nightly and submitted to the PBM for pharmacy claims adjudication. The pharmacy claims platform can adjudicate both primary and secondary claims in real-time, according to the eligibility flag set by the Enrollment & Billing team. The Pharmacy Services Helpdesk is available Monday – Friday, 7am – 6pm, for any pharmacy adjudication issues that arise at the point-of-sale and will work with the Enrollment & Billing team to ensure accurate eligibility setup.

(e) PSCS has the capacity to process pharmacy Prior Authorizations (PA) with in-house staff and through a contracted PBM. PSCS maintains an internal Pharmacy Helpdesk, available Monday – Friday, 7 am – 6 pm, to which prescribers or pharmacies are able to submit PAs. The Pharmacy Helpdesk works directly with pharmacies and providers to ensure timely processing of all Coverage Determinations, which are defined as Prior Authorizations, Formulary Exceptions and other Utilization Management edits. Providers and pharmacies are able to contact the Pharmacy Helpdesk via direct telephone line or via fax during normal business hours (above). Members can reach the helpdesk through our Member Customer Service team. The helpdesk also triages emergency faxes and voicemails received after business hours and on weekends to ensure timely resolution of all requests. The helpdesk is staffed with 4 full-time pharmacy technicians, a full-time pharmacy team leader and a clinical pharmacist. All coverage determinations are logged in a proprietary Authorization Tracking software which tracks decisions, communication points with providers, members and pharmacies and timeliness of decisions made.

(f) Requested information regarding PSCS's contractual arrangement with its PBM can be found in Appendix B – Pharmacy Contract Information. Please see attached.

(g) PSCS has the ability to engage and utilize 340B enrolled providers and pharmacies as a part of the CCO. Mosaic Medical, the local FQHC, is pursuing a vendor based 340B program. St. Charles Medical Center is developing a 340B pharmacy program. PSCS is actively engaged in dialogue and will partner with these organizations to ensure eligible partners receive the lowest available cost for prescription medications.

(h) PSCS's ability and intent to use Medication Therapy Management (MTM) as part of a Patient Centered Primary Care Home is as follows: PSCS has an active MTM program in place for its MAPD beneficiaries, including dual eligibles. PSCS contracts with local pharmacists to provide face-to-face consultation to our most vulnerable Medicare members. Eligible members can receive MTM services from their dispensing pharmacist or from consultant pharmacists in the community. PSCS provides private office space to consultant pharmacists and reaches out to patients telephonically to set up appointments in order to ensure this service is widely used. In 2012, we anticipate extending this service to our Medicaid members in a limited fashion.

(i) PSCS has the ability to utilize E-prescribing and its interface with Electronic Medical Records (EMR). Through its PBM contract(s), PSCS has access to a nationwide network of pharmacies capable of receiving electronic prescriptions. In the proposed CCO service area there are approximately 40 pharmacies currently contracted to receive electronic prescriptions. This represents the vast majority of pharmacies in the service area. PSCS is working diligently with the new PBM to provider our provider network with real-time access to the PSCS formulary through their EMR. It is anticipated that this functionality will be in place in 2013.

Standard #9 – Hospital Services

(a) PSCS will assure access for Members to inpatient and outpatient hospital service as follows. Urgent care services including mental health crisis or emergencies are covered 24 hours a day, 7 days a week whether in-area or outside the service area. Urgent care services do not require prior authorization. Members are directed to call their PCP with an urgent care condition or go to an urgent care office nearby. The PCP office will be available 24 hours a day, 7 days a week. For Mental health crisis, members are directed to call the mental health crisis line, 911, or go directly to the emergency room. Emergency services do not require prior approval. For physical emergency medical conditions, members are directed to call 911 or go to the emergency room. If members are not sure their condition is an emergency, they are encouraged to call their PCP's office that can help direct their care. Physical Health and Mental Health Emergencies are described in the PSCS member handbook and by PSCS customer service team. For outpatient services requiring prior authorization, requests will be received and processed according to regulatory timelines and notice requirements. An organizational determination to provide, authorize or discontinue a service to a member is made as expeditiously as possible. All prior authorization requests are date-stamped with the date the request is received. Compliance with required timelines is reviewed monthly by Corporate Quality Assurance and periodically by Internal Audit. If prior authorization timelines are found to be outside established guidelines, an action plan for correction is developed by the manager of Medical Services and reviewed by the Medical Director once completed.

(b) PSCS 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. Appropriate use of these services is managed through benefit design, network development, communication strategies, and care coordination and case management. Ambulance services are covered for emergencies only and in non-emergent situations when transportation in another vehicle could put member's health in danger. Emergency services are reimbursed when a patient's medical needs cannot be adequately addressed by their primary care provider or urgent care services. PSCS makes great efforts to contract with a broad network of primary care providers and urgent care facilities to decrease the need for Emergency services. This includes contractual provisions to encourage after-hours and same day access to primary care appointments and geographically dispersed urgent care clinics as well as medical home contracts which provide financial incentive to clinics whose membership maintains low utilization of Emergency Services. PSCS utilizes claims reports to identify members who frequently use Emergency Services. Dedicated Transitional Care Coordinators use these reports to identify good candidates for intervention and work to improve patient access to necessary services (medical and behavioral health care, food stamps, social support, etc) in order to reduce unnecessary use of Emergency Services. As appropriate, the Care Coordinators will refer patients with complex medical conditions to internal Case Managers and external Nurse Care Coordinators who are embedded in medical homes and/or contracted Community Health Workers. Member Handbooks and Provider Directories noting the provider's languages will be provided to members annually and upon enrollment to ensure members can choose providers that are fluent in the member's primary language. Materials are written in 6th grade reading level and will also be translated into Spanish, since we meet the thresholds in our service areas for this need. Customer Service team members can also provide members with pertinent information in another form, if required. Interpreter services are also available, upon request, for assistance at their doctor office visits, either in person or by phone. The plan will provide transportation services to and from healthcare appointments for members facing significant culture or physical transportation challenges. PSCS work with community partners in our service area to provide these services to our members to ensure they get needed care. PSCS will also provide members with newsletters that include pertinent benefit information, resources, and other important information about their health and access to ambulance, emergency, and urgent care.

(c) PSCS will monitor and adjudicate claims for Provider Preventable Conditions based on Medicare guidelines for the following:
Adverse events and Hospital Acquired Conditions (HACs) are identified through utilization management, case management, claims review, reports from physicians, and member complaints.

- Adverse Events: Adverse Events are defined as incidents in which harm resulted to an enrolled member or harm could have potentially occurred through receiving health care. Reviews of the events are performed by the health plan medical director, the QAUMPT Committee and/or an appropriate consultant. Events are logged and tracked over time. The completed reviews are peer protected and considered at the time of practitioner recredentialing.

Frequent or severe events attributable to a single provider or facility will be subject to corrective action per policy and procedure. An annual report is reviewed by the QAUMPT Committee.

•Hospital Acquired Conditions (HACs): The PSCS claims payment system is configured to stop payment and trigger clinical review for claims received which meet the definition of HACs, as defined by Medicare. All incidents of Adverse Events and/or HACs identified through the prior authorization and referral processes are reported to the Health Services Quality Improvement team. The Quality Improvement team reviews and compiles rates of Adverse Events and HACs for reporting to the Quality Assurance Utilization Management and Pharmacy & Therapeutics Committee (QAUMPT). The Adverse Event and HAC's rates are used to inform the contracting and credentialing process to ensure that PSCS maintains a high-quality network of providers and hospitals. PSCS has reported Medicare HAC's and Serious Reportable Adverse Events to CMS for the past two years. Policies and procedures have been developed and the process has been reviewed by a certified Medicare C&D Validation audit firm. The same process will be executed for Medicaid members.

(d) PSCS's readmission policy will be enforced and monitored. PSCS receives hospital census data from the major hospital system in Central Oregon. In addition, PSCS has embedded a Nurse Case Manager (NCM) in St. Charles Medical Center. The census data, along with the embedded NCM, are part of a robust case management system to reduce readmissions. All PSCS members admitted to the hospital are screened and, when appropriate, actively case managed during their inpatient stay. PSCS members who transition out of the hospital and require additional services are assigned to a Nurse Case Manager or Care Coordinator for ongoing clinical follow up. The case management and care coordination interventions target areas that are known to cause hospital readmissions and improve overall quality of care (follow-up PCP appointment, medication adherence, fall risk, etc). PSCS is also developing a telephonic outreach and care coordination program through our Transitional Care Coordinators with a structured workflow built on hospital census data, to call every member discharged from the hospital for follow-up and readmission prevention. PSCS is actively working with other inpatient facilities in the CCO service area to coordinate daily exchange of census data. Additional members at risk for re-admission are identified through our robust claims reporting suite and targeted for care coordination and case management, where appropriate. Reporting of readmissions, urgent care and ED visits using claims history will be provided to each Primary Care Medical Home contracted with PSCS. This data is used to inform process improvement and quality improvement opportunities with our provider network.

(e) PSCS employs the innovative strategies above including targeted interventions based on predictive modeling through our reporting suite (Thomson Reuters) to decrease unnecessary hospital utilization.

Section 3 - Assurances of Compliance with Medicaid Regulations and Requirements

1. Medicaid Assurance #1 - Emergency and Urgent Care Services: Provider shall be responsible for responding to or making arrangements for emergent needs of Members with respect to Covered Services twenty-four (24) hours per day, seven (7) days per week, including holidays. In the event that Provider is unable to provide required Covered Services, Provider shall arrange for a Covering Practitioner.

2. Medicaid Assurance #2 - Continuity of Care: The Medical Services staff documents all authorizations and referrals in a software application which are then available for providers and nurse case managers to review to ensure care coordination and reduce duplication of services. The Medical Services management receives a daily report with the total number of authorizations and referrals which includes the date the request was received. This allows them to ensure requests received will be processed according to regulatory timelines and notice requirements established by the Oregon Health Authority.

3. Medicaid Assurance #3 - Medical Record Keeping: Policies and procedures are in place to ensure protected health information (PHI) maintained by PSCS is appropriately safeguarded against inappropriate uses or disclosures. The procedures describe appropriate storage and destruction of PHI. PSCS performs medical record reviews of primary care provider record keeping on an annual basis. Providers will be reviewed every 3 years in coordination with their re-credentialing cycle.

4. Medicaid Assurance #4 - Quality Improvement: PSCS has a QAPI program which was reviewed by External Quality Review Organization in 2011 and was found to have "Fully Met" the general Rules and basic elements of for Quality Assurance Performance Improvement programs.

5. Medicaid Assurance #5 – Accessibility: PSCS surveys providers annually for appointment wait times for routine, urgent and emergent appointments and reports those findings to the QAUMPT Committee. PSCS

monitors the number of members who do not have a PCP assigned within 30 days. Member grievances are monitored for indications of access problems.

6. Medicaid Assurance #6 Grievance System: PSCS has written policies and procedures available for review by OHA, which outline the process by which the plan accepts, processes, and responds to all complaints and appeals from members and their representatives. Information on these processes is shared with members as well as with PSCS providers upon entering a contract and more often as needed. PSCS's grievance system is described above in more detail.

7. Medicaid Assurance #7 - Potential Member Informational Requirements: PSCS has the ability to provide potential members with pertinent information to make a decision about enrollment. These materials would be in both printed format and available online. However, current rules prohibit PSCS from marketing to our potential members, so we do not provide this information currently.

8. Medicaid Assurance #8 - Member Education: Members receive a handbook annually or when significant changes are made. A member newsletter is sent three times per year and includes topics related to benefits, prevention, utilization and health improvement. The member website includes health care information for PSCS members. Members identified for quality improvement projects are sent materials on self-management related to the topic targeted for improvement. Materials are available in Spanish. Member Handbooks and Provider Directories noting the provider's languages will be provided to members annually and upon enrollment to ensure members can choose providers that are fluent in the member's primary language.

9. Medicaid Assurance #9 - Member Rights and Responsibilities: Member Handbooks are provided to members upon enrollment and annually to ensure members have pertinent information about their rights and responsibilities as a member of the plan. The handbook is written in 6th grade reading level and is being translated into Spanish, since we meet the thresholds in our service areas for this need.

10. Medicaid Assurance #10 - Intensive Care Coordination: Intensive care coordination services may be requested by the member, the member's representative, physician, other medical personnel serving the member, or the member's agency case manager. PSCS will respond to request for intensive care coordination services with an initial response by the next working day following the request. PSCS will ensure transitional care coordinators and case manger case manager's name and telephone number are available to agency staff and members or member representatives when intensive care services are provided to the member. ENCC members will have direct access available to specialists represented as an exception to the referral process.

11. Medicaid Assurance #11 - Billing and Payment Standard: PSCS will participate as a trading partner of OHA in order to timely and accurately conduct electronic transactions in accordance with HIPAA electronic transactions and security standards.

12. Medicaid Assurance #12 - Trading Partner Standard: PSCS has and will continue to execute necessary trading partner agreements and conducted business-to-business testing that are in accordance with accepted professional standards.

13. Medicaid Assurance #13 - Encounter Data Submission and Validation Standard – Health Services and Pharmacy Services: PSCS contracts with PH Tech for the processing of claims and encounters and the transmission of those encounters to OHA. PH Tech maintains policies and procedures that promote the accurate and timely submission of encounter data to OHA. PH Tech performs multiple levels of encounter validation and auditing to ensure overall quality and adherence to customer and OHA requirements.

14. Medicaid Assurance #14 - Enrollment and Disenrollment Data Validation Standard:

PSCS contracts with PH Tech for the processing of enrollment and disenrollment transactions received from OHA. PH Tech has built an automated system to accept and import both enrollment and disenrollment records in the HIPAA 4010 and 5010 834 format. All transmission from OHA are archived on the PH Tech file servers and imported into PH Tech's data warehouse for storage and reporting on enrollment, revenue and expense.

APPENDIX C – Accountability Questionnaire

Section 1 – Accountability Standards

C.1.1. Background information

C.1.1.a. PSCS has developed robust reporting systems that will be utilized in quality and accountability measurements. PSCS submits HEDIS Medicaid administrative measures through certified HEDIS software. Upon validation of results, these measures are utilized to benchmark performance, identify opportunities for improvement, identify discrepancies in care and generate indicators for Performance Improvement Projects. PSCS currently utilizes a software engine purchased from Ingenix; however this is being transitioned to a Thomson Reuters application during 2012. These reporting systems integrate member demographics, disease burden and claims history to identify members who are likely to require high resource levels in the near future. This data is overlaid with Clinical Intelligence Rules which help to identify members with interveneable conditions. PSCS is also engaging a new Fraud Waste & Abuse (FWA) vendor in 2012 to target cases of overutilization. This vendor, Thomson Reuters, will provide monthly reports to a FWA team at PSCS who will be responsible for identifying legitimate FWA cases and reacting appropriately (contract termination, recoupment of payments, law enforcement referral, etc). Through its Pharmacy Benefit Management contract, PSCS also receives Fraud, Waste & Abuse reports that highlight over-utilization of prescription medications. These reports are provided to an internal team of pharmacists and pharmacy technicians to curb drug abuse in collaboration with local prescribers. In 2011, approximately 14 PSCS members were identified as abusing prescription medications and the claims system was configured to ensure they only received medications from specific prescribers and/or pharmacies.

PSCS has created multiple data warehouses that integrate claims, enrollment and referral information. The data warehouse allows PSCS staff to analyze the data and identify over and under utilization of services. PSCS partners with its subcontractor Ph-Tech to capture all viable encounters between members and providers within a single unified system. These data sets incorporate the State's own risk and rate member stratifications, revenue buckets and claims buckets and have been key resources in the development of both the lowest cost and base cost estimate exercises performed at the request of OHA. The combination of data elements allows PSCS to compare its funding to the expenses incurred by rate group for inpatient, outpatient, and other service types. It also allows Ph-Tech and PSCS to run Ad hoc reports. PSCS will continue to utilize and build upon these reporting systems for quality and accountability measurements as the CCO is implemented and evolves over time.

C.1.1.b. PSCS will participate in external quality measurement and reporting programs (e.g. HEDIS reporting related to NCQA accreditation, federal reporting for Medicare Advantage lines of business). PSCS has participated in HEDIS Reporting to NCQA through PacificSource

Community Health Plans which has participated in HEDIS reporting to NCQA for the Medicare Advantage Line of Business since 2000, including individuals who are dually eligible.

C.1.1.c. PSCS upholds high internal quality standards and performance expectations and works to ensure that providers and sub-contractors are held accountable for acceptable performance and quality care. PSCS has several community partners including Central Oregon Independent Practice Association (COIPA) who share PSCS's commitment to quality and are working to reinforce quality and performance standards among providers and sub-contractors. COIPA negotiates contracts with PSCS on behalf of its membership. In the Provider Services Agreement between COIPA and PSCS, Section 2.8 states the following: "Compliance with Health Plan Policies and Procedures requires provider compliance with Health Plan requirements relating to member grievances, credentialing, utilization review, quality assurance, medical management". In addition, Section 2.9 states the following: "Cooperation with UM and Quality Improvement Activities: Health Plan Committee of the Agreement requires cooperation with utilization management and quality management procedures". Section 2.9 also requires COIPA providers to agree to serve on Health Plan committees if requested to do so by the Health Plan. PacificSource holds providers to record keeping standards through an audit of medical records every 3 years. As a part of this process, Provider Medical Record Review (PMRR) requires providers who do not achieve a passing score of 80% to complete a corrective action plan. Internal claims and authorization processes ensure Oregon Health Plan guidelines are followed such as those related to evidence based practice for radiology and requiring the submission of consent forms with claims for sterilization.

PSCS contracts with a Pharmacy Benefit Manager to establish quality assurance measures and systems for the contracted pharmacy network of more than 60,000 pharmacies nationwide. These include review for compliance with minimum standards for pharmacy practice, concurrent drug utilization review systems, policies, and procedures.

C.1.1.d. PSCS has several mechanisms for sharing performance information with providers and contractors for Quality Improvement. Performance information is shared through the PSCS Quality Committee. Feedback is mailed or faxed to providers on individual performance related to quality improvement projects. Information is also shared through regular provider meetings.

C.1.1.e. PSCS has a mechanism to share performance information in a culturally and linguistically appropriate manner with members. Currently, the most significant language population other than English in the proposed service area is Spanish. PSCS provides the member handbook in Spanish and describes how to obtain information in other alternative formats. Interpreter services and demographic reports are monitored to identify the emergence of other significant populations of members with primary languages other than English or Spanish. In addition, the Provider Directory indicates which providers speak other languages.

PSCS is a subsidiary of PacificSource Community Health Plans (PCHP). PCHP has a section in the Medicare member handbook informing members how to obtain quality performance information. It is anticipated that this information will be added the CCO member handbook.

C.1.1.f. PSCS's payment methodologies will support and promote the goals of the Triple Aim. PSCS will include quality measures and reporting in connection with provider and sub-contractor incentive payments. PSCS will provide comprehensive coordination and create shared responsibility by shifting alternative payment methodologies, from volume-of-service based financial incentives toward incentives that reward primary care (including those who have applied for and received PCPCH status) for providing the "right care at the right time". This framework provides shared savings incentives for PCPCH primary care providers as well as specialty providers for appropriate management of care as measured by performance in a specialty care fund, a hospital fund, and a prescription drug fund.

PSCS's alternative payment methodologies will be differentially determined, For example financial agreements for certain PCPCH providers have been and will continue to be provided for different PCPCH-tiered providers based on PSCS agreement with the COIPA. These agreements provide for special funding mechanisms (i.e. additional PMPM payments) for enhanced delivery of primary care. In addition, PSCS has provided grant-based funding to many of the PCPCH providers based on capability and the need for investment dollars for new innovative models.

In addition, PSCS will align financial incentives with evidence based and best emerging practices. PSCS's existing payment methodologies, which include Medical Home incentive payments aligned with quality and best practice metrics, are designed to promote high quality care in tandem with cost-efficiencies. In addition, PacificSource has partnered with the COIPA as it invests in strengthening informational capabilities, which will lead to community-wide evidence-based best practices and will provide a data-based solution to variations in care in the CCO population.

C.1.1.g. PSCS has the ability to collect and report to OHA the accountability quality measures as listed in the Table included as part of the RFA. PSCS has experience producing performance measures from specifications such as HEDIS, which includes both administrative method from claims data and hybrid method from medical record collection. A member survey is currently administered to members with special health care needs (Exceptional Needs Care Coordination) and Medicare members to perform health risk assessment. The member surveys are used to identify high-risk members and enroll them into the PSCS Care Management and Care Coordination program.

Section 2 – Quality Improvement Program

C.2.1.a. PSCS QAPI program was reviewed by an External Quality Review Organization in 2011 and was found to have "Fully Met" the general rules and basic elements of the Quality

Assurance Performance Improvement Requirements. The Quality Improvement program has the following elements:

- Policies and procedures.
- Access Monitoring.
- Annual program evaluation and improvement plan.
- Performance Improvement Projects designed to improve health outcomes and member satisfaction, use objective indicators, focus on clinical and nonclinical areas, evaluate the effectiveness of the interventions, and employ activities that increase or sustain improvement.
- Integration of physical and behavioral health.
- Monitoring of utilization compared to benchmarks as well as monitoring for under and overutilization of services.
- Assesses the quality and appropriateness of care to members with special health care needs.
- Generation of state performance measures.
- Monitors member safety through Adverse Events tracking.
- Assurance of the quality of the provider panel through adverse events tracking and auditing provider medical records for consistency with state and federation regulations and professional standards. Provider Corrective Action policies and procedures are in place.
- QI committee called the Quality Assurance Utilization Management Pharmacy and Therapeutics (QAUMPT) that meets at least 10 times per year, reports to the PSCS Board, is chaired by the medical director, and has members representing the scope of services delivered. Committee minutes are recorded and maintained.
- Prevention.
- Disease management.
- ENCC annual evaluation.
- Quarterly review of Grievance and Appeals data.
- Assessment of member satisfaction.
- Member education.

In addition, the Central Oregon Regional Health Improvement Plan as referenced in Appendix A has identified 10 Priority Areas:

- Disparity/Inequity
- Access to Resources
- Early Childhood Wellness
- Food Insecurity
- Oral Health
- Safety, Crime & Violence

- Chronic Disease
- Alcohol, Drug & Tobacco Use
- Behavioral/Mental Health
- Healthy Environments

The PSCS QI Program currently has interventions or elements that address seven of the ten Priority Areas. These priority areas will be addressed through community and public health programs in collaboration with PSCS community partners.

C.2.1.b. PSCS's Quality Committee is called the Quality Assurance Utilization Management Pharmacy and Therapeutics Committee (QAUMPT). This committee has a reporting responsibility to the PSCS Board that is accomplished through the PSCS Medical Director. The committee provides oversight to the quality program and provides a mechanism for stakeholder input. The committee membership includes adult and pediatric primary care providers and specialty members including a neurologist, a physiatrist, and a neurosurgeon. The committee also includes a community pharmacist, a public member, and a behavioral health professional. Two committee members are experts in the care of elderly and/or disabled persons to meet the requirements of the Medicare Part D program. Two committee members represent Mosaic Medical and St Charles Family Care which are local federally qualified health clinics who provide services to Medicaid members.

The current Quality Assurance Committee (QAC) is the Quality Assurance Committee for behavioral health. It consists of representation from county partners, the ABHA Medical Director, ABHA Quality Manager, ABHA Member Affairs Specialist, and at least 25% member representation. The QAC reports to the Administrative Council and is accountable to the ABHA Governing Board. This committee and function will transition to the COHB as the CCO evolves.

Both the QAC and the QAUMPT have cross-representation from each committee to ensure that committees are well-informed and work towards consistent clinical outcomes.

C.2.1.c. PSCS maintains a process in which the Quality Plan is developed, reviewed and updated annually. The elements are reviewed according to current OAR's, CFR's and appropriate contracts. Elements are added and removed based on changes to regulations, changes in focus for quality improvement and feedback from members and providers. QI topics are selected with input from the QAUMPT Committee based on performance measurement, comparisons to benchmarks, and community priorities.

C.2.1.d. PSCS's practitioners, culturally diverse community-based organizations and members will be engaged to assist in the planning, design and implementation of the QI program. Practitioners have the opportunity to be involved through participation in the QAUMPT Committee and the QAC Committee. There is also the opportunity to provide input and receive relevant QI Program information through educational provider meetings held several

times per year. As an example, community stakeholders were invited to participate in the selection and development of a project targeted toward members with Serious Persistent Mental Illness. PSCS with its community partners will identify additional opportunities to engage practitioners, community based organizations and members.

C.2.1.e. PSCS's QI program specifically addresses health care and health outcome inequities, care coordination and transitions between care settings. The QI program has elements designed to monitor access issues and identify discrepancies in care. Reports from claims data are reviewed and compared to benchmarks or compared to rates for the general population. A process is undertaken to identify the causes of the discrepancies and create actions to mitigate the inequities. The current collaborative Performance Improvement Project is focused on improving preventive services to member with Serious Persistent Mental Illness. This project was selected after reviewing data indicating the population was seeing their primary care providers but not getting preventive exams. A second project is focused on improving low rates of diabetes indicators in members with diabetes.

Members requiring care coordination are identified from health risk assessments, self referrals, utilization management and prospective risk reporting. Hospital census data, inpatient utilization review, and authorizations are used to identify the need for transitions coordination. Dedicated staff assesses the needs of these members and coordinate transitions.

C.2.1.f. PSCS has regular monitoring of provider's compliance and Corrective Action. The monitoring of provider compliance occurs through claims processes, utilization management, quality assurance, and grievance and appeals processes. Corrective Actions are monitored through credentialing processes and by the quality team with oversight by the medical director. Fraud, Waste and Abuse policies and procedures are in place. Policies and procedures document provider corrective action processes. As an example, PSCS audits provider medical record keeping and has developed a process verifying whether services billed by providers were received.

C.2.1.g. PSCS identifies QI opportunities through activities focused on customer satisfaction: clinical, facility, cultural appropriateness; Fraud and Abuse/Member protections; and Treatment planning protocol review/revision/dissemination. Customer satisfaction is addressed through analysis of the CAHPS survey (Consumer Assessment of Health plans Providers and Systems). Statistically different results will be assessed for the need to implement an improvement plan. Member grievances are monitored for trends and patterns that would indicate a need to change processes, provide education, or initiate corrective action. A satisfaction survey has been utilized to assess member satisfaction with the Grievance and Appeals process and identify opportunities for improvement. In addition to CAHPS results, satisfaction with behavioral health services is solicited by County partners through use of member comment cards. Hospitals and some clinics also perform surveys on PSCS members for satisfaction and to identify opportunities for improvement.

PSCS also identifies QI opportunities through fraud and abuse/member protections. PSCS has a Fraud and Abuse Reporting policy and procedure to ensure a non-retaliatory process for reporting suspected instances of fraud, abuse or other misconduct. Reported issues are investigated immediately, and confidentially. Confirmed fraud or abuse violations will be reported to the Audit committee and appropriate government agency, if necessary and followed by corrective action. PSCS is also engaging a new Fraud Waste & Abuse vendor in 2012 to target cases of overutilization. This vendor, Thomson Reuters, will provide monthly reports to a FWA team at PSCS who will be responsible for identifying legitimate FWA cases and reacting appropriately (contract termination, recoupment of payments, law enforcement referral, etc). In addition, PSCS has developed and implemented a process to verify with members whether services billed by providers were received. Grievances are also monitored for potential Fraud and Abuse issues.

Evidence-based guidelines are disseminated to providers as part of Quality Improvement Project interventions. Guidelines are also embedded in all medication coverage policies and disseminated to providers when prior authorizations for certain medications are requested. Medical Coverage Policies are developed after consultation with the most current evidence based medicine, State & Federal rules & regulations, and national treatment guidelines. All policies are reviewed & approved by the Quality Assurance Utilization Management Pharmacy & Therapeutics Committee (QAUMPT).

C.2.2. Clinical Advisory Panel

C.2.2.a. PSCS will establish a Clinical Advisory Panel (CAP) as a means of assuring best clinical practices. The CAP will serve as a subcommittee of the Central Oregon Health Council (COHC). The role of the CAP will be to provide clinical oversight and leadership to community clinical integration efforts, clinical quality improvements projects and improvements in the local health care system and delivery. The CAP will also serve a central role in coordination of the quality committees of the health plan, Central Oregon Health Board (COHB) and the Central Oregon IPA (COIPA). The CAP will consist of 15-17 members. Members will include a COHC member, Operating Council and Community Advisory Council as liaisons. Additional members will include representatives of behavioral health, oral health, the local FQHC, hospital system, health plan, COIPA, public health, clinical pharmacy, Long Term Care, Alcohol & Drug, Alternative Medicine, Obstetrics, and other Specialty Care. The representatives from COIPA, PSCS and behavior health will be members of their respective organizations quality committees. Through all CAP members, PSCS will also obtain representation from each of the following regions: Bend, LaPine, Sisters, Redmond, Prineville, Madras and Warm Springs. The CAP will also include members that provide representation of underserved populations. At least two positions each will be for members presenting Jefferson & Crook Counties.

C.2.3. Continuity of Care/Outcomes/Quality Measures/Costs

C.2.3.a. PSCS has policies, processes, practices and procedures 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. PSCS has collaborated with community partners on the Emergency Department Diversion community health integration project. This project focused on high utilization patients who were disconnected from the regular healthcare system. The successful interventions were community wide treatment plans, a health engagement team concept, use of community health workers and behavioral health consultants. This project realized a 49% reduction in ED visits. Patient reports of pain issues hindering work or home activities were improved and participating patients no longer perceived there were barriers to accessing the care they needed.

PSCS will be incorporating a complex care clinic to care for those members with intense care physical and mental health needs. PSCS has adjusted reimbursement processes to facilitate the placement of a behavioral health nurse practitioner at Mosaic Medical, the community FQHC s to specifically address behavioral health needs in the primary care setting.

PSCS has Case Management policies and procedures to ensure early identification of members with special needs in order to allow interventions that can significantly impact the quality and cost associated with their care without sacrificing medical appropriateness or member satisfaction. Staff is dedicated for case management to members with special health care needs. The staff has been trained in motivational interviewing and is working on patient engagement and activation. Newly enrolled members with special health care needs are mailed a health risk assessment called the Wellness Survey. The survey includes some plan specific questions as well as the SF12. The SF12 is a valid and reliable survey that measures functional health and well-being from the patient's point of view. It is a widely used tool for monitoring population health, comparing and analyzing disease burden, and predicting medical expenses. Scoring is based on comparisons to national age related norms and is used to risk stratify members who may need case management or conditions support.

Transitional Care Coordinators make outbound phone calls to all members meeting threshold criteria and ask a series of questions designed to identify gaps in care, barriers to access, educational need, and the need for referral to case management by an RN or BH specialist. If members are not able to be reached after two outbound phone calls, a "Cannot Reach" letter is sent to the member with the transitional care coordinator contact number in an effort to engage the member to call them back. For those members that are contacted, Care Coordinators and case managers complete assessment forms that are based on NCQA standards.

As a part of integrated care strategy, members meeting the threshold for prospective risk scores are brought to a weekly Integrated Care Management (ICM) meeting. The ICM meeting is designed as a collaborative effort to address gaps in care and bring community partners and resources together to bring the appropriate care and utilization of health services. This workgroup is comprised of behavioral health providers, ED diversion representatives, chemical dependency representatives, community health workers, the member and any other community

health partners involved in the member's health care. Prior to the meeting, members or the member's representative is contacted to inform them of this meeting and to identify the member's concerns, barriers or issues they see with their own health care. This information obtained from the member is included in the discussion. After the meeting, a care plan is then initiated and the case manager, care coordinator, pharmacist and/or behavioral health specialists works with the PCPs office, member and community partners such as the brokerage, transportation office, disability offices, member's state case worker, specialist's office, home health provider to develop a targeted, consistent approach. Once the member or member's representative is successfully engaged, the member is transitioned from the ICM workgroup to ongoing assessment and coordination with their nurse case manager. Six months after discharge from the ICM group, the member's prospective risk score is re-assessed and brought back to the ICM group if thresholds are again met.

Care Coordinators have facilitated care for members experiencing appointment delays. In one case the intervention by the care coordinator resulted in an experience where the member no longer felt "like a number" and ultimately had significant improvement in activities of daily living.

C.2.3.b. PSCS processes HEDIS Medicaid administrative measures through certified HEDIS software. These measures provide benchmark performance data and assist in identifying opportunities for improvement, identifying discrepancies in care and generating indicators for Performance Improvement Projects. Currently, an Asthma performance measure is run monthly for the PSCS Medicaid population. This includes medication controller ratios, rescue medication use, ED visits for asthma, and rate of follow up visits. CAHPS member satisfaction survey results are reviewed and compared to state and national benchmarks.

C.2.3.c. PSCS has implemented wellness and health improvement activities and practices within the PSCS organization for Members and staff to strengthen this aspect of health care. PSCS has a wellness program for employees with a mission to help employees achieve and maintain wellness through year-round education and events that promote health and disease prevention. Participation is encouraged by ensuring that events are interactive, fun, and interesting. One very successful ongoing employee event is the Better Bites program. For this event, the organization supplies a piece of fruit per day per employee and has other healthy snacks available at cost. In an additional program element each employee was given a pedometer as a holiday gift and teams are competing to increase their activity. Employees can earn wellness points with certain point thresholds triggering company donations to a charity of the employee's choice.

A health fair was held in November 2011 at Deschutes County for members in the SPMI population as part of a Performance Improvement Project. A second event is planned for 2012. The event had booths with the following topics: Medication adherence, Blood Pressure checks, Health & Wellness Information, Health Snacks, A Flu Shot Clinic, and Assistance to Make a PCP Appointment.

The member website includes Health Coach 4 Me which includes information on Diet and Nutrition, Exercise and Activity, Medicine, Smoking Cessation, Stress Management, Vaccination, Weight Management and chronic conditions such as Asthma, Breast Cancer, COPD, Diabetes, Heart Disease, and Migraine. Members with chronic conditions are encouraged by case managers to enroll in local Living Well with Chronic Conditions programs. Living Well with Chronic Conditions (the Chronic Disease Self-Management Program or CDSMP) is a six-week workshop that provides tools for living a healthy life with chronic health conditions, including diabetes, arthritis, asthma and heart disease. Through weekly sessions, the workshop provides support for continuing normal daily activities and dealing with the emotions that chronic conditions may bring about.

C.2.3.d. PSCS has experience in 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 PSCS. PSCS underwent review by the External Quality Review organization and were found to have Fully Met the ISCA requirements. PSCS has policies and procedures in place which will encourage and provide guidance for collection of necessary electronic data and other data. Experienced staff is able to produce reports from the data warehouse. Other PSCS Staff have experience in producing HEDIS reports and validating the results as well as producing measures from medical record collection. As noted above, PSCS has reporting systems that integrate member demographics, disease burden and claims history. This data is overlaid with Clinical Intelligence Rules which help to identify members meeting specific criteria. This reporting system will assist PSCS in collecting data to meet performance benchmarks.

C.2.3.e. PSCS has implemented other strategies to improve patient care outcomes, decrease duplication of services, and make processes more efficient as referenced above through current reporting capabilities and coordination of care processes.

In addition, PSCS has a weekly Integrated Care Management meeting (ICM). The ICM meeting is designed as a collaborative effort to address gaps in care and bring community partners and resources together to bring the appropriate care and utilization of health services. A care plan is then initiated and the case manager, care coordinator, pharmacist and/or behavioral health specialist works with the PCPs office, member and community partners such as the brokerage, transportation office, disability offices, member's state case worker, specialist's office, home health provider to develop a targeted, consistent approach. Once the member or member's representative is successfully engaged, the member is transitioned from the ICM workgroup to ongoing assessment and coordination with their nurse case manager. Six months after discharge from the ICM group, the member's prospective risk score is re-assessed and brought back to the ICM group if thresholds are again met.

Examples of Success with ICM:

1. Member had a stroke and had to be revived.

At first contact, member was very depressed and was unaware of available resources and having a very difficult time navigating the system.

Between the ENCC Transitional Care Coordinators and the Nurse Case Manager, working with the member, the member has been connected with several resources. Member complex issues were discussed in a weekly ICM meeting. Member was given American Blind Association information where member can order free books, other media choices and have access to other resources. PSCS worked with member and found providers in closer proximity to member. Member has been connected with a mental health (MH) provider. Member has been given information on how to obtain much needed dentures (nutrition issue) with this dental plan. Member has been given several other resources including transportation information.

2. When a member called Grievance and Appeals, staff referred the member to PSCS Care Coordinators. Upon calling the member, the Care Coordinator learned that member had been told the other pain clinic in town had a three month wait before next appointment. Knowing it was a Monday and member only had 2 more days of pain meds on hand (and the clinic the member had been dismissed from was not going to refill anymore), member was very frustrated and "ready to give up on insurance and doctors all together". Member was bed ridden after a failed back surgery and needed assistance with all ADL's. After Care Coordinator discussed with other staff, it was realized there was a pain clinic in town that was currently going through the credentialing process, but was not yet contracted. After calling and making arrangements, PSCS Care Coordinator was able to approve visits to the out-of-network provider to get the member the care needed. Member had an appointment that Friday morning which was four days out. Staff called and followed up that next Tuesday and member is able to move around and able to start caring for self and doing all ADL's independently.

C.2.3.f PSCS has 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 authorizations.

Care Coordination services may be requested by the member, the member's representative, physician, other medical personnel serving the member, or the member's agency case manager. Care coordination will be identified through wellness survey scoring as well as prospective risk scores generated by our claims analysis software, Ingenix & Thomson Reuters. Interpreter Services (including sign language) are covered for doctor visits for members who do not speak English or have a hearing impairment. These services are available by phone or in person.

Transitional Care Coordinators make outbound phone calls to all members meeting threshold criteria and ask a series of questions designed to identify gaps in care, barriers to access, educational need, and the need for referral to case management by an RN or BH specialist. Care Coordinators and case managers complete assessment forms that are based on NCQA standards. If members are not able to be contacted after two outbound phone calls, a "Cannot Reach" letter

is sent to the member with the transitional care coordinator contact number in an effort to engage the member to return the call.

As noted above, members meeting the threshold for prospective risk scores are brought to a weekly Integrated Care Management (ICM) meeting. This workgroup is comprised of behavioral health providers, ED diversion representatives, chemical dependency representatives, community health workers, the member and any other community health partners involved in the member's health care. Prior to the meeting, members or the member's representative is contacted to inform them of this meeting and to identify the member's concerns, barriers or issues as identified by the member or the member's representative.

PSCS has Case Management policies and procedures to ensure early identification of members with special needs in order to allow intervention that can significantly impact the quality and cost associated with their care without sacrificing medical appropriateness or member satisfaction. Staff is dedicated for case management of members with special health care needs. Care Coordination or case management services may be requested by the member, the member's guardian or representative, a physician, other medical personnel serving the member, or the member's agency case manager.

Newly enrolled members with special health care needs are mailed a health risk assessment called the Wellness Survey. The survey includes some PSCS specific questions as well as the SF12. The SF12 is a valid and reliable survey that measures functional health and well-being from the patient's point of view. It is a widely used tool for monitoring population health, comparing and analyzing disease burden, and predicting medical expenses. Scoring is based on comparisons to national age related norms and is used to risk stratify members who may need case management or conditions support.

PSCS tracks and documents all referrals and prior authorizations. PSCS contracts with PhTech for administrative services including authorization and referral tracking and claims payment. Daily reports are sent with the total number of authorizations and referrals which includes the date the request was received. This process ensures requests will be received and processed according to regulatory timelines with completion of notice requirements established by DMAP and DCBS. Authorization criteria are based on OHP benefits and guidelines and evidence based tools such as American College of Radiology (ACR) appropriateness criteria, Milliman, and Hayes Health Technology. Other references used in the process are Medicare criteria and guidelines and in-panel and out-of-panel physician specialty consultants and industry best practices. Clinical staff conducts medical review under the direction of the Medical Director. The Medical Services staff documents all authorizations and referrals in a software application called CIM, which is provided by PhTech. All prior authorizations and referrals are maintained in this application and available for providers and nurse case managers to review to ensure care coordination and reduce duplication of services. The Medical Services management receives a daily report with the total number of authorizations and referrals which includes the date the request was received. This allows them to ensure requests will be received and processed

according to regulatory timelines and notice requirements established by the Oregon Health Authority. Timeliness for completion of prior authorization requests is reviewed monthly by Corporate Quality Assurance and periodically by Internal Audit. If internal review demonstrates prior authorization timelines are outside established guidelines, the manager of Health Services is notified and an action plan for correction is developed. This report is reviewed by the Medical Director once completed.

Name of Publicly funded program	Type of Public Program	County in which program provides service	Specialty/Sub-Specialty Codes	
Immunization Program Immunizations	Public Health	Deschutes, Crook, Jefferson	286	
Communicable Disease Program (STD exams, TB tests, HIV testing)	Public Health	Deschutes, Crook, Jefferson	286	
Family Planning Program Family Planning Services OHP	Public Health	Deschutes, Crook, Jefferson	286	
HIV Program HIV Counseling and Testing	Public Health	Deschutes, Crook, Jefferson	286	
Well-Child Care	Public Health	Deschutes	286	
School Based Health Services	Public Health	Deschutes, Crook SBHC is run by Mosaic Medical	286	

The Following Table has services that the public health providers will coordinate with the PSCS

Name of Publicly funded program	Type of Public Program	County in which program provides service	Specialty/Sub-Specialty Codes	
Living Well Self Management Program	Public Health	Deschutes, Crook, Jefferson	286 Specialty	
Maternity Case Management	Public Health	Deschutes, Crook, Jefferson	286 Specialty	
Babies First Cocoon Tareted Case Management	Public Health	Deschutes, Crook, Jefferson	286 Specialty	
Screening services to provide early detection of health care problems among low income women and children, migrant workers and other special population groups; and	Public Health	Deschutes, Crook, Jefferson	286 Specialty	

Community Health Assessment	Public Health	Deschutes, Crook, Jefferson	This includes the actual community assessment and possibly of providing focus groups and other services to assist the CCO in their mission to improve the health of the region. : 286 specialty	
Health Improvement Plan	Public Health	Deschutes, Crook, Jefferson	Public Health Can lead the effort in the region to update the plan and work with the CCO on specific sections for implementation.: 286 specialty	
Tuberculosis-Direct Observed Therapy	Public Health	Deschutes, Crook, Jefferson	Visits to clients receiving medication for active disease: 286 specialty	
STD Treatment	Public Health	Deschutes, Crook, Jefferson	Exams are paid for, not treatment visits: 286 specialty	

Service Area Description County	Zip Code	Maximum Number of Members-Capacity Level
Crook	97751, 97752, 97753, 97754, 97760	3800
Deschutes	97701, 97702, 97707, 97708, 97709, 97712, 97739, 97756, 97759, 97760	28000
Jefferson	97730, 97734, 97741, 97760, 97761, 97711	5500
Klamath (Members in these four zip codes access care in Deschutes County)	97731, 97733, 97737, 97739	250

Pending Counties:

Grant	97817, 97820, 97825, 97845, 97848, 97856, 97864, 97865, 97869, 97873, 97877	1100
Harney	97710, 97720, 97721, 97722, 97732, 97736, 97738, 97758, 97904, 97911	1250
Lake (Members in Lake County seek care in Deschutes County)	97638, 97640, 97641, 97735, 97739	1300
Wheeler	97750, 97825, 97830, 97874	250

APPENDIX D – Medicare/Medicaid Alignment Questionnaire

Section 2 - Ability to Serve Dually Eligible Individuals

PSCS will provide integrated and coordinated health care and care management for all PSCS members, including members who are dually eligible for Medicare and Medicaid services. PSCS has an affiliated Medicare Advantage Plan through PacificSource Community Health Plan (PCHP) Medicare Advantage. As such, PSCS (Medicaid) and PCHP (Medicare) have the capability to provide both the Medicaid and Medicare benefits to dually eligible members in the proposed service area in a coordinated manner.

Currently, coordination of benefits and care occurs for dual members who are members of both PSCS and PCHP and reside in the PSCS service areas. PSCS anticipates that this system will continue moving forward with the Central Oregon CCO. PSCS did submit a Notice of Intent for the CMS Medicare/Medicaid Alignment Demonstration for 2013. The CMS Medicare/Medicaid Alignment Demonstration has been delayed until 2014. Recognizing this delay of the Demonstration, PSCS will meet the requirement to coordinate care for its members who are dually eligible through PSCS as the CCO and its affiliated Medicare Advantage Plan through PCHP to provide both the Medicaid and Medicare benefits to its members. PSCS will once again consider meeting the requirement for 2014 through participation in the CMS Medicare/Medicaid Alignment Demonstration.

Appendix H: Transformation Scope Elements

PSCS and its community partners recognize that Appendix H contains certain Health System Transformation elements that can serve as a starting point for contract discussions. PSCS and its community partners also recognize that the PSCS CCO will be evolving over the next 12 months. As such, PSCS and its community partners hesitate to submit any contract language due to the evolutionary nature of the CCO and the high probability that changes will be occurring over the next 12 months in relation to Governance, Payment Methodologies, Health Information Systems, and the Delivery System. To include wording in the contract at this time is premature and would commit the Central Oregon Community to language that will most certainly change and in some cases, could become no longer applicable over the next 18 months.

For example:

- The Governance of PSCS CCO is currently being developed. As such, PSCS is specifically named as the Applicant for this application process. There is a desire by the community that more accountability be shared in the near term. PSCS and its community partners would like to have the opportunity to work with OHA to allow this evolution to be reflected in our contract as the discussion becomes more concrete and final.

- There are current rules and requirements in the system that need to be evaluated as CCOs are implemented such as the ISSRs. For example, the ISSRs as they are currently stated are not realistically applicable to current PCPCH models. As such, one area that PSCS and its community partners would like to see included in a Core Contract is some relief if possible from the ISSRs in specific parts of the system where the ISSRs may not be realistic in practice. This will have to be done in collaboration with the CCOs and OHA to ensure that both parties are able to maintain compliance with what requirements they may have.

- At the submission of this application, the CCO Rules are still temporary and PSCS and its community partners would not know what to address in terms of requests for flexibility in relation to local solutions.

As such, PSCS and its community partners request the opportunity to work with the OHA through the first 18 months to identify flexibilities and local transformations to be incorporated within the contract. This could be accomplished through contractual amendments.

ATTACHMENT 2 – Applicant's Designation of Confidential Materials
RFA # 3402

Applicant Name: PacificSource Community Solutions, Inc.

Instructions for completing this form:

Applicant may not designate any portion of its Letter of Intent to Apply or CMS Notice of Intent to Apply as confidential.

As a public entity, OC&P is subject to the Oregon Public Records Law which confers a right for any person to inspect any public records of a public body in Oregon, subject to certain exemptions and limitations. *See* ORS 192.410 through 192.505. Exemptions are generally narrowly construed in favor of disclosure in furtherance of a policy of open government. Your Application will be a public record that is subject to disclosure except for material that qualifies as a public records exemption.

It is OC&P's responsibility to redact from disclosure only material exempt from the Oregon Public Records Law. It is the Applicant's responsibility to only mark material that legitimately qualifies under an exemption from disclosure. To designate a portion of an Application as exempt from disclosure under the Oregon Public Records Law, the Applicant should do the following steps:

1. Clearly identify in the body of the Application only the limited material that is a trade secret or would otherwise be exempt under public records law. If an Application fails to identify portions of the Application as exempt, Applicant is deemed to waive any future claim of non-disclosure of that information.

2. List, in the space provided below, the portions of your Application that you have marked in step 1 as exempt under public records law and the public records law exemption (e.g., a trade secret) you believe applies to each portion. If an Application fails to list in this Attachment a portion of the Application as exempt, Applicant is deemed to waive any future claim of non-disclosure of that information.

3. Provide, in your response to this Attachment, justification how each portion designated as exempt meets the exemption criteria under the Oregon Public Records Law. If you are asserting trade secret over any material, please indicate how such material meets all the criteria of a trade secret listed below. Please do not use broad statements of conclusion not supported by evidence.

Application of the Oregon Public Records Law shall determine whether any information is actually exempt from disclosure. Prospective Applicants are advised to consult with legal counsel regarding disclosure issues. Applicant may wish to limit the amount of truly trade secret information submitted, providing only what is necessary to submit a complete and competitive Application.

In order for records to be exempt from disclosure as a trade secret, the records must meet all four of the following requirements:

- The information must not be patented;
- It must be known only to certain individuals within an organization and used in a business the organization conducts;
- It must be information that has actual or potential commercial value; and,
- It must give its users an opportunity to obtain a business advantage over competitors who do not know or use it.

Keep in mind that the trade secret exemption is very limited. Not all material that you might prefer be kept from review by a competitor qualifies as your trade secret material. OC&P is required to release information in the Application *unless* it meets the requirements of a trade secret or other exemption from disclosure and it is the Applicant's responsibility to provide the basis for which exemption should apply.

In support of the principle of an open competitive process, "bottom-line pricing" – that is, pricing used for objective cost evaluation for award of the RFA or the total cost of the Contract or deliverables under the Contract – will not be considered as exempt material under a public records request. Examples of material that would also not likely be considered a trade secret would include résumés, audited financial statements of publicly traded companies, material that is publicly knowable such as a screen shot of a software interface or a software report format.

To designate material as confidential and qualified under an exemption from disclosure under Oregon Public Records Law, an Applicant must complete this Attachment form as follows:

Part I: List all portions of your Application, if any, that Applicant is designating as exempt from disclosure under Oregon Public Records Law. For each item in the list, state the exemption in Oregon Public Records Law that you are asserting (e.g., trade secret).

> "This data is exempt from disclosure under Oregon Public Records Law pursuant to [*insert specific exemption from ORS 192, such as a "ORS 192.501(2) 'trade secret'"*], and is not to be disclosed except in accordance with the Oregon Public Records Law, ORS 192.410 through 192.505."

In the space provided below, state Applicant's list of material exempt from disclosure and include specific pages and section Letters of Support of your Application.

1. Appendix B Pharmacy Contract Information - Additional Information Appendix B

2. Attachment 3.5.1 Case Mgt Screens – Appendix A Extra Info

3.

[This list may be expanded as necessary.]

Part II: For each item listed above, provide clear justification how that item meets the exemption criteria under Oregon Public Records Law. If you are asserting trade secret over any material, state how such material meets all the criteria of a trade secret listed above in this Attachment.

In the space provided below, state Applicant's justification for non-disclosure for each item in the list in Part I of this Attachment:

1. Confidential negotiated and contracted rates for Pharmacy

2. Proprietary Case Mgt Program for PacificSource Health Plans

3.

[This list may be expanded as necessary.]

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In the space provided below, state Applicant's list of material exempt from disclosure and include specific pages and section Letters of Support of your Application.

1. Appendix E and all related attachments

2. Appendix F and all related attachments

3.

[This list may be expanded as necessary.]

Part II: For each item listed above, provide clear justification how that item meets the exemption criteria under Oregon Public Records Law. If you are asserting trade secret over any material, state how such material meets all the criteria of a trade secret listed above in this Attachment.

In the space provided below, state Applicant's justification for non-disclosure for each item in the list in Part I of this Attachment:

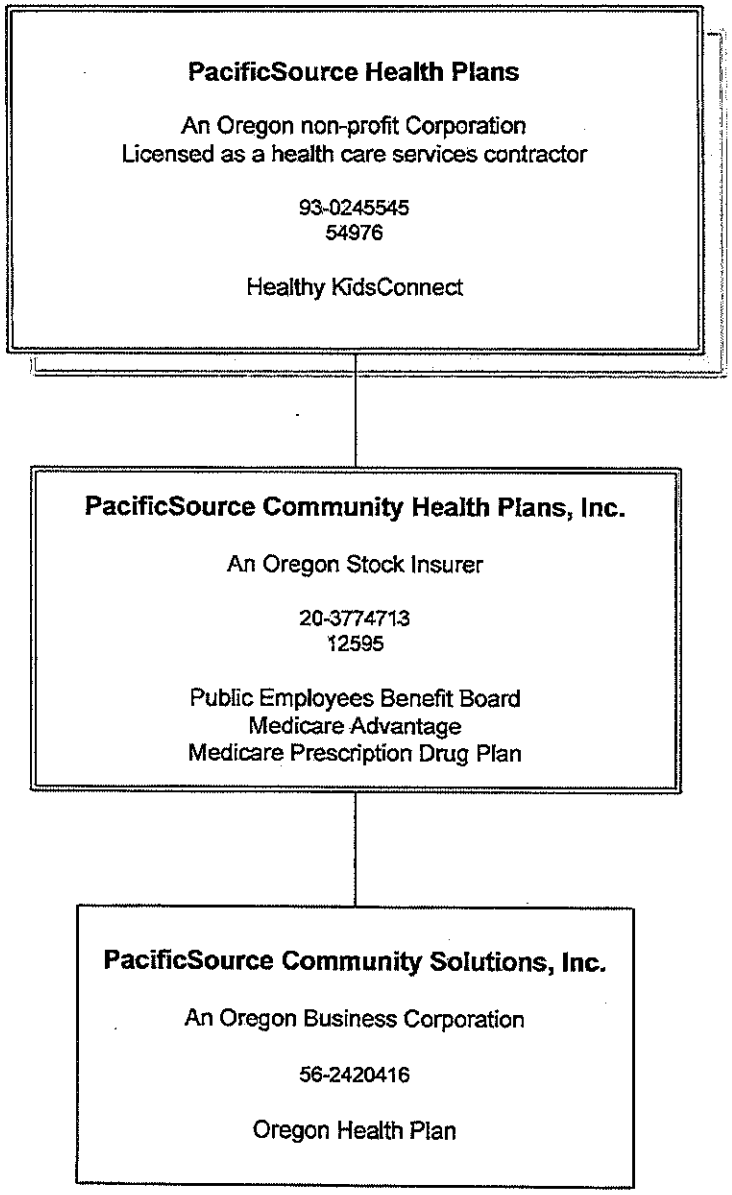
1. Proprietary information

2. Proprietary information

3.

[This list may be expanded as necessary.]

Attachment A.1.m



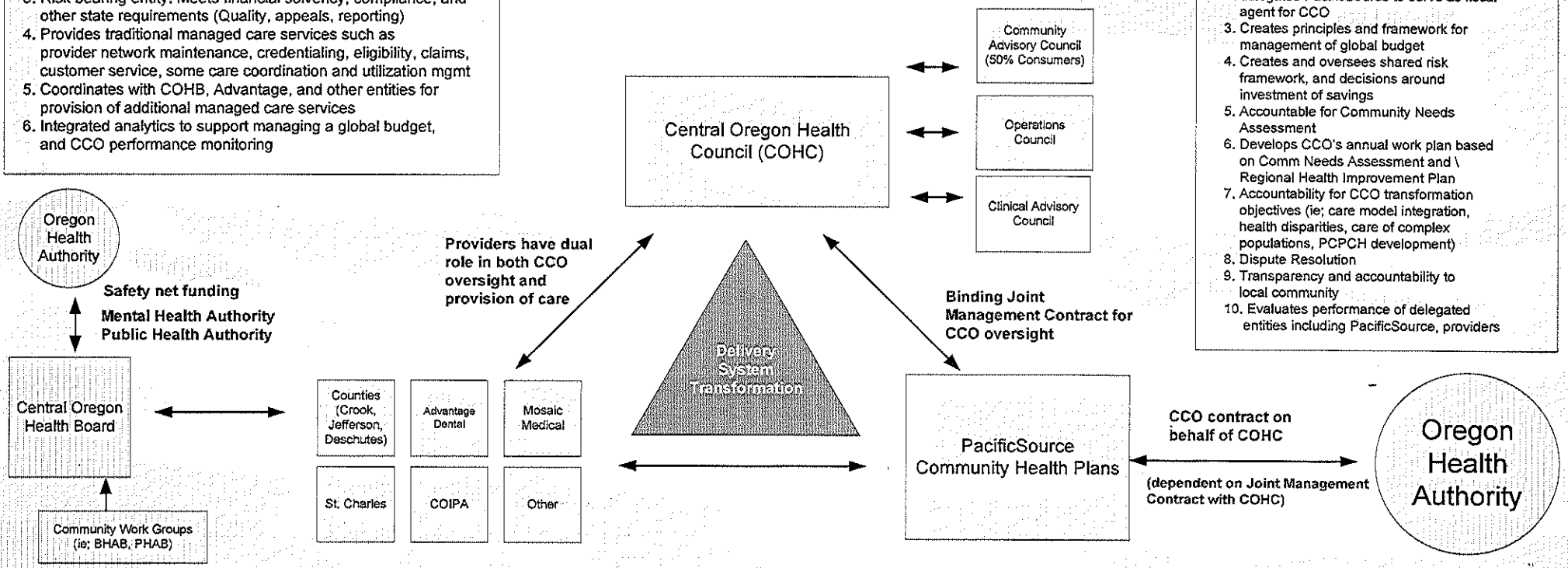
Central Oregon CCO Structural Model
April, 2012

PacificSource Community Solutions Fiscal Agent Functions

1. CCO fiscal agent, based upon binding Joint Management Contract with COHC
2. Maintains appropriate State and Federal licensure for CCO and other involved lines of business
3. Risk bearing entity. Meets financial solvency, compliance, and other state requirements (Quality, appeals, reporting)
4. Provides traditional managed care services such as provider network maintenance, credentialing, eligibility, claims, customer service, some care coordination and utilization mgmt
5. Coordinates with COHB, Advantage, and other entities for provision of additional managed care services
6. Integrated analytics to support managing a global budget, and CCO performance monitoring

COHC Oversight Functions

1. Community entity with meaningful oversight role of CCO
   - Policy
   - Strategy
   - Quality
2. Through Joint Management Contract, delegates PacificSource to serve as fiscal agent for CCO
3. Creates principles and framework for management of global budget
4. Creates and oversees shared risk framework, and decisions around investment of savings
5. Accountable for Community Needs Assessment
6. Develops CCO's annual work plan based on Comm Needs Assessment and \ Regional Health Improvement Plan
7. Accountability for CCO transformation objectives (ie; care model integration, health disparities, care of complex populations, PCPCH development)
8. Dispute Resolution
9. Transparency and accountability to local community
10. Evaluates performance of delegated entities including PacificSource, providers



C.O. Health Board Key Functions

1. Oversight of counties provision of care in region
2. Leveraging County & State funds toward success in Global Budget
3. Ensure coordination of safety net services with health care services
4. Public and population health efforts
5. Early learning council hub

Provider Key Functions

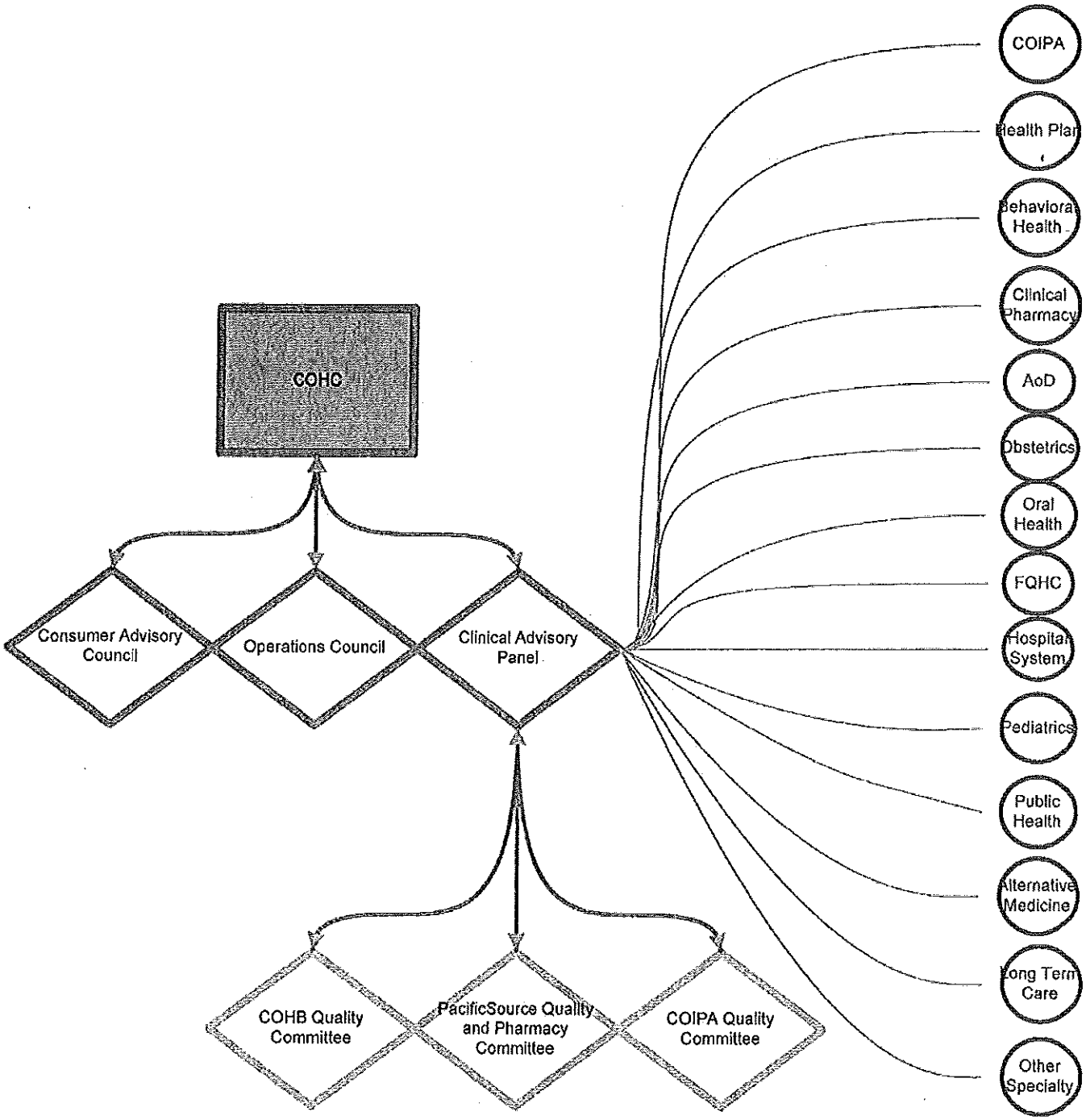
1. Provision of care
2. Development, implementation and ongoing support of transformation initiatives
3. Patient engagement in transformative care models
4. Integration of transformation workforce (health navigators, CHWs, peer wellness specialists)

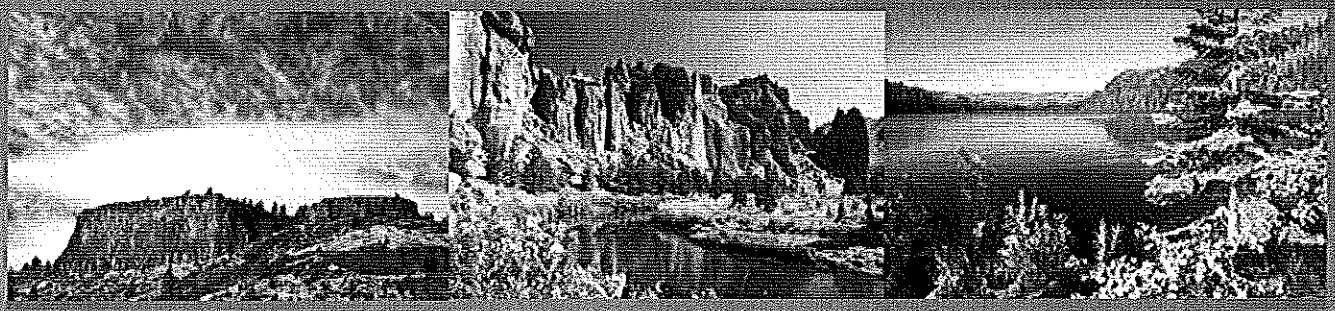
Oregon Health Authority Non negotiables

- Clear accountability for financial solvency, licensure, capital requirements, and regulatory/compliance deliverables
- Accountability for transformation deliverables

COHC VISION and GUIDING PRINCIPLES

Attachment A.1.2 - CAP





Central Oregon Health Report, 2012

EXECUTIVE SUMMARY

4/18/2012

Photos: Gary Halvorson, Oregon State Archives

THE CONFEDERATED TRIBES OF THE WARM SPRINGS RESERVATION OF OREGON

CROOK COUNTY

DESCHUTES COUNTY

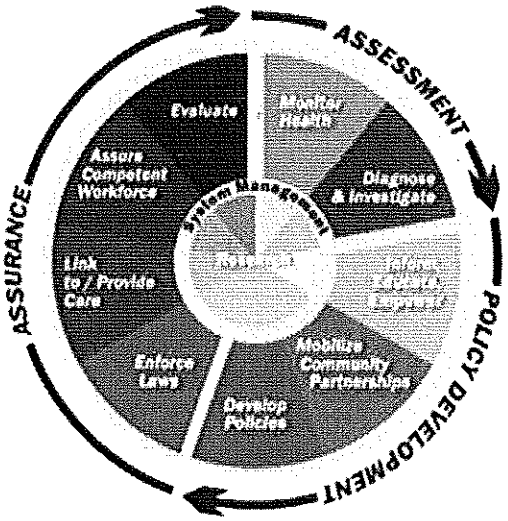
Jefferson County

Community Health is not simply a state free from disease but is the **capacity of people to be resilient** and manage life's challenges and changes."

–Public Health Accreditation Board, 2011

What is Community health?

"Community health" is a discipline of public health that examines and seeks to improve the health-related characteristics of the relationships between people and their physical and social environments.



The Essential Public Health Services and Core Functions Source: Core Public Health Functions Steering Committee, Fall 1994

"The term 'community' in community **health tends to focus on geographic areas rather than people with shared characteristics.** From a community health perspective, health is not simply a state free from disease but is the capacity of people to be resilient and manage life's challenges and changes.

Community health **focuses on a broad range of factors** that impact health, such as the **environment** (including the built environment), **social structure, resource distribution** (including, for example, access to healthful foods), **social capital** (social cohesion), and **socio-economic status.**

A key approach or methodology of community health is the **creation and empowerment of community partnerships to take action** that will improve the health of the community. Community health partnerships include representation from a wide variety of sectors of the community, for example, recreation, the faith community, law enforcement, city planners and policy makers, businesses, human and social services, as well as public health and health care providers."

–Public Health Accreditation Board, 2011

ABOUT THIS HEALTH REPORT

The Central Oregon Health Report (COHR) 2012 is an overview of data related to health in communities and populations. COHR 2012 aims to provide useful data for three Oregon counties commonly referred to as "Central Oregon" or Central Oregon's "tri-county region": Crook, Deschutes and Jefferson Counties. Recognizing that many factors impact the health of individuals and communities, a range of data from multiple sectors are included in the report.

The Central Oregon Health Report is not meant to answer all questions. It is meant to provoke them.

How to Use

We acknowledge that the Central Oregon Health Report, 2012 is not a compendium of all indicators and analyses applicable in community health assessment. Thus, we highly encourage readers to dig deeper, check sources, and pull-in additional information to help you complete a more in-depth understanding of our community.

COHR 2012 is not a static, single point-in-time document. Instead, it is intended to be a first-step in our region's effort to continuously assess data in order to: identify where to celebrate successes, recognize weaknesses or areas of concern, instigate community discussions on how to capitalize on strengths and turn weaknesses into opportunities for positive change.

The COHR is not intended to answer all questions. Instead, it should provoke them. We encourage readers to ask more questions, dig deeper and explore. Many data reports and fact sheets on numerous relevant topics exist for our area – check them out! (See the full report for a list of suggested documents and resources).

This Executive Summary calls attention to a fraction of indicators and is a companion – not a replacement – to the full report.

Ask more questions, dig deeper, explore... engage in conversations

As you look and dig deeper, consider the weaknesses and limitations of the data. Engage in conversations with colleagues, peers, friends, family, neighbors, community members, and strangers. Seek-out qualitative, personal and experiential information to complement the numbers you see. Only when communities engage in this process can we draw the map to improved health and well-being for our neighborhoods, our communities and our region.

Data

This health report utilizes multiple sources of data. Some of this data is available through the state of Oregon, some through national government and non-government agencies, and some from local organizations. Sources include Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), U.S. Census Bureau's census statistics, Oregon Health Authority Department of Public Health's public health and community data, Oregon Department of Education's school data, and data from local organizations compiled by Deschutes County Health Services.

A Note About Data: There are many great and widely-used data sources available today. Data sets like these require significant amounts of labor and resources before they are made publicly available. This can mean unavoidable lag-time where data is many months, often several years old. This lag can present complications when trying to interpret and apply the information for the present day. While the data is still very valuable, it is important to always look at the data sources' dates and time frames, and to become familiar with what and how it is measured. For example, the County Health Rankings is a great and useful public health resource, but data used to calculate 2012 County Health Rankings can date as far back as 2003 (with 2010 being the most recent year). Similarly, several indicators in this health report pre-date the recession. These indicators are useful, but cannot help us fully understand how difficult economic times have impacted our region.

Why?

A core function of public health agencies and public health practice is to examine the community of interest. A wide range of data and indicators that known to be related to population and community health are used to describe the community's health status and factors that affect the health of a community.

Attention to this data can help identify areas of need, target populations at increased risk of poor health outcomes, population health outcomes or factors that appear better or worse than comparison populations, or characteristics that may increase or decrease risks of poor health. The process is also important in gaining a better understanding of how a community's characteristics play a role in the health and wellbeing of a community.

Establishing a regular health assessment processes ultimately functions to inform timely public health strategies that are responsive to a community's distinctive needs and to lay the groundwork for assessing and tracking health changes in the future.

This community health report is the first step in creating a more coordinated, collaborative and on-going process to continually assess our community's unique needs.

In recent years, Central Oregon gained national attention when unemployment rates approached 20% in some areas and subsequent shifts in the economic climate dramatically altered day-to-day living for many Central Oregonians. Other counties in Oregon and the nation experienced similar economic difficulties, but not with the magnitude of Central Oregon.

The health impacts of these economically difficult times should be monitored in the coming years, as many effects will not be seen for several years.

Many of the statistics that could describe Crook County's health reside in the gaps of state and national data systems. Several reliable nationwide surveys are unable provide estimates or data for Central Oregon, making it difficult to derive local meaning from some of the more readily available secondary data. For example, there are gaps in large data sets such as the Behavioral Risk Factor Surveillance System (BRFSS), the National Health and Nutrition Examination Survey (NHANES) and the Youth Risk Behavior Surveillance System (YRBSS), which many counties rely on for data to drive community health assessments.

Similarly, indicators collected in nationwide surveys are not always applicable to many rural populations. For example, environmental exposures that may be important indicators of environmental health to the nation as a whole (e.g., number of quality air days) may provide a false sense of environmental health in Central Oregon when other exposures such as pesticides or arsenic may be more relevant to the population. Yet, this information is not easily accessed or routinely assessed.

Based on these factors, the following components will be essential components to establish on-going community health assessment in Central Oregon in the future:
a) community and regional partnerships,
b) utilization of existing data from outside sectors and organizations, c) improved data sharing among collaborating agencies, d) dedicated resources to compile existing data into comprehensive, meaningful and interpretable formats, e) sharing results broadly in accessible formats, and f) engaged community-member and stakeholder input, feedback and collaborative processes.

EXECUTIVE SUMMARY

There are unique characteristics in Central Oregon that set our region apart from the rest of Oregon. Over many decades, climate, land types, resources, history, economics, and policies have influenced our population, who lives here, what we do for work and pleasure, and the health of our community.

Central Oregon has many strengths – from wide-open spaces to groups dedicated to improving access to outdoor recreation, from a vibrant workforce to organizations leading the charge for a more collaborative, healthier Central Oregon. Those communities, organizations and decision-makers who work together in identifying our unique strengths will be empowered to craft strategies and initiatives that capitalize on the elements that make our communities strong.

Data shows that Central Oregon counties are markedly different.
There are distinct and substantial differences between our counties. Community characteristics linked to health outcomes are found to have a wide range between our counties. Thus, there may be issues or areas of concern that are specific to individual counties. Similarly, our counties have different strengths, capacity and resources to address issues and concerns. The critical point to remember for program, policy and decision-making is that while there are many similarities among counties, there are also many differences that must be acknowledged for strategies to be successful.

In the same vein, **differences exist within each county at city, community and neighborhood levels.** Bend and La Pine are not the same. One neighborhood of Madras may be different from others in the same town. Day-to-day in Prineville is different from remote, unincorporated areas of Crook County. Sometimes these differences impact people's health. Sometimes they do not. Regardless, these differences can affect whether or not a program, policy or initiative will be successful and must be acknowledged.

When coupling constraints on available data due to the nature of data sources, collection methods, data sharing agreements and fundamental rules of statistics together with Central Oregon's small population size,

WARM SPRINGS—A SOVEREIGN AUTHORITY

While part of Warm Springs Reservation is located within borders of Jefferson County, it is important to remember Warm Springs is a sovereign authority.

From the Confederated Tribes of Warm Springs Reservation of Oregon Declaration of Sovereignty, 1992:

Today, the people of the Confederated Tribes continue to assert and exercise sovereign authority over the tribal reservation, over other territory within tribal jurisdiction, over territory that may come under tribal jurisdiction in the future, and over the protection of our rights and our people and their welfare in all places. This complete sovereign power encompasses legislative authority, such as the power to define individual conduct, to regulate business enterprises, to zone land, to tax, to regulate the use of natural resources, to protect the environment, to make provisions for education, health, and social welfare, to protect our right to worship according to our own religions and to follow our traditional ways, and to make other laws appropriate to the exercise of the full range of lawmaking authority possessed by any nation. The Confederated Tribes' sovereign powers also include executive authority to implement tribal legislation and judicial authority to enforce valid legislative and executive orders. Our sovereign authority includes the right to choose not to adopt formal, written laws, procedures, or policies governing particular subjects; formal laws can be intrusive and inflexible, and we have learned that some issues are best addressed by informal, traditional ways.

It is difficult – often impossible – to get town and neighborhood-level data for numerous indicators. COHR 2012, therefore, is limited in its ability to provide detailed information for smaller geographic areas. In the future, availability and utility of data could improve by investing in:

- strengthened partnerships and collaboration;
- changes in existing data systems;
- and establishing regional infrastructure and capacity to collect, analyze and interpret data with quality and reliability.

OREGON COUNTY HEALTH RANKINGS 2010, 2011, & 2012

CHANGE IN ROBERT WOOD JOHNSON FOUNDATION* OREGON RANKINGS

	Crook				Deschutes				Jefferson			
	2010	2011	2012	CHANGE FROM 2010	2010	2011	2012	CHANGE FROM 2010	2010	2011	2012	CHANGE FROM 2010
Health Outcomes	14	14	12	⇧	6	7	5	⇧	33	33	33	–
Health Factors	21	30	29	⇩	2	4	5	⇩	33	33	33	–
Mortality	13	10	10	⇧	5	7	4	⇧	32	33	32	–
Morbidity	16	21	9	⇧	8	9	9	⇩	31	30	21	⇧
Health Behaviors	21	21	25	⇩	1	1	2	⇩	31	30	30	⇧
Clinical Care	9	20	14	⇩	3	5	5	⇩	28	30	25	⇧
Social & Economic Factors	27	30	33	⇩	6	11	16	⇩	33	33	32	⇧
Physical Environment	17	22	13	⇧	5	3	11	⇩	2	18	23	⇩

*Only 33 of 36 counties ranked

= Bottom Quartile in State Rank of Counties
= Top Quartile in State Rank of Counties
⇩ = State ranking in 2012 lower than 2010
⇧ = State ranking in 2012 higher than 2010

S. Kingston, Deschutes County Health Services/Public Health Department, 04/2012
Robert Wood Johnson Foundation, County Health Rankings: Oregon 2010, Oregon 2011, & Oregon 2011. Retrieved from http://www.countyhealthrankings.org/ranking-methods/exploring-data

10 important things to know about HEALTH

*Excerpts from "Ten Things You Should Know About Health," *Unnatural Causes (2008)* (California Newsreel, 2008. Retrieved from http://www.unnaturalcauses.org/ten_things.php)

1. Health is more than health care

Doctors treat us when we are ill, but what makes us healthy or sick in the first place? Research shows that social conditions—the jobs we do, the money we're paid, the schools we attend, the neighborhoods we live in—are as important to our health as our genes, our behaviors and even our medical care.

2. Social policy is health policy

Average life expectancy in the U.S. improved by 30 years during the 20th century. Researchers attribute much of that increase not to drugs or medical technologies but to social changes such as improved wage and work standards, universal schooling, improved sanitation and housing, and civil rights laws. These are as much health issues as diet, smoking and exercise.

3. We all pay the price for poor health

It's not only the poor but also the middle classes whose health is suffering. We already spend $2 trillion a year to patch up our bodies, more than twice per person than the average rich country spends, and our health care system is strained. Yet we are far from the top for life expectancy and infant mortality. As a society, we face a choice: invest in the conditions that can improve health today or pay to repair bodies tomorrow.

4. Inequality (economic and political) is bad for health

5. Health is tied to distribution of resources

The single strongest predictor of our health is our position on the class pyramid. Whether measured by income, schooling, or occupation, those at the top have the most power and resources and on average live longer and healthier lives. Those at the bottom are most disempowered and get sicker and die younger. The rest of us fall somewhere in between. On average, people in the middle are almost twice as likely to die an early death compared to those at the top; those on the bottom, four times as likely. Even among people who smoke, poor smokers have a greater risk of dying than rich smokers.

6. The choices we make are shaped by the choices we have

Individual behaviors – smoking, diet, drinking, and exercise – matter for health. Making healthy choices isn't just about self-discipline. Some neighborhoods have easy access to fresh, affordable produce, others have only fast food joints and liquor and convenience stores. Some have nice homes, clean parks, safe places to walk, jog, bike or play, and well-financed schools offering gym, art, music and after-school programs. And some don't. How can we better ensure healthy spaces and places for everyone?

7. Chronic stress can be toxic (and is a strong predictor of poor health outcomes)

Exposure to fear and uncertainty triggers a stress response. Our bodies go on alert: the heart beats faster, blood pressure rises, glucose floods the bloodstream – all so we can hit harder or run faster until the threat passes. But when threats are constant and unrelenting our physiological systems don't return to normal. Like gunning the engine of a car, this constant state of arousal, even if low-level, wears us down over time, increasing our risk for disease.

8. High demand + low control = chronic stress

The lower in the pecking order we are, the greater our exposure to forces that can upset our lives – insecure and low-paying jobs, uncontrolled debt, capricious supervisors, unreliable transportation, poor childcare, no healthcare, noisy and violent living conditions – and the less access we have to the money, power, knowledge and social connections that can help us cope and gain control over those forces.

9. Racism and discrimination in any form imposes an added health burden

Segregation, social exclusion, encounters with prejudice, the degree of hope and optimism people have, differential access and treatment by the health care system – all of these can impact health.

10. Health inequities are not natural

Health differences that arise from our inequities result from decisions we as a society have made – and can make differently. Two important strategies: make sure inequality is less and try to ensure that everyone has access to health promoting resources regardless of their personal wealth (e.g., good schools and health care are available to everyone, not just the affluent).

Demographics

Since 1990, Central Oregon has experienced dramatic population growth. From 1990 to 2010, the population increased in Crook from 14,111 to 20,978, in Deschutes from 74,958 to 157,733, and in Jefferson from 13,676 to 21,720 residents.

Crook County has an older population, with a median age of 42.4 years and 20% of residents age 65 years or older. Deschutes County's median age is 39.7 years, and 14.9% of residents are 65 years or older. Jefferson County has the youngest median age of 38.1 years and 15.3% of residents in Jefferson are 65 years or older.

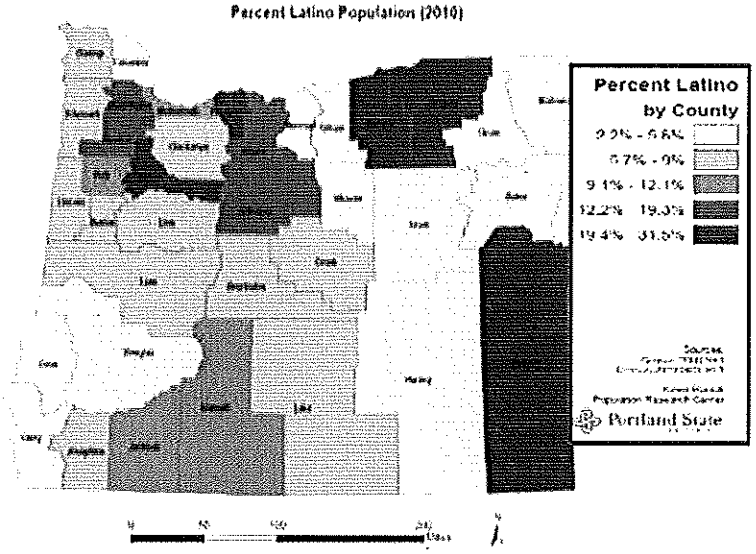
In Jefferson, both the birth rate and the percent of residents younger than 18 years old are than the highest in Central Oregon. More than 1 in 4 residents in Jefferson are younger than 18 years old. In Deschutes, 23% of the population is under 18 years, compared to 21.9% in Crook. Since 2000, Jefferson's age-adjusted birth rate has been higher than Crook, Deschutes, and the state of Oregon. In 2008, Jefferson's age-adjusted birth rate was 16.8 per 1,000—higher than Oregon's rate of 13 per 1,000, and higher than Crook (8.3) and Deschutes (11.6).

Deschutes County is the most urban in Central Oregon. Only 27.6% of residents live in rural designations, compared to 48.02% in Crook and 63.12% in Jefferson. Deschutes County also has higher population density—an average of 2,110 people per square mile in areas with a population greater than 50,000 people, and 1,750.1 people per square mile in areas with populations of 2,500-50,000 people. Rural areas of Crook County have the smallest population density: 3.4 people per square mile.

AT A GLANCE...

	Crook	Deschutes	Jefferson
MEDIAN AGE	42.4	39.7	38.1
% 65+ YEARS OLD	20%	14.9%	15.3%
% RURAL	48%	28%	63%
% HISPANIC/LATINO	7%	7.4%	19.3%
% WHITE (NON-HISPANIC/ LATINO)	89.4%	88.4%	61.8%
AMERICAN INDIAN/ ALASKA NATIVE	1.4%	0.9%	16.9%
2 OR MORE RACES	2%	2.5%	3.8%
BLACK/ AFRICAN-AMERICAN	0.2%	0.4%	0.6%
ASIAN	0.5%	0.9%	0.4%

Percent Latino Population (2010)



FAST FACTS

CROOK COUNTY has an older population, more dependent-age residents for every working-age resident, and relatively high rates of poverty compared to the rest of Oregon.

DESCHUTES COUNTY has fewer dependent-age residents for every working-age resident and higher per capita income.

JEFFERSON COUNTY has a younger population, a higher birth rate, and higher rates of poverty compared to much Oregon. Jefferson County has the most racial/ethnic diversity in Central Oregon.

Countries W/ similar life expectancies to Central Oregon & Country's Life Expectancy world rank:
CROOK
Israel (17th)
Iceland (18th)
DESCHUTES
Spain (14th)
Switzerland (15th)
JEFFERSON
Tunisia (78th)
Brunei (79th)
OREGON
E.U. (44th),
Bosnia & Herzegovina (45th)

Life Expectancy & Births

Life Expectancy at birth in CROOK COUNTY:

80.1 years

Life Expectancy at birth in DESCHUTES COUNTY:

81.1 years

Life Expectancy at birth in JEFFERSON COUNTY:

75.8 years

Jefferson County is the only county in Oregon where the life expectancy has declined since the year 2000.

Age-Adjusted birth rates (per 1,000)
Crook: 8.3
Deschutes: 11.6
Jefferson: 16.8
Oregon: 13

Preliminary birth and death data reveal that Crook, unlike Deschutes and Jefferson, had more deaths than births in 2010 and 2011: 181 births to 229 deaths in 2010 & 176 births to 220 deaths in 2011.

2,170 babies were born to Central Oregon residents. Of these, 8.3% were from Crook, 78.8% were from Deschutes, and 12.9% were from Jefferson.

In Crook and Deschutes, birth rates and total number of births appear to be in decline since 2007.

38% of Crook County births, 35% of Jefferson County births & 42% of Deschutes County births were to first-time mothers.

Modifiable Risks & Behaviors

Jefferson county's rate of death from motor vehicle crashes is more than Crook and Deschutes County rates combined.

½ of motor vehicle fatalities in Jefferson County involve alcohol.

87% of CROOK
92% of DESCHUTES &
91% of JEFFERSON
8th graders report they live in a SMOKE-FREE HOME

Crook County's adult smoking rate is among the highest in the state at 23%.

11% to 12.5% of Central Oregon adults use smokeless tobacco.

Deschutes County has the highest rate of tobacco quit attempts in a year (61% of tobacco users).

69.4%of CROOK
61.1% of DESCHUTES &
51.4% of JEFFERSON
adults met recommendations for PHYSICAL ACTIVITY*

More than 6,400 people die every year from a serious illness caused by TOBACCO USE in Central Oregon.

An estimated 6.7% of all Central Oregonians age 12 and older have ALCOHOL DEPENDENCE That is more than 14,000 Central Oregonians.

% Adults who are Overweight*

CROOK:	39.1%
DESCHUTES:	41.0%
JEFFERSON:	41.9%
OREGON:	36.1%

14% of CROOK
26% of DESCHUTES &
32% of JEFFERSON adults consume at least
5 SERVINGS OF FRUITS & VEGGIES PER DAY*

% Adults who are Obese*

CROOK:	31.5%
DESCHUTES:	15.7%
JEFFERSON:	25.3%
OREGON:	24.5%

Last month, of all Central Oregonians age 12 and older,
8.1% used MARIJUANA
4.6% used ILLICIT DRUGS other than marijuana
6.1% used PRESCRIPTION PAIN RELIEVERS to get high

75.9 % of CROOK
69.4% of DESCHUTES &
77.1% of JEFFERSON
Two-year olds were up to date on immunizations

(4 DTaP, 3 IPV, 1 MMR, 3 Hib, 3 HepB (or 2-dose Merck Series), and 1 Varicella)

A growing number of parents opt out of some or all immunizations for school-age children. Deschutes' kindergarten religious exemption rate of 9.0% for is substantially higher than the state average of 5.6% (2010-2011 school year).

*age-adjusted rates, BRFSS 2006-2009

FAST FACTS

In 2003-2007,
81 Central Oregonians were killed in motor vehicle accidents involving alcohol.

7.4% from CROOK,

54.3% from DESCHUTES,

38.3% from JEFFERSON

Even though Jefferson accounts for 11% of Central Oregon's population, it had nearly 40% of all fatal motor vehicle accidents involving alcohol.

FAST FACTS

CROOK
1,305 children live in poverty.
26% of all children—more than 1 in 4 under age 18—live in poverty.

DESCHUTES
6,764 children live in poverty.
19.1% of all children—fewer than 1 in 5 under age 18—live in poverty.

JEFFERSON
1,606 children live in poverty.
29.9% of all children—approx. 1 in 3 under age 18—live in poverty.

Socio-Economic Health

The census tracts with the highest median incomes in Central Oregon are in Deschutes County. These tracts have median incomes from $61,000 to more than $82,000 per year.

The 7 census tracts with the lowest median incomes in Central Oregon are: Crook (1 tract), Deschutes (4 tracts), Jefferson (2 tracts). Each of these have median incomes less than $40,000 per year.

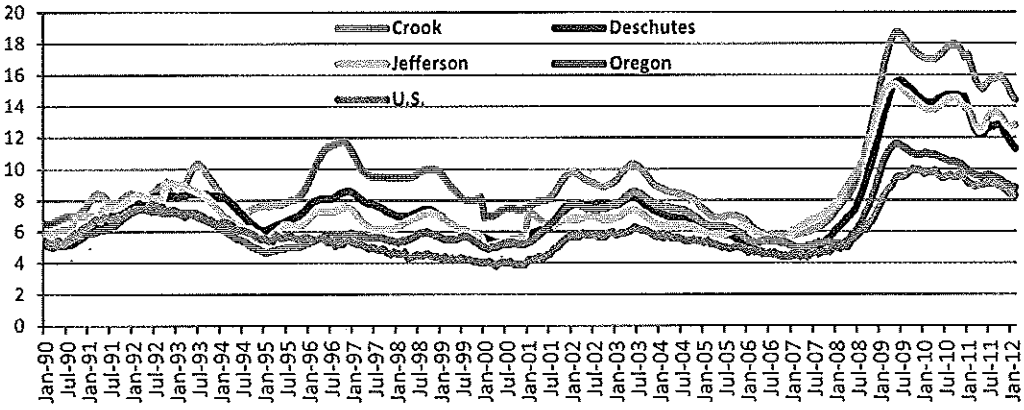
Deschutes County has more jobs per capita than Crook and Jefferson (2009 estimates).

Food Insecurity is believed to impact 22.2% of Crook residents, 18.2% of Deschutes Residents, and 20.4% of Jefferson residents (compared to 16.8% of Oregon).

Nearly 84% of Jefferson County School District children are eligible for free or reduced lunch—more than any other Central Oregon school district.

In 2011, a 1-night shelter count revealed a total of 2,373 homeless individuals in the tri-county area. 229 in Crook, 1,873 in Deschutes, and 271 in Jefferson.

UNEMPLOYMENT RATES (SEASONALLY ADJUSTED, %) 1/1990 to 2/2012



While unemployment is trending downward across the nation, unemployment remains high in Central Oregon. In Feb 2012, unemployment rates were: CROOK 14.4%, Deschutes 11.3%, JEFFERSON 12.8%, OREGON 8.8%, U.S. 8.3%

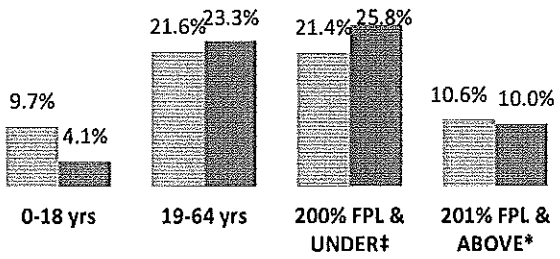
Oregon Labor Market Information System (OLMIS), (03 April 2012) Oregon Employment Department, Local Area Unemployment Statistics, 01/1990 -- 2/2012, Retrieved from http://www.qualityinfo.org/olmisj/labforce

Central Oregonians Uninsured

Not having access to health insurance prevents individuals from accessing needed care and preventive services. The majority of uninsured utilize fewer services than those with insurance; and those who do seek services are confronted with bills that many cannot afford to pay. Delaying health care can be costly and life threatening—particularly in circumstances where early detection and treatment could provide a cure or prolonged life.
Nearly 1 out of every 6 Central Oregonians are uninsured—about 1 in 5 adults age 19-64—suggesting more than 30,300 individuals are uninsured (based on results from the 2011 Oregon Health Insurance Survey).

POINT-IN-TIME ESTIMATE

Crook & Jefferson* 15.7% | Deschutes 15.4%



2,588 children 0-18 years old

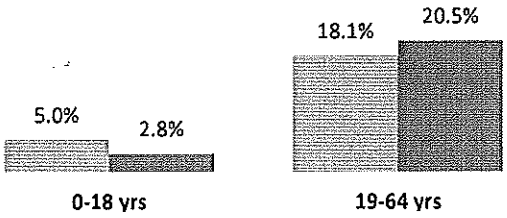
468 in Crook, 1,559 in Deschutes, and 561 in Jefferson

27,723 adults 19-64 years old

2,581 in Crook, 22,419 in Deschutes, and 2,723 in Jefferson

UNINSURED FOR 1 ENTIRE YEAR†

Crook & Jefferson* 12.4% | Deschutes 13.3%



1,595 children 0-18 years old

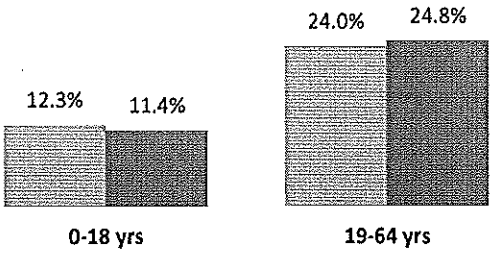
241 children in Crook, 1,065 children in Deschutes, and 289 children in Jefferson

27,305 adults 19-64 years old

2,163 in Crook, 22,419 in Deschutes, and 2,723 in Jefferson

GAP IN INSURANCE COVERAGE

Crook & Jefferson* 17.9% | Deschutes 18.3%



In the last 12 months:

5,639 children 0-18 years old

594 children in Crook, 4,334 children in Deschutes, and 711 children in Jefferson

29,756 adults 19-64 years old

2,868 in Crook, 23,863 in Deschutes, and 3,025 in Jefferson

*Oregon Health Insurance Survey estimated state uninsurance rates by ***region.*** Crook & Jefferson Counties were estimated in Region 2, with Gilliam, Grant, Hood River, Morrow, Sherman, Wasco & Wheeler Counties. Deschutes County was the only county in region 2.
‡Estimate for % of FPL is individuals of all ages
† All of previous 12 months
DHS/OHA Office for Oregon Health Policy and Research. (2011). Regional Health Insurance Coverage in Oregon: results from the 2011 Oregon Health Insurance Survey, September 2011. Retrieved from http://www.oregon.gov/OHA/OHPR/RSCH/docs/Uninsured/OHIS_2011_Uninsured_Regional_Fact_Sheet_Nov21.pdf

Chronic Disease & Preventive Screenings

	OREGON	CROOK	DESCHUTES	JEFFERSON
Arthritis	25.8%	**28.4%**	**28.0%**	**47.5%**
Asthma	9.7%	**13.1%**	9.2%	6.6%†
Heart Attack	3.3%	**7.3%†**	2.7%	3.0%†
Angina	3.4%	**7.7%†**	2.4%	2.8%†
Stroke	2.3%	–	1.2%*	1.9%†
Diabetes	6.8%	**9.0%**	5.0%	6.5%
High Blood Pressure	25.8%	**46.2%***	20.6%*	16.9%*
High Blood Cholesterol	33.0%	**41.8%**	32.1%	20.2%†

* Statistically significant difference compared with Oregon.
† This number may be statistically unreliable and should be interpreted with caution.
– This number is suppressed because it is statistically unreliable.
Age-adjusted estimates adjusted to the 2000 Standard Population using three age groups.

Source: Oregon BRFSS County Combined Dataset 2006-2009
http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Documents/TableIV.pdf

The % of adults who had cholesterol checked within past 5 years is lower in Jefferson than Oregon and the region (age-adjusted rate).

Lower rate of new of lung & bronchus cancer cases in Deschutes than Oregon and US: 57.7 per 100,000 people*

Higher rate of new cancer cases each year in Crook than Oregon and US: 527.7 per 100,000 people*

Higher rate of new prostate cancer cases each year in Deschutes than Oregon and US: 172.1 per 100,000 males*

56.3% of adults in Jefferson had their cholesterol checked in last 5 years, compared with 71.3% in Oregon, 81.7% in Crook and 73.3% in Deschutes.

*Age-adjusted incidence, statistically significant).

FAST FACTS

Oral health

Timely, relevant and reliable oral health data for children and adults is lacking for our region.

However, based on experience, community organizations, health care providers, programs, schools and individuals in Central Oregon **recognize oral health is an area of concern.**

Prevention, affordable and convenient access to high quality dental care for all Central Oregonians are areas of concern.

More than 72% of all Central Oregon 8th and 11th graders surveyed said they have had a cavity.

How many Central Oregon Children & Adults:
...get adequate oral health/dental care when they need it?
...avoid getting needed dental care due to cost?
...benefit from fluoride?
...lose teeth because they could not afford to pay for dental care before it was too late?

Healthy Environments

Though we do not always consider it, environments are part of your everyday life. Look around you. What do you see?

At every moment, you are part of an environment.

The way people interact with the environment and the qualities of the environment itself affect quality of life, health and health disparity.

Striving for healthy environments means more than thriving natural areas, woods, streams or lakes, but also seeking to ensure the places we work, live, play, learn, and visit are safe and free from accidents, unnecessary exposures to toxins, carcinogens, violence, and other hazardous substances or circumstances.

If you ever drink water, swim in a pool or eat at a restaurant, you are benefitting from existing environmental health efforts that safeguard drinking water, public pools and restaurants every day.

Average Annual Asthma Hospitalizations Rates, All-Ages
per 10,000 (age-adjusted), 2000-2007

CROOK: 6.7
DESCHUTES: 5.3
JEFFERSON: 11.1
OREGON: 6.5

Asthma is the leading chronic health condition among children in the U.S. A person's immediate environment—whether in the home, workplace, outdoors, at school—may have triggers that cause serious asthma attacks. Common triggers found indoors include: smoke, dust mites, mold, mildew, animals with fur or feathers, chemicals and strong fragrances. Common outdoor triggers include pollens from plants, air pollution caused by industrial emissions, smoke, and exhaust from machinery and automobiles.

OHA/DHS Public Helath Division, Environmental Public Health Tracking, (2012). Ashtma: Hospitalizations, All Counties, 2000-2007. Retrieved from http://epht.oregon.gov/IRMA

% of households that are Low Income and...

	CROOK	DESCHUTES	JEFFERSON
more than 1 mile to grocery store*	15.9%	12.97%	25.3%
more than 10 miles to grocery store*	3.15%	0.14%	7.83%

*Data for this indicator from 2006. US Department of Agriculture Food Atlas Data, 2006, 2007, 2008, Retrieved from http://maps.ers.usda.gov/FoodAtlas/

There are several identified causes of **cancer**—family history, lifestyle and personal choices, diet, drug, alcohol and tobacco use, and repeated exposure to carcinogens. Carcinogens can be found in the air, food, drugs, workplace by-products, chemicals, pesticides, x-rays and radiation. While many cancers are caused by genetics or personal choices, cancer rates can also be indicators of the health of an environment.

Crook County has the 3rd highest average annual incidence of cancer among Oregon counties (2004-2008). Even when looking at 10 years of data, Crook County's cancer rates remain higher than the state at a statistically significant level.

Average Annual Cancer Incidence Rates, All-Ages
per 10,000 (age-adjusted), 2004-2008

CROOK: 51.79
DESCHUTES: 47.64
JEFFERSON: 41.37
OREGON: 46.5

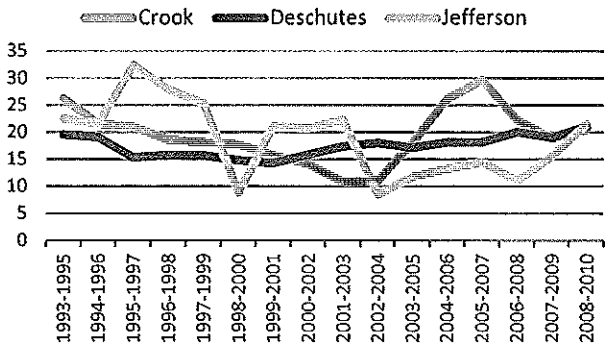
Rates calculated using SEER*Stat. http://statecancerprofiles.cancer.gov

Behavioral, Mental & Emotional Health

The estimated number of adults with serious mental illness:
CROOK: 1,037
DESCHUTES: 7,178
JEFFERSON: 906

*based on CMHS prevalence estimation/ Kessler Adult SMI and 2010 census data.

Suicide Rates by County, 3-Year Moving Averages* 1993-2010

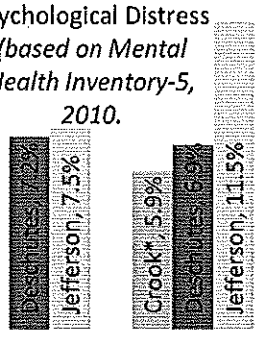


*Crude (unadjusted) rate per 100,000 population; Using Intercensal Revised Population Estimates (July 1st) for 1993-2010. **Note:** Suicide data for 2010 is preliminary data.

More than 3,300 consumers of mental health services were HOMELESS in Central Oregon in 2010.

From 1993 to 2010, there were
533 deaths from suicide.
69 in CROOK
398 in DESCHUTES
66 in JEFFERSON

% of youth who exhibited psychological Distress *(based on Mental Health Inventory-5, 2010.*



An estimated 5,153 children HAVE SERIOUS MENTAL ILLNESS in Central Oregon (2008 estimate).

18.4% of CROOK
20.6% of DESCHUTES
& 30.5% of JEFFERSON
11th graders had a depressive episode in 2010.

FAST FACTS

Age-groups with the **Highest Rates of Suicide** in Central Oregon

CROOK
65+ years,
40.5 per 100,000

DESCHUTES
45-64 years,
25.7 per 100,000

JEFFERSON
25-44 years,
27.2 per 100,000

Communicable Disease

FAST FACTS

Top Sexually-Transmitted Infection Incidence:
#1 Chlamydiosis
#2 Gonorrhea
#3 Early Syphillis

More people contracted **chlamydia** in the last 5 years than any other sexually-transmitted infection.

In 2011, **681** Central Oregonians contracted Chlamydia*

More than **75%** were 15-24 years old

*preliminary estimate

Reportable Disease Rankings by County & Type*:

FOOD, WATER, SANITATION & HYGIENE

CROOK
#1 Campylobacteriosis (22.4)
#2 Cryptosporidiosis (8.8)
#3 Salmonellosis (6.8)

DESCHUTES
#1 Campylobacteriosis (29.6)
#2 Giardiasis (18.8)
#3 E. coli 0157 (10.6)

JEFFERSON
#1 Campylobacteriosis (26.6)
#2 Shigellosis (12.4)
#3 Giardiasis (9.5)

DROPLET & AIRBORNE

CROOK
#1 Haemophilus influenza (2.9)
#2 Pertussis (1.9)
3 Tuberculosis (1.9)

DESCHUTES
#1 Pertussis (4.9)
#2 Haemophilus influenza (1.6)
#3 Meningococcal disease (1.5)

JEFFERSON
#1 Haemophilus influenza (6.7)
#2 Tuberculosis (2.9)
#3 Meningococcal disease (0.95)

*Rate per 10,000
Unadjusted aggregated incidence rates, 2005-2010

2011 INCIDENCE RATES OF SEXUALLY TRANSMITTED INFECTIONS

	CROOK	DESCHUTES	JEFFERSON	OREGON
Early Syphilis	.95	.06	--	.44
Gonorrhea	.95	.38	--	3.89
Chlamydiosis	13.35	32.52	64.46	35.73

Unadjusted incidence (per 10,000)
preliminary rates

Oregon DHS/OHA Public Health Department (2012) Oregon STD Cases by County & Quarter of Report.
http://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/DiseaseSurveillanceData/Pages/

What is killing us?

Top 3 Killers

by % of County's Deaths(2009)

Crook County

1. CANCER, 24.3%
2. HEART DISEASE, 17%
3. CHRONIC LOWER RESPIRATORY DISEASE, 9.8%

Deschutes County

1. CANCER, 23.8%
2. HEART DISEASE, 20.6%
3. CHRONIC LOWER RESPIRATORY DISEASE, 6.61%

Jefferson County

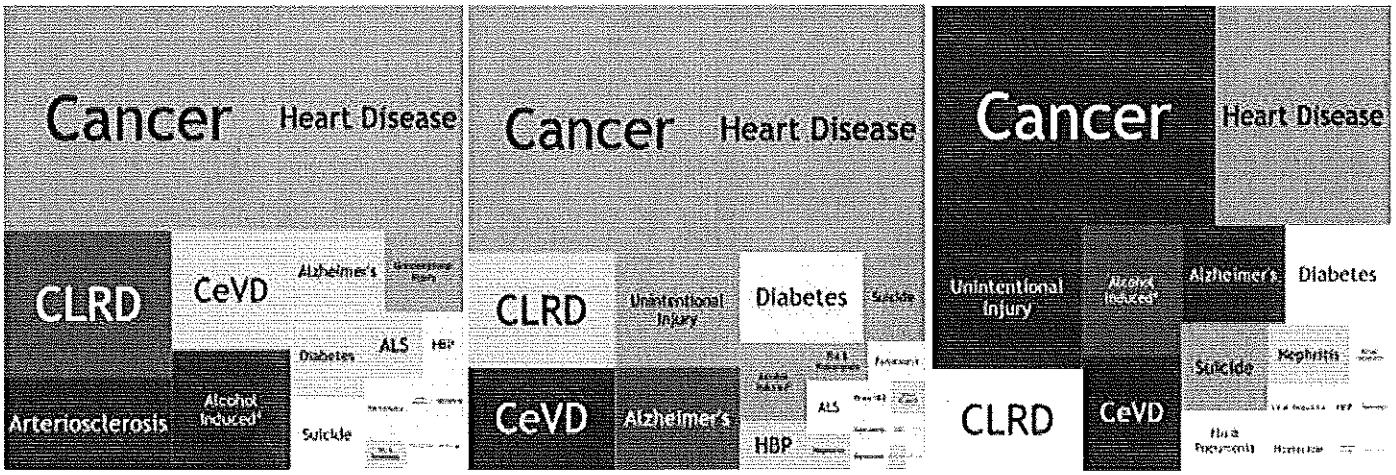
1. CANCER, 20.3%
2. HEART DISEASE, 13.9%
3. UNINTENTIONAL INJURY, 7.9%

The 2009 death rate was lower than the state of Oregon (8 per 10,000) in both Crook (7.1 per 10,000) and Deschutes (6.7 per 10,000) at a statistically significant level. However, Jefferson's death rate, was higher than the state (9.5 per 10,000) at a statistically significant level.

Chronic disease continues to be the number one killer in Central Oregon. Cancer, heart disease, cerebrovascular disease, arteriosclerosis and chronic lower respiratory disease claim numerous lives every year. In 2009, Central Oregon lost 369 lives to Cancer, 300 to Heart Disease and 107 to chronic lower respiratory disease (CLRD).

Death rates from heart disease in Oregon are higher in rural areas than urban areas (Oregon DHS/OHA Heart Disease and Stroke in Oregon: Update 2010). Approximately 5.3% of Oregon adults have coronary artery disease (2010).

Unintentional Injury claimed 86 lives, almost as many as Cerebrovascular Disease (87 lives) and was the 3rd leading cause of death in Jefferson.



CLRD: Chronic lower Respiratory Disease
CeVD: Cerebrovascular Disease
HBP: Hypertension with/without renal disease
ALS: Amyotrophic Lateral Sclerosis

Note: **Unadjusted, crude rates**

Size represents the % of each county's overall deaths for that year; color represents the difference in the county's unadjusted crude to the state of Oregon's rate for that cause of death (green means county's rate is lower than the state, red means county's rate is higher than the state's)

U.S. Deaths & Attributable Causes, 2000:

246k low education
193k myocardial infarction
176k racial segregation
168k cerebrovascular disease
162k low social support
156k lung cancer
133k individual poverty
119k accidents
39k area-level poverty

Silent Killers

Social factors are not diseases, nor are they unintended injuries or accidents. Yet social factors are responsible for killing numerous Americans. In the United States, **poor education is as deadly as a heart attack.**

The impact of social disadvantage deserves a closer look at what we consider healthy and sick, and what we believe helps us or kills us.

Sandro Galea, Melissa Tracy, Katherine J. Hoggatt, Charles DiMaggio, and Adam Karpati. Estimated Deaths Attributable to Social Factors in the United States. American Journal of Public Health: August 2011, Vol. 101, No. 8, pp. 1456-1465.
doi: 10.2105/AJPH.2010.300086

Regional Health Improvement Plan: 10 Priority Areas

CENTRAL OREGON HEALTH COUNCIL

(Following items are in not in meaningful order [i.e., NOT listed in order of importance])

Disparity/Inequity

Comparative mortality ratios in areas of Southern Deschutes County and Northern Jefferson County are significantly higher than state average and this difference is considered a health disparity – geographic area is related to a difference in mortality. But, the disparity can be considered a health inequity because it could possibly be avoided or unjust. Central Oregonians are often not surprised to learn that our rural areas have high rates of poverty, less access to services, greater distances to travel for needed care, and many individuals struggle to meet basic needs. What is often overlooked, however, is that these systematic barriers needlessly impact individuals' health.

This is just one example of disparity and inequity in our region, but many other disparities exist. Attention must be devoted to uncover disparities unique to Central Oregon and to determine which must be addressed as inequities. Improving our population's health will *require* working toward health equity—communities where all individuals have the opportunity to attain their full health potential, and no one is disadvantaged from achieving her/his potential because of socially determined circumstances related to rural or urban living, race, socioeconomic status, education, etc.

Access to Resources

The ability to access resources, services or assistance is impacted by numerous factors, such as transportation, distance and travel time, finances, social and cultural barriers, waiting time, and existing systems of care and program eligibility, availability, location and capacity. For example, an elderly person living alone with no social support and unable to drive may have financial means to see a dentist, but limited access due to transportation issues. Similarly, a working single mother with no car may have access to public transportation, but if she cannot afford taking unpaid time off of work, her access to service diminishes. Similarly, factors related to access impact rural residents differently than urban residents -- an important point to consider when planning for programs and services – since more than 41% of Central Oregonians live in unincorporated areas and towns with less than 2,500 people.

Early Childhood Wellness

A child's growth begins in pregnancy and continues into adulthood. Interacting internal and external factors impact a child's social, environmental, physical, and cognitive potential. Children in surroundings unable to support their healthy growth or meet their needs have increased risk for poor health, safety, development and ability to learn. These unmet needs during childhood pose threats to health long into adulthood and later life. Ensuring early childhood wellness is a short-term investment for today and a long-term investment for business, health, education and social sectors in decades to come.

Food Insecurity

Crook and Jefferson counties were among the top 5 Oregon counties with highest food insecurity. Deschutes County has the largest total number of food insecure individuals in Central Oregon. In Crook County, the average cost per meal is nearly $1 higher than in Deschutes County and the rest of Oregon. It is estimated that more than 37% of children in Jefferson and Crook Counties may be food insecure. In Deschutes County, of all the food insecure adults and children, 45% are not eligible for SNAP or other federal food programs—a sizeable number of children and adults who may not be able to access much needed assistance.

Oral Health

Oral health is frequently identified by providers, teachers and community members as an area of concern in Central Oregon. Existing data systems do not currently support mechanisms to arrive at accurate and timely estimates of the burden poor oral health causes in the region. Poor oral health can cause pain, discomfort, and disfigurement. It can affect an individual's quality of life, ability to eat and to speak, or interfere with opportunities to learn, work, participate, engage and contribute. What's more, oral health is related to chronic disease in later life. While prevalence and incidence data for the region may be lacking, community and stakeholder input suggests improving the oral health of all Central Oregonians is important and necessary.

Safety, Crime & Violence

A community's safety impacts the population's health in numerous ways—from victims of violence to post-traumatic stress, from psychological distress to exercise and diet. Exposure to violence is known to increase stress, which is linked to increased hypertension, stress-related disorders and chronic disease. Trauma from violence can have intergenerational effects. Central Oregon's rates of total crime appear to be on the decline since the late 1990s, and more work should be done to continue this trend. Deschutes is in the top 5 Oregon counties with the highest rates (unadjusted 2010 rates) of both total crimes and violent crimes per 10,000. Jefferson County was among the 10 Oregon counties with the fewest number of police per 1,000 population. Last year, more than 1,450 individuals in Central Oregon called an emergency crisis line about domestic violence alone. Healthy populations require safe communities to live, work and play where individuals affected by violence or crime can access necessary support and services to heal.

Chronic Disease

In the last 65 years, adult chronic disease has grown into the main health problem for industrialized nations. Cardiovascular disease, cancers, diabetes and chronic obstructive pulmonary disease account for at least 50% of the global mortality burden. In Central Oregon, chronic diseases are the leading causes of death for each county. Crook's age-adjusted prevalence of adults with high blood pressure is 46.2%, significantly higher than 25.8% of adults for all of Oregon. Deschutes' age-adjusted prostate cancer incidence rate is higher than the state, while Jefferson's age-adjusted prevalence of arthritis is higher than its neighboring counties and the state. Multiple types of exposures, modifiable behaviors and risk factors are known to play a role in the development of chronic disease in later life, such as personal dietary and exercise choices, chronic stress, exposures in utero and throughout early childhood, income, genetics, and the built environment to name a few.

Alcohol, Drug & Tobacco Use

Heavy drinking, drug use and tobacco use is associated with higher rates of all-cause mortality, chronic disease, violence and abuse. Excessive alcohol and drug use is also a risk factor for motor vehicle fatalities, fetal alcohol syndrome, interpersonal violence, overdose and sexually transmitted infections. Tobacco use causes multiple diseases such as cancer, respiratory disease, and other adverse health outcomes. In 2009, more than 19% of adult males in Central Oregon reported binge drinking in the last 30 days. In Central Oregon, younger adults have higher rates of alcohol dependence (in past 12 months) than older adults—17% of adults age 18-25 years, compared to 6.8% of adults 26 years and older. Jefferson County has higher rates of death from alcohol-induced disease and motor vehicle fatalities that involve alcohol. Since 2001, Crook's age-adjusted rates of death from drug-induced causes have been higher than Jefferson and Deschutes (Crook –13.7, Deschutes –10.1, Jefferson –10.5 per 100,000).

Behavioral Health

Around the world, major depression is a major cause of disability. In Deschutes County, suicide is claiming nearly as many lives as motor vehicle accidents. It is estimated more than 9,000 adults in the tri-county region have serious mental illness. Roughly 1/3 of Central Oregon 11th graders reported having a depressive episode in the last year—high depression scores in youth are associated with poor academic achievement, anxiety, and poor peer and teacher relationships. Central Oregon can improve behavioral health by working to prevent behavioral/mental health issues at the individual and community level, to identify early risk factors and warning signs and to ensure the capacity and infrastructure exists to provide quality, affordable and accessible services for all individuals in need.

Healthy Environments

There is much to learn about the environmental health characteristics specific to Central Oregon's communities. The ecologies of individuals, families, communities and regions often determine options available for individuals to reach their full potential. Environments exist on many scales – individuals, homes, neighborhoods, geographic regions. Environments simultaneously shape and are shaped by organisms and individuals within them. For example, built and natural environments directly impact human health, and humans directly impact the built and natural environments. Until recent decades, "environments" in public health were most often associated with the natural outdoors – woods, streams, rivers and lakes. Growing bodies of research are showing relationships with environments on other scales to the health of our populations. Locations of stores to purchase affordable fresh fruits and vegetables impact healthy choices. Safe and affordable alternative commute options impact the behaviors of individuals to choose alternatives to driving, thus impacting the environment and the often the individual. Safe and easily accessible places to play outdoors impact the ability of children to play outside, thus impacting their physical activity and health.

Central Oregon lacks current and relevant data on multiple scales of environment to uncover relationships between where people live, work and play to their overall health and well-being. This knowledge about the region is expected to expand in coming years, particularly with recent collaborative efforts with local agencies and individuals looking at transportation, commuting options, healthy housing, farmers markets, and healthy spaces for kids and adults to play and exercise.

Special thanks to these individuals:

Muriel DeLavergne-Brown	Crook County Health Department
Jolene Estimo	Confederated Tribes of Warm Springs Health & Human Services
Carolyn Harvey	Jefferson County Health Department
Ken House	Mosaic Medical
Scott Johnson	Deschutes County Health Services
Jessica Kelly	Deschutes County Children & Families Commission
Sarah J. Kingston	Deschutes County Health Services
Thomas Kuhn	Deschutes County Health Services
Maggi Machala	Deschutes County Health Services
Tom Machala	Jefferson County Health Department
Kat Mastrangelo	Volunteers in Medicine
Kate Moore	Deschutes County Health Services
Minda Morton	Jefferson County Commission on Children & Families
Hillary Saraceno	Deschutes County Children & Families Commission
Diane Skinner	Deschutes County Health Services
Stephanie Sundborg	Deschutes County Children & Families Commission
Erin Tofte	Let's Talk Diversity Coalition (Jefferson County)
Kate Wells	Kids@Heart

And to these organizations:

Central Oregon Health Board
Central Oregon Health Council
Crook Co. Health Department
Deschutes Co. Public Health Advisory Board
Deschutes Co. Behavioral Health Advisory Board
Jefferson County Health Department
Let's Talk Diversity Coalition (Jefferson County)
Mosaic Medical
Oregon Health Authority/Dept. of Public Health
Saving Grace
Volunteers in Medicine, Clinic of the Cascades

For additional information, contact:

Sarah J. Kingston, MPH
Research Analyst
Deschutes County Health Services
sarahk [at] deschutes.org

Pharmacy Contract Information Redacted

Case Mgmnt Screens
Attachment 3.5.1.
Redacted

APPENDIX E – Financial Reporting and Solvency Questionnaire

Section 1 - Financial Organization

E.1.1. Corporate Organization and Structure

E.1.1.a. PacificSource Community Solution's (PSCS) articles of incorporation are attached. Please see Attachment 1.

E.1.1.b. PacificSource Community Solutions, Inc. is a wholly-owned subsidiary of PacificSource Community Health Plans, Inc., an Oregon stock insurer. Please see stock information in Attachment 2.

E.1.1.c. PSCS does not possess any special licenses.

E.1.1.d. PSCS is a current MCO. There will not be any organizational changes that occur to conduct operations as a CCO. The proposed service area for PSCS CCO is part of the current service area for PSCS FCHP and MHO.

E.1.1.e. PSCS does not provide any administrative services or management contracts to other parties where PSCS is the provider of services under this contract.

E.1.2. Corporate Affiliations, Transactions, Arrangements

E. 1.2.a Please find PacificSource Health Plans expanded organizational chart attached including the corporate structure, character state abbreviation of the state of domicile, Federal Employer's Identification Number and NAIC code for insurers. There are not any instances of interrelationships that are a 50/50% ownership. Please see Attachment 3.

E. 1.2.b PSCS has an ASA agreement with its parent company, PacificSource Community Health Plans, Inc (PCHP). PCHP provides general management, technical, contracting, medical management and accounting services, as well as corporate reporting for PSCS. PSCS paid ASA fees to PCHP of $3,405,833 and $4,184,820 in 2010 and 2011, respectively. Please find PSCS S Organizational Chart attached as Attachment 4.

E1.3 General Questions

E.1.3.a PSCS deferred submission of supporting documents, tables, and data that are part of its Technical Application until its readiness review under Section 6.7.1. PSCS is requesting deferred submission of the following documents:

1. Analysis of Encounterable or Unencounterable breakout of expenses pending further review and analysis.
2. Provider contracts including rate exhibits.

E.1.3.b PSCS has demonstrated experience and capacity for:

- Managing financial risk and establishing financial reserves: PSCS and its affiliated entities, PacificSource Community Health Plan and PacificSource Health Plans have extensive experience managing financial risk. The consolidated entities manage premiums in excess of $1B and carry an AM Best rating of B++. PSCS has long-term experience in establishing and managing its reserve accounts as an MCO. Additionally, its affiliates PCHP and PacificSource Health Plans have significant experience establishing reserves under DCBS guidelines and reporting under statutory accounting principles.

- Meeting the minimum financial requirements for restricted reserves and net worth in OAR 410-141-3350: PSCS currently meets the schedule G reserve requirements for an MCO. Additionally, PSCS's current and projected capital and surplus position results in a Statutory Risk Based Capital ratio in excess of 600% and therefore in excess of the specified minimum financial requirement.

Section 2: Demonstration of Financial Solvency

E.2. **Applicable Measurement Standard**

- PSCS seeks to convert from an MCO to a CCO. As such, Section E.2.1 questions apply.

E.2.1. **Measurement Standard—Applies to MCO converting to CCO**

Financial Solvency Minimum Standard

E.2.1.a. PSCS will maintain restricted reserve funds required by its MCO contract(s), Exhibit G, Section 7. The restricted reserves will be in place before terminating the PSCS's current MCO contract(s) to begin operations as a CCO. PSCS understands that restricted reserves previously held by PSCS may, with consent of OHA, be transferred to the CCO.

E.2.1.b. PSCS shall maintain a level of net worth as required by its MCO contract(s), Exhibit G, Section 8. If PSCS has a net worth less than the calculated minimum requirement, PSCS's net worth must be increased to an amount greater than or equal to the minimum requirement prior to the award of a Contract under this RFA.

E.2.1.c. PSCS financial statements demonstrate that PSCS currently possess funds greater than the financial solvency minimum standard. The financial statements are prepared using the standards and forms required under PSCS MCO Contract(s), Exhibit G. The most recent audited financial statements and financial statements of PSCS are attached. Please see Attachment 5 and Attachment 6.

A copy of the Assignment & Assumption Agreement providing a guarantee from PacificSource Community Health Plans to PSCS is attached. Based on the capital position and CCO requirements, it is PSCS's intention to cancel this agreement at the time the CCO is initiated. Please see Attachment 7.

E.2.1.d. A developmental budget delineating all expenses prior to beginning operation using Table E-2: Monthly Developmental Budget is attached as Attachment 8.

E.2.1.e. An operational budget covering the initial two years of operation using Table E-3: Monthly Operational Budget is attached as Attachment 8.

E.2.1.f. PSCS's monthly staffing plan for the last three months of the CCO developmental or planning budget and the initial three years of the CCO is as follows. In the past, PSCS has staffed its operations with an administrative service agreement with PacificSource Community Health Plans. It is PSCS plan to continue this practice as a CCO. Additional hires to accomplish the work of transition will be completed in

PCHP and will become part of the ASA expense for PSCS. The expense budget for the CCO shows as a one line item titled ASA/Compensation which includes the cost of all staff. Accordingly, no monthly staffing plan has been provided with this document.

E.2.1.g. PSCS's pro forma balance sheet, income statement (p&l) and cash flow schedules reflecting anticipated assets, capital, revenue, expense, and cash flow using Table E-1: Pro Forma Projections for the First Five Years is attached as Attachment 8.

Section 3 - Demonstration of Ability to Achieve the Financial Goals

E.3.1. General Questions Relating to Financial Management

E. 3.1. a PSCS uses best practices in the management of finances, contracts, claims processing, payment functions and provider network administration through internal control measures and regular monitoring and review of procedures. Monthly financials are prepared, reconciled and compared to budget. Contracts are reviewed by multiple parties prior to finalization. Claims processing is outsourced to a sophisticated subcontractor specializing in Medicaid payments. Payment functions follow best practices for internal controls and are audited at multiple levels. The provider network contracting is done through a dedicated department with oversight by the Vice President of Provider Network.

E.3.1.b Information related to PSCS's assets and financial and risk management capabilities, is as follows.

- Access to capital and ability to generate capital growth to fulfill restricted reserve and net worth requirements: PCSC carries capital in excess of net worth requirements. PSCS has the ability to generate additional capital though requests for investment from its parent PacificSource Community Health Plans, subject to DCBS and Board approval.

- Risk management measures: PSCS has risk sharing with providers. Along with effective utilization management programs, risk sharing is one of our most effective risk management strategies. The already implemented integrated approach in Central Oregon (integrating behavioral and medical health) also improves PSCS's ability to manage costs through better coordination of care that has already occurred.

- Delegated risk; risk sharing arrangements: PSCS has deferred submission of risk sharing contracts or terms sheets until Readiness Review.

- Reinsurance and stop loss. Reinsurance or stop loss policy will reduce the risk borne by PSCS CCO through shared risk with Presidio for certain claims over a specific dollar threshold. A copy of the Reinsurance agreement has been provided as Attachment 9.

- PSCS has developed adequate Incurred but not Reported (IBNR) and unpaid claims reserves given PSCS's expected Enrollment level and its mix of covered lives/rate category. This actuarial determination reflects health systems responsibilities required by HB 3650 as well as the effects of alternative payment methodologies implemented by PSCS in its payments to hospitals, physician groups, or other providers and risk-sharing arrangements:

- Claims payment: A combination of methods is used to estimate the claim liability on unpaid claims. The "development method" is used for older and more credible months and a combination of regression methods and PMPM methods are used for more recent months. In addition to claim lag, other considerations in setting claims liability would be seasonality, claims cost trends, growing/diminishing membership, claims administration disruption/backlogs, shock claims and capitation changes. Margin for error is added to the estimate to ensure adequacy within an acceptable standard deviation. Risk arrangements if any are general adjustments to the liability estimate.

- Participation in the All Payer All Claims reporting program: PSCS contributes data to the All Payer All Claims program.

- Internal auditing and financial performance monitoring: There is an internal peer review process to make sure IBNR reserves meet statutory standards. The appointed actuary certifies reserves as part of the annual statement process. External auditors confirms and certifies these reserves as well.

- Administrative cost allocation across books of business (including Medicaid, Medicare, and commercial). PSCS has an ASA agreement with its parent company, PacificSource Community Health Plans, Inc (PCHP). PCHP provides general management, technical, contracting, medical management and accounting services, as well as corporate reporting for PSCS.

CERTIFICATE

State of Oregon

OFFICE OF THE SECRETARY OF STATE
Corporation Division

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

That the attached Document File for:

PACIFICSOURCE COMMUNITY SOLUTIONS, INC.

is a true copy of the original documents that have been filed with this office.

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

KATE BROWN, Secretary of State

April 18, 2012

FILED

NOV 07 2003
OREGON SECRETARY OF STATE

FILED
NOV 07 2003
OREGON SECRETARY OF STATE

REGISTRY NUMBER: 182820-95

ARTICLES OF INCORPORATION

OF

CENTRAL OREGON INDIVIDUAL HEALTH SOLUTIONS, INC.

Pursuant to the Oregon Business Corporation Act (the "Act"), the undersigned incorporator adopts the following articles of incorporation:

ARTICLE I
Name of Corporation

The name of the corporation is Central Oregon Individual Health Solutions, Inc.

ARTICLE II
Purpose of Corporation

The corporation is organized to provide healthcare services to enrollees of managed healthcare plans, and such other purposes and activities as may be determined from time to time which are in accordance with the provisions of ORS Chapter 60.

ARTICLE III
Authorized Shares

The aggregate number of shares that the corporation shall have authority to issue is 10,000 shares of no par value, voting common stock.

ARTICLES IV
Action of Shareholders Without a Meeting

Any action required or permitted to be taken at a meeting of the shareholders may be taken without a meeting if one or more consents in writing, setting forth the action so taken, shall be signed by the number of shareholders having not less than the minimum number of votes that would be necessary to take such action at a meeting at which all shareholders entitled to vote on the action were present and voted, and such consent(s) are delivered to the corporation for inclusion in the minute book. Action taken pursuant to this Article IV is effective when the consent or consents bearing sufficient signatures are delivered to the corporation, unless the consent or consents specify an earlier or later effective date. If the action to be taken requires that notice must be given to nonvoting shareholders, the corporation shall give the nonvoting shareholders written notice of the proposed action promptly after the action is taken. The corporation shall also provide written notice of the action, promptly after the action

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11.7.03

110603 24 8 SZP

CENTRAL OREGON INDIVIDUAL HEALT

is taken, to those shareholders who were entitled to vote upon the matter but did not consent to the action so taken. Notice that is required to be given pursuant to this Article IV shall contain or be accompanied by the same material that would have been required to be sent to the nonvoting and/or regular shareholders, as applicable, in a notice of meeting at which the proposed action would have been submitted to the shareholders for action, as such notice of meeting requirements are further set forth in the corporation's bylaws. A consent signed under this Article IV has the effect of a meeting vote and may be described as such in any document.

ARTICLE V
Indemnification and Advancement of Expenses

5.1 Indemnification. To the fullest extend permitted by the Oregon Business Corporations Act, the corporation shall indemnify any director of the corporation made a party to a proceeding because the person is or was a director of the corporation against liability incurred in that proceeding; provided, however, no indemnification pursuant to this provision shall indemnify any director from or on account of: (1) any breach of the director's duty of loyalty to the corporation; (2) acts or omissions not in good faith or involving intentional misconduct or a knowing violation of the law; (3) any unlawful distribution; (4) any transaction from which the director derived an improper personal benefit; and (5) any act or omission in violation of ORS 60.357 to 60.367.

5.2 Advancement of Expenses. The corporation may, but shall not be required to, pay for or reimburse the reasonable expenses incurred by a director who is party to a proceeding in advance of the final disposition of the proceeding to the fullest extent permitted by the Oregon Business Corporation Act.

5.3 Certain Definitions. For the purposes of this Article, the terms director, expenses, liability, officer, party and proceeding shall have the meanings given to them in ORS 60.387 as in effect as of the date these Articles of Incorporation are filed.

ARTICLE VI
Registered Office and Agent

The address of the initial registered office of the corporation is 2650 NE Courtney Dr., Bend, Oregon 97701, and the name of the initial registered agent of the corporation at such address is Patricia Gibford.

ARTICLE VII
Address for Notices

The mailing address of the corporation where the Corporation Division may mail notices is 2650 NE Courtney Dr., Bend, Oregon 97701.

182800-73

ARTICLE VIII
Incorporater

The name and address of the incorporator is:

Brent M. Crew
5000 Meadows Rd., Suite 150
Lake Oswego, Oregon 97035

DATED: November 3, 2003.

By _____
Brent M. Crew, Incorporator

Person to contact about this filing:

Brent M. Crew
(503) 624-5789

Articles of Amendment - Business/Professional

Secretary of State - Corporation Division - 255 Capitol St NE, Suite 151 - Salem, OR 97310-1327 - http://www.FilingInOregon.com - Phone: (503) 986-2200

FILED

JAN 12 2011

OREGON
SECRETARY OF STATE

For office use only

REGISTRY NUMBER: 182820-95

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.

Please Type or Print Legibly in Black Ink.

1) ENTITY NAME: Central Oregon Individual Health Solutions, Inc.

2) STATE THE ARTICLE NUMBER(S): and set forth the article(s) as it is amended to read. (Attach a separate sheet if necessary.)

Article I - The name of the corporation is PacificSource Community Solutions, Inc.

3) THE AMENDMENT WAS ADOPTED ON: January 5, 2011

(If more than one amendment was adopted, identify the date of adoption of each amendment.)

4) CHECK THE APPROPRIATE STATEMENT:

☒ Shareholder action was required to adopt the amendment(s).

The vote was as follows:

Class or series of shares	Number of shares outstanding	Number of votes entitled to be cast	Number of votes cast FOR	Number of votes cast AGAINST
Common	1,000	1,000	1,000	0

☐ Shareholder action was not required to adopt the amendment(s). The amendment(s) was adopted by the board of directors without shareholder action.

☐ The corporation has not issued any shares of stock. Shareholder action was not required to adopt the amendment(s). The amendment(s) was adopted by the incorporators or by the board of directors.

5) EXECUTION: (Must be signed by at least one officer or director.)
By my signature, I declare as an authorized authority, that 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: Kenneth P. Provencher Title: President/CEO

CONTACT NAME: (To resolve questions with this filing.)
Kristin Kernutt

PHONE NUMBER: (Include area code.)
541-225-1967

FEES
Required Processing Fee $100
Confirmation Copy (Optional) $5
No Fee for President/Secretary Change.
Processing Fees are nonrefundable. Please make check payable to "Corporation Division."

11 - Articles of Amendment - Business Professional (01/10)

PACIFICSOURCE COMMUNITY SOLUTIO

1R2R9105-12395596 AMDART

INCORPORATED UNDER THE LAWS OF OREGON.

NUMBER ** 1 **

THE UNION

SHARES *1,000*

PacificSource Community Solutions, Inc.

This Certifies that PacificSource Community Health Plans, Inc.

is the owner of One Thousand (1,000) Shares of the Capital Stock of

PacificSource Community Solutions, Inc.

transferable only on the books of this Corporation in person or by Attorney upon surrender of this Certificate properly endorsed.

IN WITNESS WHEREOF, the said Corporation has caused this Certificate to be signed by its duly authorized officers and its Corporate Seal, if any, to be hereunto affixed this 30th day of April A. D. 2012

President

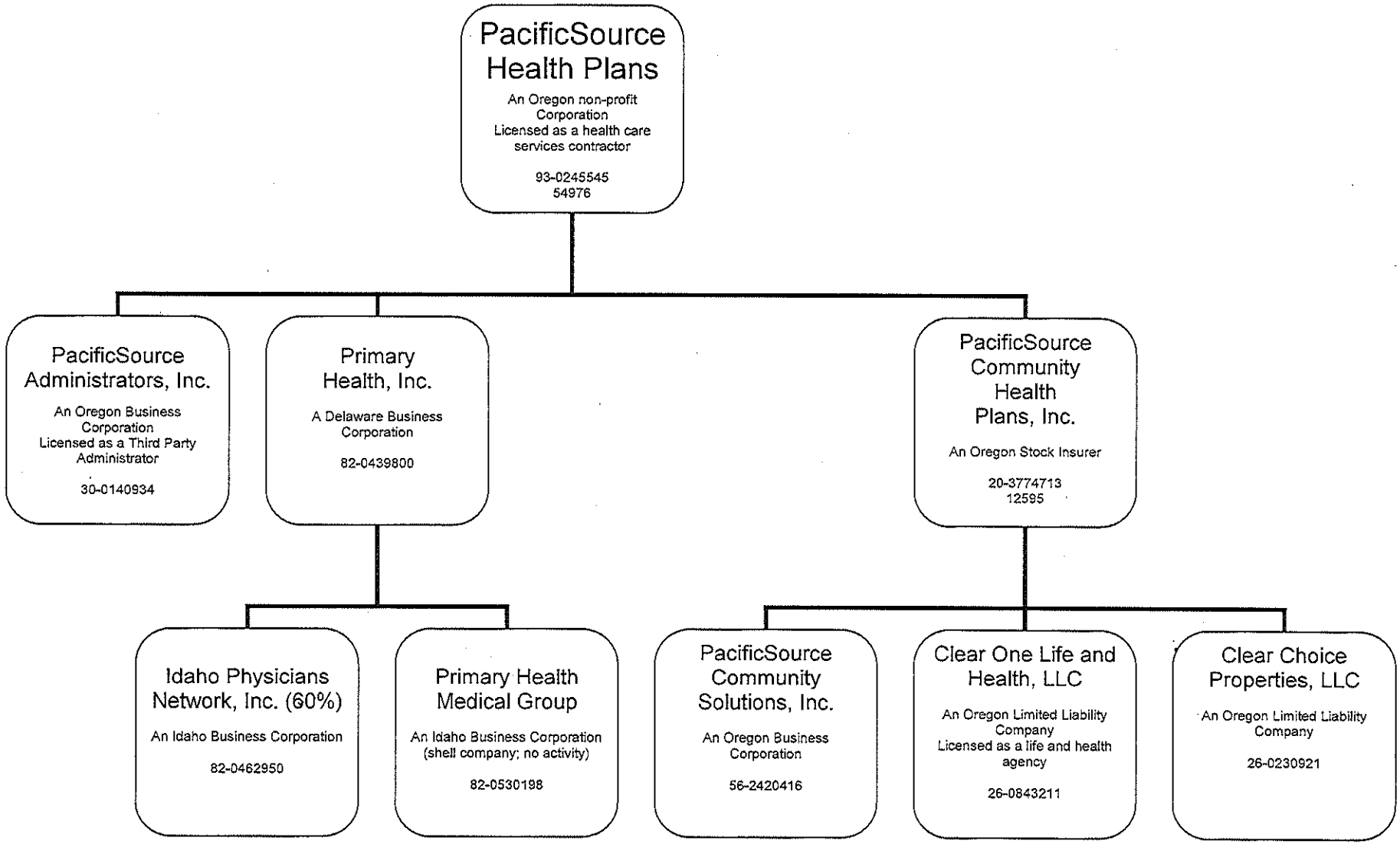
Secretary

SEAL

SHARES

DATED

GOES 230


PacificSource Health Plans
An Oregon non-profit Corporation
Licensed as a health care services contractor
93-0245545
54976
PacificSource Administrators, Inc.
An Oregon Business Corporation
Licensed as a Third Party Administrator
30-0140934
Primary Health, Inc.
A Delaware Business Corporation
82-0439800
PacificSource Community Health Plans, Inc.
An Oregon Stock Insurer
20-3774713
12595
Idaho Physicians Network, Inc. (60%)
An Idaho Business Corporation
82-0462950
Primary Health Medical Group
An Idaho Business Corporation
(shell company; no activity)
82-0530198
PacificSource Community Solutions, Inc.
An Oregon Business Corporation
56-2420416
Clear One Life and Health, LLC
An Oregon Limited Liability Company
Licensed as a life and health agency
26-0843211
Clear Choice Properties, LLC
An Oregon Limited Liability Company
26-0230921

April 9, 2012

PACIFICSOURCE HEALTH PLANS AND SUBSIDIARIES

INDEPENDENT AUDITORS' REPORT

and

CONSOLIDATED FINANCIAL STATEMENTS AND SUPPLEMENTAL INFORMATION

YEARS ENDED DECEMBER 31, 2011 AND 2010

PACIFICSOURCE HEALTH PLANS AND SUBSIDIARIES

KERNUTT STOKES

INDEPENDENT AUDITORS' REPORT

Board of Trustees
PacificSource Health Plans and Subsidiaries:

We have audited the accompanying consolidated balance sheets of PacificSource Health Plans and Subsidiaries (the Company) as of December 31, 2011 and 2010, and the related consolidated statements of income, comprehensive income, fund balance and cash flows for the years then ended. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we express no such opinion. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the consolidated financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2011 and 2010, and the results of its operations and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidated schedules of general and administrative expenses are presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Kernutt Stokes LLP

Eugene, Oregon
April 9, 2012

PACIFICSOURCE HEALTH PLANS AND SUBSIDIARIES

Consolidated Balance Sheets

	December 31 2011	2010
ASSETS		
Investments	$ 157,773,378	$ 125,678,610
Cash and cash equivalents	25,849,704	42,529,263
Trust funds	4,549,629	7,234,012
Accounts receivable	21,755,372	18,245,327
Prepaid expenses and deposits	4,094,227	4,814,221
Prepaid income taxes	1,014,700	3,425,859
Prepaid pension costs	-	885,062
Property, net	50,015,825	54,940,724
Goodwill	12,611,772	13,611,772
Intangible assets, net	8,989,732	10,297,789
Group life insurance and purchased annuities	1,950,895	1,992,959
Total	$ 288,605,234	$ 283,655,598
LIABILITIES AND FUND BALANCE		
LIABILITIES:		
Unpaid claims and claims adjustment expenses	$ 76,902,301	$ 75,534,434
Book overdraft	4,664,460	849,966
Line of credit	2,420,660	-
Accounts payable	6,126,305	8,881,661
Accrued expenses	6,483,726	6,816,610
Accrued pension liability	4,714,111	-
Unearned premiums	7,508,388	6,636,517
Payable for securities	-	180,374
Incentive compensation payable under managed care plans	2,706,986	1,434,872
Accrued retro settlements	1,290,224	1,126,571
Collections for others	4,549,629	7,234,012
Deferred compensation payable to member physicians	1,950,895	1,992,959
Deferred tax liabilities	2,612,177	4,230,309
Notes payable	11,073,231	14,771,999
Total	133,003,093	129,690,284
FUND BALANCE:		
Fund balance, unrestricted	162,151,267	154,496,481
Accumulated other comprehensive loss	(6,923,261)	(854,574)
Noncontrolling interests	374,135	323,407
Total	155,602,141	153,965,314
Total	$ 288,605,234	$ 283,655,598

See accompanying notes.

PACIFICSOURCE HEALTH PLANS AND SUBSIDIARIES

Consolidated Statements of Income

	Year Ended December 31	
	2011	2010
PREMIUMS:		
Commercial premiums	$ 652,038,430	$ 600,854,513
Medicare premiums	118,468,331	69,590,212
Medicaid premiums	126,604,314	55,950,516
Total	897,111,075	726,395,241
CLAIMS EXPENSE:		
Commercial	576,116,555	524,513,614
Medicare	87,179,015	44,569,021
Medicaid	121,352,244	46,005,070
Commissions on premiums	18,281,981	18,586,464
Total	802,929,795	633,674,169
EXCESS OF PREMIUMS OVER CLAIMS EXPENSE	94,181,280	92,721,072
ADMINISTRATIVE SERVICE CONTRACTS:		
Payments received from self-insured employers	2,128,379	1,203,079
Claims paid on behalf of self-insured employers	(525,309)	(229,384)
Service fees earned	1,603,070	973,695
EXCESS OF PREMIUMS AND FEES OVER COSTS	95,784,350	93,694,767
ADMINISTRATIVE REVENUES	12,116,141	11,471,676
GENERAL AND ADMINISTRATIVE EXPENSES	100,104,083	88,201,183
UNDERWRITING GAIN	7,796,408	16,965,260
OTHER INCOME (EXPENSE):		
Investment income	6,722,674	7,696,837
Interest expense	(1,134,168)	(771,605)
Charitable contributions	(1,135,634)	(2,011,364)
Miscellaneous expense	(86,962)	(192,260)
Total	4,365,910	4,721,608
INCOME BEFORE INCOME TAXES	12,162,318	21,686,868
INCOME TAX EXPENSE	4,442,526	8,047,389
TOTAL INCOME	7,719,792	13,639,479
LESS INCOME ATTRIBUTABLE TO NONCONTROLLING INTERESTS	65,006	56,995
NET INCOME	$ 7,654,786	$ 13,582,484

See accompanying notes.

PACIFICSOURCE HEALTH PLANS AND SUBSIDIARIES

Consolidated Statements of Comprehensive Income

	Year Ended December 31	
	2011	2010
NET INCOME	$ 7,654,786	$ 13,582,484
OTHER COMPREHENSIVE (LOSS) INCOME, NET OF TAXES:		
Unrealized appreciation and depreciation of investments available-for-sale	(2,760,395)	1,306,343
Reclassification adjustment for gains and losses realized in net income	151,920	1,119,952
Net unrealized appreciation and depreciation	(2,608,475)	2,426,295
Deferred income taxes	822,000	(982,000)
Unrealized appreciation and depreciation of investments available-for-sale, net of deferred taxes	(1,786,475)	1,444,295
Defined benefit pension plan net loss and prior service credit	(7,062,212)	(886,545)
Deferred income taxes	2,780,000	350,000
Defined benefit pension plan adjustments, net of deferred taxes	(4,282,212)	(536,545)
Total other comprehensive (loss) income	(6,068,687)	907,750
COMPREHENSIVE INCOME	$ 1,586,099	$ 14,490,234

See accompanying notes.

PACIFICSOURCE HEALTH PLANS AND SUBSIDIARIES

Consolidated Statements of Fund Balance

	Fund Balance	Accumulated Other Comprehensive Income (Loss)	Noncontrolling Interests	Total
BALANCE, January 1, 2010	$ 140,913,997	$ (1,762,324)	$ 281,781	$ 139,433,454
Net income	13,582,484	-	56,995	13,639,479
Redemption of IPN common stock	-	-	(15,369)	(15,369)
Unrealized appreciation of investments available-for-sale (net of reclassification adjustment), net of deferred taxes of $982,000	-	1,444,295	-	1,444,295
Defined benefit pension plan net loss and prior service credit, net of deferred taxes of $350,000	-	(536,545)	-	(536,545)
BALANCE, December 31, 2010	154,496,481	(854,574)	323,407	153,965,314
Net income	7,654,786	-	65,006	7,719,792
Redemption of IPN common stock	-	-	(14,278)	(14,278)
Unrealized depreciation of investments available-for-sale (net of reclassification adjustment), net of deferred taxes of $822,000	-	(1,786,475)	-	(1,786,475)
Defined benefit pension plan net loss and prior service credit, net of deferred taxes of $2,780,000	-	(4,282,212)	-	(4,282,212)
BALANCE, December 31, 2011	$ 162,151,267	$ (6,923,261)	$ 374,135	$ 155,602,141

See accompanying notes.

PACIFICSOURCE HEALTH PLANS AND SUBSIDIARIES

Consolidated Statements of Cash Flows

Change in Cash and Cash Equivalents

	Year Ended December 31	
	2011	2010
CASH FLOWS FROM OPERATING ACTIVITIES:		
Premiums collected	$ 896,103,503	$ 732,180,413
Claims paid	(800,126,161)	(637,810,758)
General and administrative expenses paid	(90,183,102)	(93,436,945)
Investment income received	5,296,200	3,807,981
Other revenue received	12,116,141	9,164,589
Interest paid	(1,135,067)	(772,443)
Income taxes paid	(47,499)	(223,726)
Net cash provided by operating activities	22,024,015	12,909,111
CASH FLOWS FROM INVESTING ACTIVITIES:		
Proceeds from sale of investments	112,073,582	241,494,954
Investments purchased	(145,015,481)	(205,495,498)
Payment for purchase of PacificSource Community Health Plans Inc. (Formerly Clear One Health Plans, Inc.), net of cash acquired	-	(33,598,919)
Proceeds from sale of Trusteed Plans Service Corporation (TPSC), net of cash disposed	608,523	-
Proceeds from sale of property	15,810	8,750
Property purchased	(5,093,622)	(3,903,678)
Net cash used in investing activities	(37,411,188)	(1,494,391)
CASH FLOWS FROM FINANCING ACTIVITIES:		
Net proceeds from line of credit	2,420,660	-
Payments on notes payable	(3,698,768)	(278,763)
Redemption of common stock	(14,278)	(15,369)
Net cash used in financing activities	(1,292,386)	(294,132)
CHANGE IN CASH AND CASH EQUIVALENTS	(16,679,559)	11,120,588
CASH AND CASH EQUIVALENTS, beginning of year	42,529,263	31,408,675
CASH AND CASH EQUIVALENTS, end of year	$ 25,849,704	$ 42,529,263

(Continued)

See accompanying notes.

PACIFICSOURCE HEALTH PLANS AND SUBSIDIARIES

Consolidated Statements of Cash Flows (Continued)

Reconciliation of Net Income to Net Cash Provided by Operating Activities

	Year Ended December 31	
	2011	2010
NET INCOME	$ 7,654,786	$ 13,582,484
ADJUSTMENTS TO RECONCILE NET INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES:		
Income attributable to noncontrolling interest	65,006	56,995
Depreciation and amortization	10,237,547	8,213,476
Deferred tax expense	1,983,868	7,241,827
Gain on sale of investments	(1,162,082)	(4,343,503)
Loss on disposal of property	845,225	107,820
Adjustments resulting from changes in:		
Accounts receivable	(3,482,513)	7,394,822
Accrued investment income	(264,392)	73,483
Prepaid income taxes	2,411,159	578,617
Prepaid (accrued) pension costs	(1,463,039)	(1,706,474)
Prepaid expenses and deposits	663,424	(963,553)
Unpaid claims and claims adjustment expenses	1,367,867	(6,296,043)
Book overdraft	3,814,494	849,966
Accounts payable	(2,676,631)	(5,982,342)
Unearned premiums	871,871	(4,700,174)
Incentive compensation payable	1,272,114	(78,565)
Accrued retro settlements	163,653	1,350,817
Accrued expenses	(278,342)	(2,470,542)
NET CASH PROVIDED BY OPERATING ACTIVITIES	$ 22,024,015	$ 12,909,111

(Continued)

See accompanying notes.

PACIFICSOURCE HEALTH PLANS AND SUBSIDIARIES

Consolidated Statements of Cash Flows (Continued)

Schedule of Noncash Investing Activities

The following is a summary of transactions in the deferred compensation plan with respect to member physicians for 2011 and 2010:

	Group Life Insurance Contract	Annuity Contracts	Total
Balance at December 31, 2009	$ 1,575,786	$ 478,517	$ 2,054,303
Earnings on contracts, net	62,736	23,189	85,925
Purchase of annuity	(4,909)	4,909	-
Payments to annuitants	-	(147,269)	(147,269)
Balance at December 31, 2010	1,633,613	359,346	1,992,959
Earnings on contracts, net	39,878	16,534	56,412
Payments to annuitants	-	(98,476)	(98,476)
Balance at December 31, 2011	$ 1,673,491	$ 277,404	$ 1,950,895

Other Non-Cash Investing and Financing Activities

During 2011, the Company sold the stock of TPSC for $1,000,000 in cash ($608,523 net of cash disposed) and received a note receivable for $300,000.

The Company has a payable of $0 and $180,374 at December 31, 2011 and 2010, respectively, for securities that were purchased but had not settled by year-end.

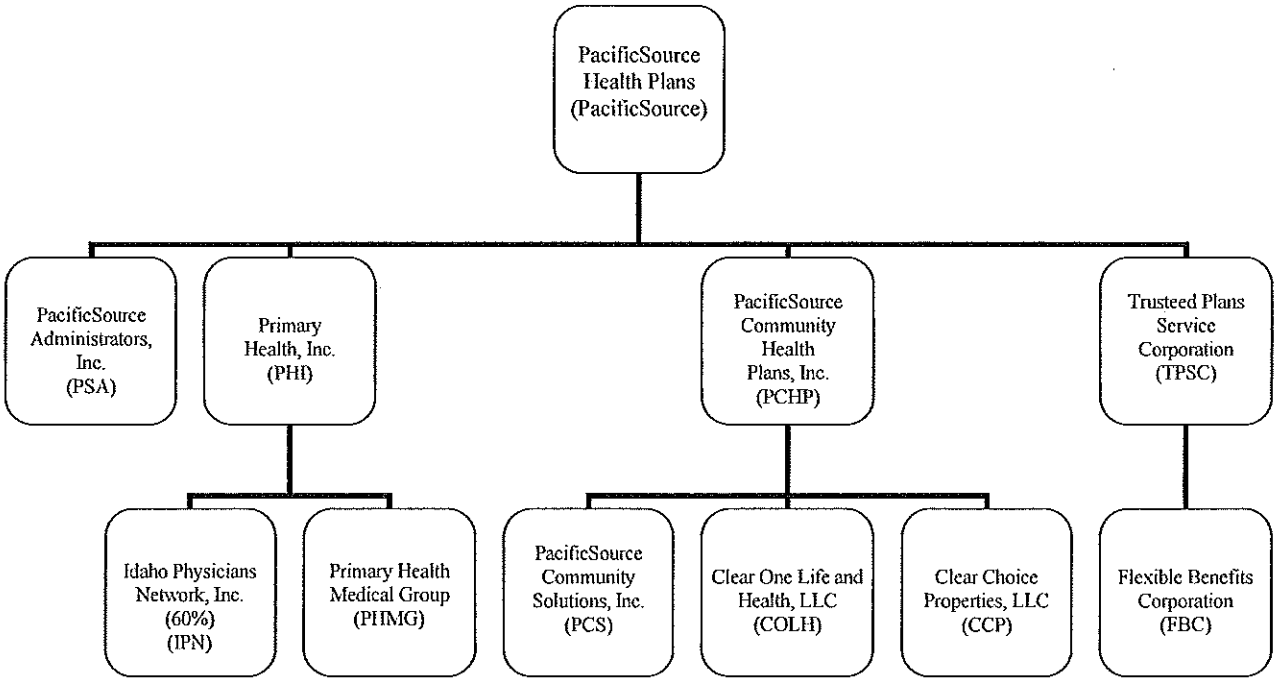
At December 31, 2011, there was unrealized appreciation and depreciation of investments, net of reclassification adjustments of $2,608,475 with deferred taxes of $822,000. At December 31, 2010, there was unrealized appreciation and depreciation of investments, net of reclassification adjustments of $2,426,295 with deferred taxes of $982,000.

At December 31, 2011, there were defined benefit pension plan adjustments of $7,062,212 with deferred taxes of $2,780,000. At December 31, 2010, there were defined benefit pension plan adjustments of $886,545 with deferred taxes of $350,000.

See accompanying notes.

1. Organization and Summary of Significant Accounting Policies

PacificSource and its subsidiaries are organized as follows:



The relative proportion of gross revenue attributable to each entity for the years ended December 31 are as follows:

	2011		2010	
PacificSource	$ 646,938,875	71.2%	$ 585,171,853	79.3%
PCHP and subsidiaries	250,297,460	27.5%	141,266,588	19.1%
PSA	4,715,315	0.5%	5,998,278	0.8%
TPSC and subsidiary	4,885,949	0.5%	3,315,371	0.5%
PHI and subsidiaries	2,389,617	0.3%	2,114,827	0.3%
Gross revenue	$ 909,227,216	100.0%	$ 737,866,917	100.0%

Principles of Consolidation. The accompanying financial statements of PacificSource Health Plans (PacificSource) are consolidated with their wholly owned subsidiaries (collectively the Company). PacificSource owns 100% of the stock of four subsidiary corporations. These entities are: PSA, PHI, PCHP (formerly Clear One Health Plans, Inc.) and TPSC. All significant intercompany balances and transactions have been eliminated in the consolidation.

(Continued)

1. Organization and Summary of Significant Accounting Policies (Continued)

PacificSource purchased a 100% interest in PCHP, an Oregon domiciled stock insurance company, and its wholly owned subsidiaries PCS (formerly Central Oregon Individual Health Solutions, Inc.), CCP, COLH and TPSC on May 21, 2010 for $45,497,600. (See Note 2.) Subsequent to the acquisition, PCHP distributed TPSC to PacificSource. TPSC is the 100% owner of FBC, a Washington based for-profit non-insurance entity. TPSC was sold effective November 30, 2011.

PacificSource is an independent, not-for-profit community health plan offering commercial medical and dental plans in Oregon, Idaho, Montana and Washington.

PCHP is a health insurance company licensed in the states of Oregon, Idaho and Montana. They offer Medicare Advantage and supplement products and, through their subsidiary, Medicaid plans.

PSA is a third-party administrator specializing in administration of self-funded employee health benefit plans, flexible spending accounts, health reimbursement arrangements and COBRA administration based in Oregon.

PHI is a shell corporation which owns 60% of the outstanding shares of IPN, an Idaho based for-profit non-insurance entity and 100% of PHMG, an inactive company holding no assets or liabilities.

TPSC is a full-service third-party administrator and benefits consulting firm providing administration of self-funded employee benefit health plans, flexible spending accounts, health reimbursement arrangements and COBRA administration based in Washington. On November 30, 2011, the Company sold its 100% ownership interest in TPSC. The sale was for $1 million in cash and a note receivable for $300,000, with payments due over three years and interest at 4.5%.

Basis of Presentation. The accompanying financial statements have been prepared in accordance with generally accepted accounting principles (GAAP) that differ from statutory accounting practices (SAP) used by regulatory authorities.

Operations. Services include commercial medical and dental insurance plans, Medicare and Medicaid policies. The Company had written policies at December 31 follows:

	2011	2010
Commercial	192,892	179,856
Medicare	10,691	9,430
Medicaid	41,662	34,529
Total	245,245	223,815

(Continued)

1. Organization and Summary of Significant Accounting Policies (Continued)

Codification. The National Association of Insurance Commissioners (NAIC) completed a process to codify statutory accounting practices for certain insurance enterprises (codification). Codification became effective on January 1, 2001. The insurance laws and regulations of the State of Oregon require insurance companies domiciled in the state to comply with the guidance provided in the NAIC Accounting Practices and Procedures Manual except as prescribed or permitted by state law.

Investments. Investments in debt securities, equity securities and mutual funds are classified as available-for-sale and are reported at fair value. Realized gains and losses on investments are recognized on the specific identification basis and recorded using the original cost of the security. Changes in fair value of investments are recorded as unrealized depreciation or appreciation directly in the fund balance as other comprehensive income or loss and have no effect on net income or loss. The certificates of deposit had a maturity of more than three months at the time of acquisition and are carried at cost, which approximates fair value.

Investments in other invested assets are accounted for using the equity method. Other invested assets consist of investments in partnerships. The equity method of accounting for investments requires the Company to recognize its pro rata share of the income or loss and distributions of the investments and to increase or decrease the carrying value of the investment accordingly.

Statutory Deposit. PacificSource and PCHP maintain statutory deposits as required by regulatory authorities. At December 31, 2011, the deposits were in the form of certificates of deposit maturing at various dates through August 2013 and were included in investments on the consolidated balance sheets. The fair value of the statutory deposit was $2,611,738 and $2,611,472 as of December 31, 2011 and 2010, respectively.

Cash Equivalents. For purposes of the consolidated statements of cash flows, the Company considers all highly liquid debt instruments purchased with maturities of three months or less at the time of purchase to be cash equivalents. Substantially all of the cash and cash equivalents are maintained at various banks whose deposits exceed federally insured limits. The Company has not experienced any losses on such accounts.

Trust Funds. Under the terms of administrative agreements related to self-insurance and third-party administrator services, the Company is required to maintain separate cash trust accounts for benefit administration services received for various employers.

(Continued)

1. Organization and Summary of Significant Accounting Policies (Continued)

Accounts Receivable. Uncollected premiums represent amounts receivable from policyholders. Amounts receivable relating to uninsured health plans are amounts collectible from groups under administrative service contracts. Pharmacy rebates are receivable based upon pharmacy claims expenses of the Company. Other receivables are claims refunds collectible from providers, insureds and third parties based upon coordination of benefits under healthcare plans. All receivables of the Company are unsecured. Management determines and evaluates past due balances on an account by account basis, and if amounts become uncollectible, they will be charged to operations when that determination is made. As of December 31, 2011 and 2010, management determined that an allowance of approximately $0 and $195,000, respectively, was necessary.

As of December 31, 2011 and 2010, pharmacy rebates were approximately $6.1 million and $4.8 million, respectively, which will be collected over the next two years in the normal course of business in accordance with contract terms and industry standards.

Property. Property is stated at cost. Depreciation is computed on the straight-line method based on the estimated useful lives of the assets. Property additions and improvements are capitalized, while repairs and maintenance are charged to expense as incurred.

Goodwill. The Company assesses the realizability of goodwill annually and whenever events or changes in circumstances indicate it may be impaired. When an impairment is indicated, any excess of carrying value over fair value of goodwill is recorded as an operating loss. The Company completed annual tests for impairment at December 31, 2011 and 2010, and determined that the fair value of goodwill exceeded the carrying value, thus goodwill is not considered impaired.

Intangible Assets. Intangible assets with finite lives are amortized on a straight-line basis over their estimated useful lives. Trade names and trademarks, customer relationships and contract arrangements are amortized over ten to twenty years; other intangible assets are amortized over fifteen years; loan fees are amortized over the life of the loan, which is five years. Estimated useful lives of intangible assets are periodically reviewed by management to determine if events or circumstances warrant a change in the remaining useful life of the asset.

Liability for Unpaid Claims and Claims Adjustment Expenses. The Company establishes a liability, based on actuarial models, for unpaid claims and related administrative costs. The Company does not discount its liability for unpaid claims. The liability is an estimate, and while the Company believes that the amount is adequate, the ultimate liability may be in excess of or less than the amount provided. The estimate is continually reviewed and adjusted as necessary as experience develops or new information becomes known; such adjustments are included in the period in which the revisions are determined.

(Continued)

1. Organization and Summary of Significant Accounting Policies (Continued)

Incentive Compensation Payable Under Managed Care Plans. The Company has entered into arrangements with certain medical provider groups that involve risk sharing of gains or losses. Providers are paid a per capita fee for providing services to insureds and a portion of certain other payments to providers are withheld (incentive pools). Based on an annual review of performance and utilization, such amounts are either retained by the Company or paid to providers.

Deferred Compensation - Management. The Company provides key employees a non-qualified deferred compensation plan whereby participants can elect to make voluntary contributions to the plan. The Company, at the discretion of the Board of Trustees, can also make contributions to the plan on behalf of key employees. The assets are payable to participants upon retirement or termination of employment. The Company includes in its assets the estimated present value of annuity contracts under the plan; there is an associated liability for the plan as the contracts are payable to participants. Plan assets were $373,943 and $317,472 at December 31, 2011 and 2010, respectively, and are recorded in prepaid expenses and deposits on the consolidated balance sheets. The Company contributed $27,906 and $21,196 to the plan for 2011 and 2010, respectively.

Income Taxes. PacificSource is incorporated in Oregon as a not-for-profit health care service contractor; it is a taxable entity as a result of the Tax Reform Act of 1987. Income taxes are provided for the tax effects of transactions reported in the financial statements and consist of taxes currently due plus deferred taxes. Deferred income taxes arise principally from temporary differences relating to the deferred compensation plan, defined benefit pension plan, unrealized appreciation and depreciation of investments, depreciation, certain accrued and prepaid expenses, group life insurance and annuity contracts, premium deficiency reserve, discounting of the claims provision, partnership differences, goodwill, bad debts, alternative minimum tax credit carryforwards, charitable contribution carryforwards and federal and state net operating loss carryforwards. PacificSource files consolidated federal income tax returns with its subsidiaries in accordance with applicable tax law.

The Company files income tax returns in the U.S. federal jurisdiction and multiple state and local jurisdictions. The Company is not subject to state and local income tax examinations by tax authorities for years prior to 2008 in jurisdictions where tax returns have been filed, as the statute of limitations has expired on those years. The Company recently completed an IRS examination for federal tax years 2005 through 2008 and there was no adjustment to federal tax liability based on the examination.

Statutory Capital Reserves. PacificSource and PCHP are required by Oregon law to maintain minimum capital reserves of 50% of their average monthly claims incurred during the last 12 months, to a minimum of $2,500,000; this amount is included in the fund balance.

Revenue Recognition. Premiums are recognized on a monthly basis over the policy term. Administrative revenues include the operations of the non-insurance subsidiaries. Revenues are recognized in the month that the service is performed.

(Continued)

1. Organization and Summary of Significant Accounting Policies (Continued)

Assessments. State mandated assessments are accrued at the time the events occur on which assessments are expected to be based.

Advertising. Costs for advertising are expensed as incurred. Advertising expense was $2,579,446 and $2,634,580 for 2011 and 2010, respectively.

Fair Value Measurements. Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The fair value framework requires the categorization of assets and liabilities into three levels based upon the ability to observe the assumptions (inputs) used to value the assets and liabilities. Level One provides the most reliable and observable measure of fair value, whereas Level Three generally requires significant judgment. When valuing assets or liabilities, GAAP requires the most observable inputs to be used.

The fair value hierarchy is categorized into three levels based on the inputs as follows:

Level One - Unadjusted, quoted prices in active markets for identical assets and liabilities.

Level Two - Observable inputs, other than those included in Level One. For example, quoted prices for similar assets or liabilities in active markets or quoted prices for identical assets or liabilities in inactive markets.

Level Three - Unobservable inputs reflecting assumptions about the inputs used in pricing the asset or liability.

The fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

Estimates. The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Business Risks and Uncertainties. The Company's investments are primarily comprised of debt and equity securities. Significant changes in prevailing interest rates and market conditions may adversely affect the timing and amount of cash flows on such investments and their related values. Due to the level of risk associated with certain investment securities and the level of uncertainty related to changes in the value of investment securities, it is at least reasonably possible that changes in values in the near term could materially affect the Company's consolidated balance sheets and the amounts reported in the consolidated statements of income.

(Continued)

1. Organization and Summary of Significant Accounting Policies (Continued)

The Company invests in mortgage backed securities (MBS) and other securities subject to prepayment and call risk. Significant changes in prevailing interest rates may adversely affect the timing and amount of cash flows on such securities. In addition, the amortization of market premium and accretion of market discount on MBS is based on historical experience and estimates of future payments on the underlying mortgage loans. Actual prepayments will differ from the original estimates and may result in material adjustments to amortization or accretion recorded in future periods.

Recently Adopted Accounting Pronouncements. Effective for the Company's 2011 annual impairment tests of goodwill, the Company adopted new guidance issued by the Financial Accounting Standards Board. The new guidance provides an entity the option to first perform a qualitative assessment to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount. If an entity determines that this is the case, it is required to perform the currently prescribed two-step goodwill impairment test. If an entity determines that the fair value of a reporting unit is greater than its carrying amount, the two-step goodwill impairment test is not required. Adoption of the new guidance did not have a material impact on the Company's consolidated financial statements.

Subsequent Events. Management evaluates events occurring subsequent to the date of the consolidated financial statements in determining the accounting for and disclosure of transactions and events that affect the consolidated financial statements. Subsequent events have been evaluated through April 9, 2012, which is the date the consolidated financial statements were available to be issued.

Reclassifications. Certain 2010 amounts have been reclassified to conform with 2011 presentation. The reclassifications had no effect on previously reported net income.

2. Business Combinations

On May 21, 2010, the Company acquired 100% of the outstanding common shares of PCHP. PCHP is an Oregon based company that had four wholly owned subsidiaries, which included PCS, COLH, CCP and TPSC and TPSC's wholly owned subsidiary, FBC. PCS manages the business related to its contract with the Oregon Department of Human Services, Division of Medical Assistance Programs. COLH sells life, disability, dental, vision and voluntary benefit programs in Oregon and Montana. CCP manages the building where the PCHP entities operate. TPSC provides administration and account management services. FBC is licensed in the State of Washington as an insurance broker as a means to negotiate insurance rates and benefits for excess loss insurance coverage for self-funded benefit plans. Subsequent to the acquisition, PCHP distributed TPSC and FBC to PacificSource.

(Continued)

2. Business Combinations (Continued)

PacificSource acquired the outstanding common stock of PCHP for $45,497,600. The allocation of the purchase price for identifiable assets acquired and liabilities assumed, as of the date of the acquisition, was as follows:

Cash and investments	$ 45,844,600
Other current assets	4,916,611
Property	2,314,249
Investment in subsidiary - PCS	24,140,496
Investment in subsidiary - COLH	29,754
Investment in subsidiary - CCP	5,405,559
Investment in subsidiary - TPSC	1,870,295
Deferred tax assets	6,733,223
Total assets	91,254,787
Liabilities	(45,757,187)
Total net assets	$ 45,497,600

The fair value of the interest in PCS was determined based upon the assets acquired and liabilities assumed at the date of acquisition. The investment in subsidiary - PCS was allocated as follows:

Cash and investments	$ 15,842,430
Other current assets	6,897,894
Intangible asset - goodwill	9,087,214
Other assets	8,349,429
Total assets	40,176,967
Liabilities	(16,036,471)
Total net assets - investment in subsidiary - PCS	$ 24,140,496

(Continued)

2. Business Combinations (Continued)

The fair value of the interest in COLH was determined based upon the assets acquired and liabilities assumed at the date of acquisition. The investment in subsidiary - COLH was allocated as follows:

Cash	$	39,251
Liabilities		(9,497)
Total net assets - investment in subsidiary - COLH	$	29,754

The fair value of the interest in CCP was determined based upon the assets acquired and liabilities assumed at the date of acquisition. The investment in subsidiary - CCP was allocated as follows:

Cash and investments	$	2,162,510
Other current assets		18,937
Property		16,519,689
Other assets		27,069
Total assets		18,728,205
Liabilities		(13,322,646)
Total net assets - investment in subsidiary - CCP	$	5,405,559

The fair value of the interest in TPSC was determined based upon the assets acquired and liabilities assumed at the date of acquisition. At the time of the acquisition, TPSC became a wholly owned subsidiary of PacificSource. The investment in subsidiary - TPSC was allocated as follows:

Cash	$	1,289,300
Other current assets		306,676
Property		253,381
Intangible asset - goodwill		1,000,000
Total assets		2,849,357
Liabilities		(979,062)
Total net assets - investment in subsidiary - TPSC	$	1,870,295

3. Investments

Investments by major class consisted of the following at December 31:

	2011	2010
Debt securities	$ 116,922,980	$ 79,726,340
Equity securities and mutual funds	30,968,056	34,903,805
Certificates of deposit	2,611,738	2,611,472
Other invested assets	6,381,674	7,812,454
Accrued investment income	888,930	624,539
Total	$ 157,773,378	$ 125,678,610

Investments in Debt and Equity Securities. The Company classifies the following investments as available-for-sale and records them at fair value.

The cost and fair value of the investments at December 31, 2011 are as follows:

	Cost	Fair Value	Unrealized Appreciation (Depreciation)	Tax Effect	Net Unrealized Appreciation (Depreciation)
U.S. Government debt securities	$ 13,356,646	$ 14,060,871	$ 704,225	$ (276,000)	$ 428,225
Mortgage/asset backed securities	45,828,390	47,190,368	1,361,978	(533,000)	828,978
Corporate debt securities	54,731,222	55,671,741	940,519	(369,000)	571,519
Debt securities	113,916,258	116,922,980	3,006,722	(1,178,000)	1,828,722
Equity securities and mutual funds	31,949,439	30,968,056	(981,383)	384,000	(597,383)
Total	$ 145,865,697	$ 147,891,036	$ 2,025,339	$ (794,000)	$ 1,231,339

The unrealized appreciation of debt securities of $3,006,722 for 2011 consisted of unrealized gains of $4,224,565 and unrealized losses of $1,217,843. The unrealized depreciation of equity securities and mutual funds of $981,383 for 2011 consisted of unrealized gains of $1,442,980 and unrealized losses of $2,424,363. Approximately $3 million of gross realized gains and $1 million of gross realized losses were included in investment income on the consolidated statements of income for 2011.

(Continued)

3. Investments (Continued)

The cost and fair value of the investments at December 31, 2010 are as follows:

	Cost	Fair Value	Unrealized Appreciation (Depreciation)	Tax Effect	Net Unrealized Appreciation (Depreciation)
U.S. Government debt securities	$ 14,678,768	$ 14,827,534	$ 148,766	$ (52,000)	$ 96,766
Mortgage/asset backed securities	25,146,820	26,324,946	1,178,126	(411,000)	767,126
Corporate debt securities	37,280,752	38,573,860	1,293,108	(451,000)	842,108
Debt securities	77,106,340	79,726,340	2,620,000	(914,000)	1,706,000
Equity securities and mutual funds	32,889,991	34,903,805	2,013,814	(702,000)	1,311,814
Total	$ 109,996,331	$ 114,630,145	$ 4,633,814	$ (1,616,000)	$ 3,017,814

The unrealized appreciation of debt securities of $2,620,000 for 2010 consisted of unrealized gains of $3,105,562 and unrealized losses of $485,562. The unrealized appreciation of equity securities and mutual funds of $2,013,814 for 2010 consisted of unrealized gains of $2,390,177 and unrealized losses of $376,363. Approximately $9 million of gross realized gains and $4 million of gross realized losses were included in investment income on the consolidated statements of income for 2010.

Management evaluates securities for other-than-temporary impairment at least on an annual basis, and more frequently when economic or market concerns warrant such evaluation. Consideration is given to the length of time and the extent to which the fair value has been less than cost, the financial condition and near-term prospects of the issuer and the intent and ability of the Company to retain its investment for a period of time sufficient to allow for any anticipated recovery in fair value.

(Continued)

3. Investments (Continued)

The aggregate fair values of securities, by category, that had gross unrealized losses at December 31, 2011, and the securities that were in a loss position at December 31, 2010 that were still in a loss position at December 31, 2011, are as follows:

	Less than 12 Months		12 Months or More		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
Debt securities	$ 23,316,490	$ (1,094,857)	$ 1,713,191	$ (122,986)	$ 25,029,681	$ (1,217,843)
Equity securities/ mutual funds	18,467,653	(1,971,509)	1,023,318	(452,854)	19,490,971	(2,424,363)
	$ 41,784,143	$ (3,066,366)	$ 2,736,509	$ (575,840)	$ 44,520,652	$ (3,642,206)

As of December 31, 2011, the Company had 156 securities in an unrealized loss position. All of these securities had a percentage decline of less than 19%. At December 31, 2011 and 2010, the Company did not hold any less-than-investment grade corporate debt securities.

At December 31, 2011, debt securities were scheduled to mature as follows:

	Cost	Fair Value	Unrealized Appreciation
Due in one year or less	$ 547,301	$ 559,019	$ 11,718
Due in one to five years	30,017,720	30,218,491	200,771
Due in five to ten years	36,489,313	38,034,530	1,545,217
Due after ten years	46,861,924	48,110,940	1,249,016
Total	$ 113,916,258	$ 116,922,980	$ 3,006,722

See Note 8 regarding investment securities pledged to secure the line of credit at December 31, 2011.

(Continued)

3. Investments (Continued)

The change in unrealized appreciation in fair value of securities available-for-sale is as follows:

	Cost	Fair Value	Unrealized Appreciation (Depreciation)	Tax Effect	Net Unrealized Appreciation (Depreciation)
December 31, 2011	$ 145,865,697	$ 147,891,036	$ 2,025,339	$ (794,000)	$ 1,231,339
Less December 31, 2010	109,996,331	114,630,145	4,633,814	(1,616,000)	3,017,814
Change in unrealized appreciation (depreciation)			$ (2,608,475)	$ 822,000	$ (1,786,475)

Investment expenses were approximately $301,000 and $383,000 for the years ended December 31, 2011 and 2010, respectively.

Other Invested Assets. Other invested assets consist of investments in partnerships that are accounted for using the equity method, which approximates fair market value. The percentage of the Company's ownership in each of these investments varies based upon total investment in the secondary market.

During 2007, the Company purchased, for $3,486,406, an interest in Jefferies Special Opportunities Partners, LLC, of which $170,289 was sold during 2010. On an annual basis, the LLC makes distributions of the annual income. The Company's pro rata share of gain was $23,000 and $27,283 in 2011 and 2010, respectively; cumulative loss prior to 2010 was $147,400.

During 2007, the Company purchased, for $19,780,256, an interest in Phoenix Fixed Income Fund, L.P. (formerly Azure Fixed Income Fund, L.P.) Standard Units 2, of which $11,672,464 was sold during 2007, $1,348,736 was sold during 2010 and $1,279,124 was sold during 2011. PacificSource's pro rata share of the limited partnership loss was $174,656 and $307,571 in 2011 and 2010, respectively; cumulative loss prior to 2010 was $1,835,031.

4. Property

Major classes of property at December 31 consisted of the following:

	2011	2010
Land	$ 3,172,078	$ 3,172,078
Buildings	20,358,271	20,318,082
Furniture and fixtures	8,335,109	8,178,983
Electronic data processing equipment	8,316,071	7,737,316
Software	47,531,150	45,753,857
Automobiles	240,185	136,361
Leasehold improvements	2,018,215	1,867,651
Work in process	316,335	-
	90,287,414	87,164,328
Less accumulated depreciation	13,537,920	11,311,891
Less accumulated amortization - software	26,733,669	20,911,713
Total	$ 50,015,825	$ 54,940,724

5. Intangible Assets

Major classes of intangible assets at December 31 consisted of the following:

	2011	2010
Customer relationships	$ 4,868,630	$ 4,868,630
Contractual arrangements	4,858,055	4,858,055
Trade names and trademarks	600,000	600,000
Other intangible assets	130,163	282,061
Loan fees	97,904	97,904
	10,554,752	10,706,650
Less accumulated amortization	1,565,020	408,861
Total	$ 8,989,732	$ 10,297,789

Intangible assets with finite lives are amortized using the straight-line method over their estimated useful lives, which range from five to twenty years. Amortization expense is expected to be as follows for each of the succeeding five years: 2012, $722,299; 2013, $717,393; 2014, $702,718; 2015, $702,718; 2016, $702,718; and $5,441,886 thereafter.

6. Group Life Insurance and Purchased Annuities

The Company includes in its assets the cash value of a group life insurance contract and the estimated present value of purchased annuities. The contracts were purchased with the proceeds of a deferred compensation plan with member physicians which was offered from 1966 through 1991. The plan is considered an unfunded, non-qualified, deferred compensation arrangement not subject to ERISA requirements. The insurance contracts are subject to claims by general creditors and are, therefore, considered a part of the Company's general assets. The contracts are payable to the member physicians and are, therefore, recorded as a liability.

As of December 31, 2011 and 2010, the single-premium group life insurance contract consisted of aggregate paid-up life insurance of $2,921,891 and a cash value of $1,673,491 and $1,633,613, respectively.

At a triggering event (such as the retirement or disability of a participant), a partial surrender of the group life insurance contract is requested and an annuity contract is purchased. The net present value of the annuity contracts was $277,404 and $359,346 at December 31, 2011 and 2010, respectively.

The agreements with the participating physicians generally do not commit the Company to obtain a specific rate of return on the deferred amounts. The following is a summary of transactions in the deferred compensation plan:

	Group Life Insurance Contract	Annuity Contracts	Total
Balance at December 31, 2009	$ 1,575,786	$ 478,517	$ 2,054,303
Earnings on contracts, net	62,736	23,189	85,925
Purchase of annuity	(4,909)	4,909	-
Payments to annuitants	-	(147,269)	(147,269)
Balance at December 31, 2010	1,633,613	359,346	1,992,959
Earnings on contracts, net	39,878	16,534	56,412
Payments to annuitants	-	(98,476)	(98,476)
Balance at December 31, 2011	$ 1,673,491	$ 277,404	$ 1,950,895

7. Liability for Unpaid Claims and Claims Adjustment Expenses

The liability for unpaid claims and claims adjustment expenses is based on the estimated amount payable on claims reported prior to the consolidated balance sheets date that have not yet been settled, claims reported subsequent to the consolidated balance sheets date that have been incurred during the period then ended and an estimate based on prior experience of incurred but unreported claims relating to such period.

Activity in the liability for unpaid claims and claims adjustment expenses is summarized as follows:

	2011	2010
Unpaid claims and claims adjustment expenses, January 1	$ 75,534,434	$ 45,299,900
Less reinsurance receivable	(1,104,602)	(394,763)
Net balance	74,429,832	44,905,137
Incurred related to:		
Current year	799,677,007	669,013,628
Prior years	2,199,365	(1,459,469)
Total incurred	801,876,372	667,554,159
Paid related to:		
Current year	(722,392,362)	(594,189,033)
Prior years	(77,733,799)	(43,840,431)
Total paid	(800,126,161)	(638,029,464)
Net balance	76,180,043	74,429,832
Plus reinsurance receivable	722,258	1,104,602
Unpaid claims and claims adjustment expenses, December 31	$ 76,902,301	$ 75,534,434

As a result of changes in estimates of insured events in prior years, the liability for unpaid claims and claims adjustment expenses (net of reinsurance recoveries of $722,258) increased by $2,199,365 in 2011. The liability for unpaid claims and claims adjustment expenses (net of reinsurance recoveries of $1,104,602) decreased by $1,459,469 in 2010. The Company records a liability for unpaid claims and claims adjustment expenses that includes an allowance for potential shock claims.

8. Line of Credit

During 2010, the Company obtained a line of credit from a bank, which provides for maximum borrowings of $40,000,000. The balance on the line of credit was $2,420,660 and $0 at December 31, 2011 and 2010. The line of credit bears interest at the Daily One Month LIBOR Rate plus 1.00% (an effective rate of 1.30% at December 31, 2011) and matures in February 2013. Certain investment accounts are assigned as collateral. The bank requires securities in the amount of twice the outstanding balance of the line and letters of credit to be pledged to secure the line of credit. Securities pledged were $4,841,320 at December 31, 2011. The line of credit is subject to certain covenants, which the Company was in compliance with at December 31, 2011.

9. Notes Payable

Notes payable consisted of the following at December 31:

	2011	2010
Note payable to bank, due in monthly installments of $71,329, including interest at 5.94% per annum, collateralized by real property, due in full at maturity April 2016.	$ 9,823,368	$ 13,368,055
Notes payable to individuals, due in monthly installments of $20,634, including interest at the prime rate plus 2% adjusted annually, not to be less than 7% or exceed 10% (effective rate of 7% at December 31, 2011), collateralized by business assets, matures March 2018.	1,249,863	1,403,944
Total	$ 11,073,231	$ 14,771,999

The note payable to the bank is subject to certain covenants, which the Company was in compliance with at December 31, 2011.

(Continued)

9. Notes Payable (Continued)

The estimated aggregate amounts of notes payable maturities are as follows:

2012	$ 443,660
2013	474,266
2014	505,210
2015	538,188
2016	8,817,062
Thereafter	294,845
	$ 11,073,231

10. Retirement Plans

The Company has a non-contributory pension plan and a participatory retirement plan (401(k)), both of which cover substantially all employees.

The non-contributory pension benefits are based on years of service and the employee's compensation during employment. The Company contributes at least the minimum funding required annually. Contributions are intended to provide not only for benefits attributed to service to date but also for those expected to be earned in the future.

The following table sets forth the plan's funded status and amounts recognized in the Company's consolidated financial statements at December 31:

	2011	2010
Projected benefit obligation for service rendered to date	$ (30,317,898)	$ (20,565,252)
Plan assets at fair value	25,603,787	21,450,314
Funded status	$ (4,714,111)	$ 885,062
Change in projected benefit obligation:		
Projected benefit obligation, beginning of year	$ 20,565,252	$ 16,091,870
Service cost	2,691,623	1,664,237
Interest cost	1,254,709	1,160,259
Benefits paid and administrative expenses	(355,759)	(346,222)
Actuarial loss	6,162,073	1,995,108
Projected benefit obligation, end of year	$ 30,317,898	$ 20,565,252

(Continued)

10. Retirement Plans (Continued)

	2011	2010
Change in fair value of plan assets:		
Fair value of plan assets, beginning of year	$ 21,450,314	$ 16,157,003
Actual return on plan assets	9,232	1,639,533
Employer contributions	4,500,000	4,000,000
Benefits paid	(308,539)	(308,018)
Administrative expenses	(47,220)	(38,204)
Fair value of plan assets, end of year	$ 25,603,787	$ 21,450,314
Net periodic benefit cost:		
Service cost	$ 2,691,623	$ 1,664,237
Interest cost	1,254,709	1,160,259
Expected return on plan assets	(1,612,260)	(1,059,884)
Amortization of loss	868,361	694,386
Amortization of prior service credits	(165,472)	(165,472)
Total net periodic benefit cost	$ 3,036,961	$ 2,293,526
Amounts recognized in accumulated other comprehensive income:		
Net loss	$ 14,134,946	$ 7,238,206
Prior service credit	(1,138,447)	(1,303,919)
Total accumulated other comprehensive income	$ 12,996,499	$ 5,934,287
Changes in other comprehensive income:		
Net loss	$ 7,765,101	$ 1,415,459
Amortization of net loss	(868,361)	(694,386)
Amortization of prior service credit	165,472	165,472
Total recognized in other comprehensive income	$ 7,062,212	$ 886,545
Accumulated benefit obligation, end of year	$ 24,282,983	$ 16,764,478

The Company estimates net loss, prior service cost and transition obligation for the defined benefit pension plan that will be amortized into periodic benefit cost in 2012 to be $1,235,056, $(165,472) and $0, respectively.

(Continued)

10. Retirement Plans (Continued)

The Company expects to contribute $4,000,000 to its pension plan in 2012. Future anticipated benefit payments from the defined benefit pension plan are as follows: 2012, $1,627,742; 2013, $984,452; 2014, $934,044; 2015, $2,115,874; 2016, $598,679; and from 2017 to 2021, $15,419,969.

Assumptions used in the accounting for the defined benefit pension plan were as follows at December 31:

	2011	2010
Assumptions used for net periodic benefit costs:		
Discount rate used in determining present values	5.5%	6.5%
Annual increase in future compensation levels	3.5	4.0
Expected long-term rate of return on assets	7.25	6.0
Assumptions used to determine benefit obligation:		
Discount rate used in determining present values	4.7%	5.5%
Annual increase in future compensation levels	3.5	3.5
Measurement date	December 31	December 31

The plan assets are invested in the following asset classes:

Debt investments	45%	68%
Equity investments	35	32
Cash equivalents	13	-
Other	7	-
Total	100%	100%

The plan assets are invested in a variety of bond and equity mutual funds. The targeted composition is set by the Company and reallocated periodically. The Company's expected rate of return on plan assets is determined by the plan assets' historical long-term investment performance, current asset allocation and estimates of future long-term returns by asset class.

(Continued)

10. Retirement Plans (Continued)

The participatory retirement plan (401(k)), which was adopted in 1984, provides for voluntary employee contributions with employer matching. The plan requires a 50% Company match on eligible elective deferrals. Elective deferrals in excess of 6% of eligible employee compensation are not eligible to receive a match. Company contributions under the plan were $750,345 and $571,553 in 2011 and 2010, respectively.

11. Income Taxes

The Company files a consolidated federal income tax return with its subsidiaries on the basis of its annual GAAP financial statements adjusted for the tax regulations. The Company files state income tax returns based on its annual statement that is filed with the insurance regulatory authorities for PacificSource and PCHP. The Company files on the basis of its annual GAAP financial statements adjusted for the state tax regulations for the remaining subsidiaries. The allocation methodology under the adopted tax allocation agreement applies the projected consolidated group income tax rate to the entities based on pre-tax net income. Federal income taxes are settled between PacificSource and its subsidiaries based on the tax sharing agreement.

The provision for income taxes consists of the following:

	2011	2010
Current income tax expense:		
Federal	$ 2,539,176	$ 468,359
State	285,218	447,264
Total current income tax expense	2,824,394	915,623
Deferred tax expense	1,618,132	7,131,766
Total income tax expense	$ 4,442,526	$ 8,047,389

The reconciliation between federal taxes at the statutory rate and the Company's income taxes are as follows:

	2011	2010
Tax expense computed at statutory rate	$ 4,135,000	$ 7,373,000
State tax expense, net of federal income tax benefit	530,000	954,000
Permanent and other differences	39,526	(199,611)
Dividend received deduction	(262,000)	(80,000)
Total income tax expense	$ 4,442,526	$ 8,047,389

(Continued)

11. Income Taxes (Continued)

Deferred income tax assets and liabilities at December 31 are as follows:

	2011	2010
Deferred tax assets:		
Federal and state net operating loss carryforwards	$ 3,450,631	$ 4,341,763
Alternative minimum tax credit carryforwards	1,560,000	2,476,000
Unrealized losses	1,430,000	151,000
Accruals	1,368,000	633,000
Contribution carryforwards	1,178,000	889,000
Defined benefit pension plan	1,045,000	-
Partnership difference	663,000	515,000
Deferred compensation	575,000	446,845
Discount of claims provision	516,000	465,560
Capital loss carryforward	258,000	-
Goodwill	17,000	19,035
Operating lease impairment	14,000	-
Bad debt reserve	-	66,242
Premium deficiency reserve	-	4,857
Total deferred tax assets	12,074,631	10,008,302
Deferred tax liabilities:		
Property	(11,128,808)	(10,225,481)
Unrealized gains	(2,225,000)	(1,683,602)
Prepaids	(1,291,000)	(1,260,000)
Subsidiary equity income	(42,000)	(290,000)
Goodwill	-	(779,528)
Defined benefit pension plan	-	(290,000)
Total deferred tax liabilities	(14,686,808)	(14,238,611)
Net deferred tax liabilities	$ (2,612,177)	$ (4,230,309)

As of December 31, 2011, the Company recognized a deferred tax asset of $3,450,631, for the anticipated utilization of federal and state net operating loss carryforwards. Federal net operating loss carryforwards of $5,786,707 will expire on December 31, 2028, if not used before then. State net operating loss carryforwards of $30,160,374 will expire on various dates through 2029. Contribution carryforwards of $3,003,820 will expire on various dates through 2015. Alternative minimum tax credit carryforwards of $2,607,034 have no expiration date.

(Continued)

11. Income Taxes (Continued)

The Company is required to record a valuation allowance when it is more likely than not that some portion or all of the deferred tax assets will not be realized. The ultimate realization of the deferred tax assets depends on the ability to generate sufficient taxable income in the future. Based on its profitable operating results in previous years, together with management's intention and active pursuit of strategies to remain successful in the health insurance industry, no valuation account has been recorded because it appears more likely than not that the full tax benefit of deferred tax assets will be realized.

12. Reinsurance

Commercial business was reinsured against inpatient hospital costs and ancillary outpatient services under the terms of an excess liability policy. The following is a summary of the coverage levels at December 31, 2011 in order of their application:

Commercial	Retention		Deductible	Aggregate Limit
Layer 1	10% up to $135,000	$	650,000	$1,350,000 per member
Layer 2	10% up to $300,000	$	2,000,000	$3,000,000 per member
Layer 3	$ -	$	5,000,000	$5,000,000 per member

Medicare and Medicaid business were reinsured against inpatient hospital costs and ancillary outpatient services under the terms of an excess liability policy. The following is a summary of the coverage levels at December 31, 2011:

Medicare and Medicaid	Retention		Deductible	Aggregate Limit
Layer 1	10%	$	350,000	Unlimited

Premiums ceded under the terms of the reinsurance policies were $5,027,828 and $4,407,871 in 2011 and 2010, respectively. The reinsurance contracts do not relieve the Company from its primary obligation to policyholders.

13. Leases

Effective November 1997, PHI entered into a lease for real property in Mountain Home, Idaho. It is a fifteen-year lease expiring November 2012. The lease has three renewal terms of five years each. The Company is responsible for substantially all executory costs. Minimum payments under the lease are subject to annual adjustment of 3%. Future minimum lease payments are as follows: $90,475 for 2012.

(Continued)

13. Leases (Continued)

Effective June 2004, the Company entered into a real property lease for the Medford, Oregon sales office under a five-year operating agreement expiring August 2009 and extended through August 2012. The Company is responsible for substantially all executory costs. Future minimum lease payments are $23,104 for 2012.

Effective August 2007, the Company entered into a real property lease for the Tigard, Oregon sales office under a seven-year operating agreement expiring October 31, 2014. The Company is responsible for substantially all executory costs. Minimum payments under the lease, which are subject to annual adjustment, are $20,443 per month. Future minimum lease payments are as follows: 2012, $253,427; 2013, $261,554; 2014, $223,359.

Effective August 1, 2009, PHI assigned its interest in their Idaho Falls, Idaho real property lease to the Company. It is a five-year lease expiring July 2013 based on the original commencement date of August 2008. Minimum payments under the lease, which are subject to annual adjustments, are $2,350 per month. The Company is responsible for substantially all executory costs. Future minimum lease payments are as follows: 2012, $29,204; 2013, $17,281.

Effective October 2010, the Company entered into a real property lease for the Boise, Idaho office under a five-year operating agreement expiring September 2015. The lease contains an option to renew the lease for an additional five-year term. The Company is responsible for substantially all executory costs. Minimum payments under the lease, which are subject to annual adjustment, are $25,485 per month. Future minimum lease payments are as follows: 2012, $310,426; 2013, $316,635; 2014, $323,771; 2015, $248,251.

Effective February 2011, the Company entered into a real property lease for the Helena, Montana sales office under a one year operating agreement, with the option to renew the lease for an additional one year term. The Company is responsible for substantially all executory costs. Future minimum lease payments are $650 for 2012.

Effective July 2011, the Company entered into a real property lease for an additional Springfield, Oregon office under a three-year operating agreement expiring June 2014. The lease contains an option to renew the lease for an additional two year, month to month term. The Company is responsible for substantially all executory costs. Minimum payments under the lease, which are subject to annual adjustment, are $15,962 per month. Future minimum lease payments are as follows: 2012, $194,447; 2013, $203,154; 2014, $104,479.

Effective June 2007, the Company entered into a real property lease for the Boise, Idaho sales office under a five-year operating agreement expiring May 2012. This lease was terminated in April 2011.

As part of the sale of TPSC, the Company transferred the real property lease for the Tacoma, Washington office effective November 30, 2011.

Amounts charged to rent expense for the various leases were $1,229,140 and $1,089,634 for 2011 and 2010, respectively.

14. Administrative Service Contracts

Administrative service contracts between the Company and certain groups require the groups to pay the actual costs of claims incurred, plus administrative service costs. In addition, the groups have the option to pay premiums for stop loss coverage, and the Company pays such excess claims on the same basis as its other indemnity contracts.

15. Commitments

The 1995, the Oregon Legislature enacted Senate Bill 152, which created individual portability plans that must be offered by all health insurers as a condition of transacting group insurance in the State of Oregon. The law, which became effective October 1, 1996, requires insurers to offer individuals who lose group coverage a choice of one of two individual portability policies. Benefits included in the policies are established by Oregon Administrative Rules. The policies are guaranteed issue and guaranteed renewable; individuals who meet eligibility criteria may not be excluded due to health conditions or pre-existing conditions. The formula for establishing and increasing rates is prescribed by law. The Company had premiums of approximately $5,137,000 for the year ended December 31, 2011, for policies issued under the provisions of the law, with associated claims expense of $7,025,000. The Company believes that any premium deficiency that may be realized on these policies is built into the rates of their other lines of business.

The 1991, the Oregon Legislature enacted Senate Bill 1076, which created a Basic Health Plan that must be offered by all health insurers as a condition of transacting insurance in the State of Oregon. Senate Bill 1076, which became effective December 31, 1992, and Senate Bill 152, which was updated in 2007 by House Bill 2002, establishes rules for all small group plans. In such plans, no employee may be excluded due to health condition or pre-existing condition, the plan must be guaranteed issue and guaranteed renewable, and the amount and timing of rate increases is prescribed by law. As of December 31, 2011, the Company has reflected profits on the aggregate policies issued under the provisions of these laws with respect to small group plans. The Company believes that its financial position, together with its reinsurance arrangements, provides a firm base to mitigate any significant adverse impact of these requirements.

In March 2010, the President of the United States signed into law a Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010. This legislation includes a number of provisions that impact the health insurance industry, including provisions on increasing the number of insured members, new rules on guaranteed issue contracts, elimination of lifetime annual maximum caps on policy payments, coverage of dependent children on the parents' policy until age 26 and many others. The Company has calculated expected costs as a result of the reform and has adjusted premium rates accordingly. In addition, this legislation created health insurance exchanges. The Company is in the process of evaluating the impact of the exchanges on future business operations.

In February 2011, Oregon Legislature enacted Senate Bill 1580 that allows for the establishment of Coordinated Care Organizations (CCOs). The Company is reviewing the opportunity to apply for various CCOs.

16. Litigation and Contingent Liabilities

The Company, consistent with the insurance industry in general, is subject to litigation in the normal course of business. The Company's management does not believe that such litigation will have a material effect on its financial position.

During 2009, as part of the acquisition of PHI, an escrow account was established for $2,000,000. The escrow account was established to cover a contingent liability of PHI due to litigation. Upon settlement of the lawsuit by PHI, its insurance company will pay up to $2,000,000 with the balance of the possible settlement covered by the escrow fund. The lawsuit was settled during 2011 and the Company, PHI's former shareholders and the reinsurer are discussing payments from the escrow account.

17. Related Party Transactions

The Board of Trustees formed the PacificSource Charitable Foundation, Inc. (the Foundation). Certain trustees of the Company are also officers of the Foundation. As of December 31, 2011 and 2010, total assets (unaudited), consisting primarily of cash equivalents and marketable securities, were approximately $5,950,000 and $6,900,000, respectively. The Foundation is a public benefit corporation organized for the purpose of providing funds for the health and welfare of the poor and needy. It qualifies as a tax-exempt organization under Section 501(c)(3) of the Internal Revenue Code. During 2011 and 2010, the Company made a contribution of $0 and $1,000,000 to the Foundation, respectively.

18. Fair Value of Financial Instruments

The following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at December 31, 2011. Valuation techniques utilized to determine fair value are consistently applied.

The carrying amounts of financial instruments including accounts receivable, accounts payable and other short-term assets and liabilities approximate fair value, because of the relatively short maturity of these instruments.

The carrying values of notes payable approximate fair value, as their interest rates approximate current market rates.

Investments in debt and equity securities are classified as available-for-sale and are reported at fair value. These securites are traded in active markets and are valued at quoted market prices. They are generally categorized in Level One of the fair value hierarchy.

Certificates of deposit are traded in active markets and are valued at quoted market prices. These investments are generally categorized in Level One of the fair value hierarchy.

(Continued)

18. Fair Value of Financial Instruments (Continued)

Other invested assets consist of investments in partnerships that are accounted for using the equity method, which approximate fair market value. These investments generally trade in the secondary market and are categorized in Level Two of the fair value hierarchy.

Fair values of assets and liabilities measured on a recurring basis are as follows:

	Fair Value Measurement at December 31, 2011			
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Available-for-sale debt securities:				
U.S. Government debt securities	$ 14,060,871	$ 14,060,871	$ -	$ -
Mortgage/asset backed debt securities	47,190,368	47,190,368	-	-
Corporate debt securities	55,671,741	55,671,741	-	-
Total debt securities	116,922,980	116,922,980	-	-
Available-for-sale equity securities:				
Mutual funds	30,968,056	30,968,056	-	-
Certificates of deposit	2,611,738	2,611,738	-	-
Other invested assets	6,381,674	-	6,381,674	-

(Continued)

18. Fair Value of Financial Instruments (Continued)

	Fair Value Measurement at December 31, 2010			
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Available-for-sale debt securities:				
U.S. Government debt securities	$ 14,827,534	$ 14,827,534	$ -	$ -
Mortgage/asset backed debt securities	26,324,946	26,324,946	-	-
Corporate debt securities	38,573,860	38,573,860	-	-
Total debt securities	79,726,340	79,726,340	-	-
Available-for-sale equity securities:				
Mutual funds				
Value	11,822,685	11,822,685	-	-
Fixed income	8,396,289	8,396,289	-	-
Growth	7,987,367	7,987,367	-	-
Balanced	6,697,464	6,697,464	-	-
Total equity securities	34,903,805	34,903,805	-	-
Certificates of deposit	2,611,472	2,611,472	-	-
Other invested assets	7,812,454	-	7,812,454	-

(Continued)

18. Fair Value of Financial Instruments (Continued)

The following presents a summary of the Company's defined benefit plan investment assets measured at fair value:

	Fair Value Measurement at December 31, 2011			
Description	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Registered investment companies:				
Fixed income funds	$ 9,034,326	$ 9,034,326	$ -	$ -
Balanced funds	4,612,013	4,612,013	-	-
Growth funds	4,044,528	4,044,528	-	-
Value funds	3,337,838	3,337,838	-	-
Money market funds	3,257,966	3,257,966	-	-
Real estate funds	1,317,116	1,317,116	-	-
Total	$ 25,603,787	$ 25,603,787	$ -	$ -

	Fair Value Measurement at December 31, 2010			
Description	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Pooled separate accounts:				
Fixed income funds	$ 6,093,590	$ -	$ 6,093,590	$ -
Balanced funds	3,162,668	-	3,162,668	-
Growth funds	1,486,468	-	1,486,468	-
Value funds	1,467,134	-	1,467,134	-
Real estate funds	637,265	-	637,265	-
Total pooled separate accounts	12,847,125	-	12,847,125	-
Registered investment companies:				
Fixed income funds	3,346,850	3,346,850	-	-
Guaranteed interest fund	5,256,339	-	-	5,256,339
Total	$ 21,450,314	$ 3,346,850	$ 12,847,125	$ 5,256,339

(Continued)

18. Fair Value of Financial Instruments (Continued)

The following is a description of the valuation methodologies used for the Company's defined benefit plan investment assets measured at fair value.

The fair value of pooled separate accounts equals the number of shares owned in the underlying separate account multiplied by the closing net asset value per unit as quoted by the contract issuer. They are generally categorized in Level Two of the fair value hierarchy.

Registered investment companies are valued at quoted market prices. They are generally categorized in Level One of the fair value hierarchy.

The fair value of guaranteed accounts is calculated by discounting the related cash flows based on current yields of similar instruments with comparable durations. They are generally categorized in Level Three of the fair value hierarchy.

The following table presents additional information about Level Three assets measured at fair value. Both observable and unobservable inputs may be used to determine the fair value of positions that the Plan has classified within the Level Three category. As a result, the unrealized gains and losses from assets within the Level Three category may include changes in fair value that were attributable to both observable and unobservable inputs.

Fair Value Measurement Using Significant Unobservable Inputs (Level 3) - Guaranteed Interest Fund

Description	Fair Value
Level 3 balance, January 1, 2010	$ 3,205,944
Interest	148,184
Purchases, issuances and settlements	2,000,000
Distributions and fees	(97,789)
Level 3 balance, December 31, 2010	5,256,339
Interest	72,507
Purchases, issuances and settlements	1,000,000
Distributions and fees	(6,328,846)
Level 3 balance, December 31, 2011	$ -

19. Subsequent Events

On February 29, 2012, the Company purchased certain commercial health business from New West Health Services located in Helena, Montana, including large employer, association and individual policies through a bulk reinsurance transfer for up to $1.25 million.

20. Statutory Financial Information

PacificSource and PCHP, which are domiciled in Oregon, prepare their statutory basis financial statements in accordance with accounting principles and practices prescribed or permitted by the State of Oregon, Department of Consumer and Business Services, Insurance Division (Insurance Division). Oregon has adopted the NAIC's statutory accounting practices (NAIC SAP) as the basis of its statutory accounting practices.

In addition, the commissioner of the Insurance Division has the right to permit other practices that may deviate from prescribed practices. Prescribed SAP are those practices that are incorporated directly or by reference in state laws, regulations and general administrative rules applicable to all insurance enterprises domiciled in Oregon. Permitted SAP encompasses all accounting practices that are not prescribed; such practices differ from state to state, may differ from company to company within a state and may change in the future. PacificSource and PCHP follow the NAIC's SAP and do not have permitted practices that deviate from NAIC SAP. Therefore, PacificSource and PCHP's statutory capital and surplus are in accordance with NAIC SAP requirements.

SUPPLEMENTAL INFORMATION

PACIFICSOURCE HEALTH PLANS AND SUBSIDIARIES

Consolidated Schedules of General and Administrative Expenses

	Year Ended December 31	
	2011	2010
Salaries	$ 37,965,545	$ 32,197,206
Payroll taxes	3,376,709	2,923,368
Employee benefits	7,822,784	7,034,901
Retirement plans	3,831,429	2,900,184
Contract labor	349,498	289,142
Administrative expense, net	1,224,165	937,971
Advertising	2,579,446	2,634,580
Automobile expense	289,958	246,745
Banking charges	191,054	132,083
Board expenses	390,589	358,177
Building rent	1,229,140	1,089,634
Computer and software	244,188	301,664
Consultant fees	7,688,502	8,246,194
Depreciation and amortization	10,237,547	8,213,476
Dues and subscriptions	643,483	424,757
Insurance	801,900	632,861
Imaging expense	363,270	340,979
Legal fees	220,909	338,847
Professional accounting, state audit and actuarial services	485,722	466,161
Office and data processing supplies	678,718	434,108
OMIP assessments	6,839,689	6,411,252
Outside service fees	1,008,742	923,638
Postage	2,256,027	1,811,316
Printing expense	1,055,836	828,822
Repairs and maintenance	1,193,247	1,087,885
Taxes and licenses	5,099,168	3,733,115
Telephone	685,282	692,073
Travel and education	910,868	750,736
Utilities	226,220	195,893
Other	214,448	586,091
Merger and acquisition fees	-	1,037,324
Total	$ 100,104,083	$ 88,201,183

PACIFICSOURCE HEALTH PLANS AND SUBSIDIARIES
Consolidated Statement of Income
Year Ended December 31, 2011

Redacted:
This section redacted
Per ORS 192.410 - 192.505

ASSIGNMENT AND ASSUMPTION AGREEMENT
("Agreement")

Parties: **Central Oregon Independent Health Services, Inc. ("COIHS"),** an Oregon corporation

Central Oregon Individual Health Solutions, Inc. ("COIH Solutions") an Oregon corporation

State of Oregon, acting by and through its Department of Human Services ("Department"), Office of Medical Assistance Programs ("OMAP")

Effective Date: January 1, 2004

RECITALS

A. COIHS desires to assign to COIH Solutions all if its right, title and interest in and to Fully Capitated Health Plan Contract #107195 between COIHS and Department, dated October 1, 2003, as amended ("OMAP Contract"). The OMAP Contract does not include any other contract to which COIHS and Department may be parties.

B. COIH Solutions desires to assume, perform and discharge all of COIHS' duties, obligations and liabilities under the OMAP Contract.

C. Department desires to consent to COIHS' assignment of its right, title and interest in the OMAP Contract and to COIH Solutions' assumption of COIHS' duties, obligations and liabilities under OMAP Contract.

AGREEMENT

For good and valuable consideration, the receipt and adequacy of which are hereby acknowledged, COIHS, COIH Solutions, and Department agree as follows:

1. Assignment and Assumption of COIHS Duties, Obligations and Liabilities

COIHS hereby assigns to COIH Solutions all of COIHS' right, title and interest in and to the OMAP Contract. COIH Solutions hereby agrees to assume, perform and discharge all of COIHS' duties, obligations and liabilities under the OMAP Contract.

2. Nature and Quality of Services Under the OMAP Contract

COIH Solutions represents and warrants that the assignment of COIHS' right, title and interest in the OMAP Contract, and COIH Solutions' assumption of COIHS' duties, obligations and liabilities under the OMAP Contract, will not result in any material change in the nature or the quality of services provided thereunder.

3. Indemnity

COIH Solutions shall be responsible for, and shall indemnify and hold the State of Oregon harmless for, any and all liabilities, known or unknown, in relation to the OMAP Contract that are outstanding on or before the Effective Date, including any stop-loss claims awaiting OMAP decision, hysterectomy/sterilization issues or other recoupments or sanctions in process with OMAP staff. COIH Solutions shall indemnify and hold the State of Oregon harmless for any cost, loss or expense incurred by the State due, directly or indirectly, to COIHS' actions or omissions regarding such claims and liabilities, both known and unknown. COIHS shall indemnify and hold the State of Oregon harmless for any reasonable attorney fees incurred by the State due to COIHS' actions or omissions related to such claims and liabilities.

4. Reporting Obligations

a. COIHS

COIHS shall provide OMAP with all information due to be reported to OMAP by COIHS, including but not limited to, encounter data, membership enrollment/disenrollment date, and financial solvency reports, for all reporting obligations arising before the Effective Date.

b. COIH Solutions

COIH Solutions shall provide OMAP with all information due to be reported to OMAP by COIH Solutions, including but not limited to, encounter data, membership enrollment/disenrollment data, and financial solvency reports, for all reporting obligations arising on or after the Effective Date.

5. Net Worth and Restricted Reserve

a. Net Worth

COIH Solutions represents that it has or will have a net worth of at least one million six hundred thousand dollars ($1,600,000) as of the Effective Date.

b. Restricted Reserve

COIH Solutions represents that is has or will have at least two hundred fifty thousand dollars ($250,000) in its Primary Restricted Reserve account as of the Effective Date. COIH Solutions also represents that it has or will have at least one million two

hundred sixty thousand six hundred twenty seven dollars ($1,260,627) in its Secondary Restricted Reserve account, for a total Restricted Reserve of at least one million five hundred ten thousand six hundred twenty seven dollars ($1,510,627). COIH Solutions further represents that it has provided OMAP with a copy of the depository agreement setting up the restricted reserve account and a level of funds statement from the third party holding the funds.

6. Relationship Between COIHS and COIH Solutions

a. Stock Subscription. COIH Solutions is a wholly owned subsidiary of COIHS. As of the Effective Date, all of the issue and outstanding stock of COIHS Solutions is or will be owned by COIHS. COIHS and COIH Solutions each represent that COIHS has subscribed for and on or before the Effective Date will have purchased all of the issued and outstanding stock of COIH Solutions, paid in cash or cash equivalents assigned, transferred or otherwise paid to COIH Solutions by COIHS.

b. Assumption of COIHS Liabilities. As a condition to the purchase of COIH Solutions stock by COIHS, and in contemplation of the execution of this Agreement and the assumption of the OMAP Contract by COIH Solutions, COIH Solutions has assumed certain liabilities of COIHS directly related to the OMAP Contract, in particular (i) current estimated "incurred but not reported" (IBNR) claims in such amount as recorded on the books of COIHS as of December 31, 2003 and (ii) current provider withhold payments as recorded on the books of COIHS as of December 31, 2003 (the "Liabilities"). The Liabilities represent approximately seven million nine hundred thirty seven thousand two hundred seventy six dollars ($7,937,276). In order to offset the Liabilities assumed by COIH Solutions, on or before the Effective Date, COIHS shall execute a promissory note, payable upon demand by COIH Solutions and secured by an unconditional pledge of certain investments assets held in the name of COIHS, the amount of which promissory note shall equal the Liabilities assumed by COIH Solutions. COIHS and COIH Solutions agree that COIH Solutions shall not forgive any amount of the principal due under the promissory note described herein or shall not amend or terminate prior to COIHS' payment in full the promissory note described herein, without first giving the Department ninety (90) days written notice thereof.

7. Net Worth and Restricted Reserve Maintenance

Notwithstanding COIH Solutions' assumption of obligations under this Agreement or any other provision in this Agreement, COIHS agrees, guarantees and warrants that if COIH Solutions fails to maintain its net worth or to maintain its restricted reserves, or to maintain both, as required under Section 5(U) of the OMAP Contract, then COIHS shall, at its election, undertake one of the following:

a. Immediately take one or more of the following actions to bring COIH Solutions into compliance with the OMAP Contract: (i) pay directly to any third parties all financial obligations necessary to maintain COIH Solutions' compliance with the net worth and restricted reserve obligations under the OMAP Contract; (ii) provide sufficient

funds to COIH Solutions to satisfy COIH Solutions' net worth and restricted reserve obligations under the OMAP Contract; or (iii) deposit sufficient funds directly into the restricted reserve account required under Section 5(U) of the OMAP Contract to satisfy COIH Solutions' restricted reserve obligations thereunder; or

b. As the sole shareholder of COIH Solutions, cause COIH Solutions to terminate the OMAP Contract within the terms thereof, pay to COIH Solutions any amounts remaining under the promissory note identified in Section 6.b hereto, and take such further actions as are necessary to dissolve COIH Solutions and wind up its affairs.

8. Assignment; Successors and Assigns

COIH Solutions shall not assign or transfer any of its interest in the OMAP Contract without Department's prior written consent. The provisions of this Agreement shall be binding upon and shall inure to the benefit of the parties hereto, and their respective successors and permitted assigns, if any.

9. No Third Party Beneficiaries

COIHS, COIH Solutions, and Department are the only parties to this Agreement and are the only parties entitled to enforce its terms. Nothing in this Agreement gives, is intended to give, or shall be construed to give or provide any benefit or right, whether directly, indirectly or otherwise, to third persons unless such third persons are individually identified by name herein and expressly described as intended beneficiaries of the terms of this Agreement.

10. Governing Law; Venue; Consent to Jurisdiction

This Agreement shall be governed and construed in accordance with the laws of the State of Oregon without regard to principles of conflicts of law. Any claim, action, suit or proceeding (collectively, "Claim") between Department and either COIHS or COIHS Solutions, or both, that arises from or relates to this Agreement shall be brought and conducted solely and exclusively in the Circuit Court for Marion County, State of Oregon; provided, however, that if a Claim must be brought in a federal forum, then it shall be brought and conducted solely and exclusively within the United States District Court for the District of Oregon. In no event shall this provision be construed as a waiver of the State of Oregon's sovereign immunity.

11. Scope of Assignment and Assumption

COIHS, COIH Solutions and Department agree that all other obligations of COIHS to Department under contracts other than the OMAP Contract remain in full force and effect and are not affected as a result of assignment by COIHS and assumption by COIH Solutions of COIHS' duties, obligations and liabilities under the OMAP Contract. This Agreement does not relieve COIHS of any outstanding obligations it may have

under any other contract between COIHS and Department, including any obligation to comply with Department's right to withhold and recoup any amount as provided under those contracts and any obligation to comply with any sanctions issued under those contracts.

12. Counterparts

This Agreement may be executed in several counterparts, all of which when taken together shall constitute one agreement binding on all parties, notwithstanding that all parties are not signatories to the same counterpart. Each copy of the Agreement so executed shall constitute and original.

13. Consent

COIHS, COIH Solutions and Department each consent to all of the provisions of this Agreement.

CCHP / COIHS merged.

Central Oregon Independent Health Services

By: Cynthia Kane

Title: Chief Operating Officer

Date: 12.23.03

OHP

Central Oregon Individual Health Solutions

By: Cynthia Kane

Title: Chief Operating Officer

Date: 12.23.03

State of Oregon by and through its Department of Human Services, Office of Medical Assistance Programs

By: Jennie Edge

Title: Asst Adm. OMAP

Date: 12/23/03

GBNII6506

Attachment 1 Appendix E - Financial Reporting and Solvency Questionnaire

Attachment 8 Tables: E-1 Pro Forma Projections for the First Five Years

This section redacted
Per ORS 192.410 - 192.505

The State of Oregon, Oregon Health Authority
Request for Applications for Coordinated Care Organizations (CCOs)
RFA 3402

Attachment 1 Appendix E - Financial Reporting and Solvency Questionnaire

Attachment 8 Tables: E-1 Pro Forma Projections for the First Five Years

This section redacted
Per ORS 192.410 - 192.505

SPECIFIC EXCESS OF LOSS REINSURANCE BINDER

This section redacted
Per ORS 192.410 - 192.505

APPENDIX F – Global Budget Questionnaire

1. Global Budget Methodology

Section 1 - General Questions Regarding Global Budgeting

F.1.1 PSCS has demonstrated experience and capacity for operating within a fixed global budget. PSCS and its affiliated entities, PacificSource Community Health Plans and PacificSource Health Plans have extensive experience managing financial risk. The consolidated entities manage premiums in excess of $1B and carry an AM Best rating of B++. PSCS has long-term experience in receiving and managing to a global budget under the current MCO process. Additionally, it has significant experience in establishing reserves and the organizational capacity to manage within a fixed global budget.

F.1.2 PSCS can provide, on a full risk basis, all services currently provided by Medicaid physical health and mental health. It is expected that PSCS will provide, on a full risk basis, all dental services by 2014 if not before.

F.1.3 PSCS has engaged with non-emergent medical transportation providers and is expecting to have necessary relationships, processes and systems in place to provide non-emergent medical transportation benefit to PSCS members by January 1, 2013.

F.1.4 PSCS is currently in discussions with Advantage Dental. It is anticipated that dental will be integrated as early as August 1, 2012, but in no event later than January, 2014.

F.1.5 PSCS can provide, under full risk contract, all programs and services currently provided as Medicaid benefits and outlined in Attachment 8, Table F-1 for inclusion in global budgets as of the requested Medicaid effective date. Those services listed as optional are still under consideration.

F.1.6 The optional programs and services outlined in Table F-1 for inclusion in global budgets are under consideration and decisions will be made as the CCO continues to evolve.

F.1.7 As noted in Appendix H and in Appendix A, PSCS CCO is still evolving and will continue to evolve over the next 18 months. As such, PSCS is expecting that flexibility and room for innovation will be needed in order to invest in care that will decrease costs and achieve better outcomes. It is too premature to identify the specific details of flexibility and innovation during the early evolution of the CCO.

F.1.8 PSCS does not anticipate the need to subcontract a portion of the health care delivery system.

F.1.9 Please find PSCS's completed Base Cost Template in the attached Attachment 8, Table F-2.

Notice for the Release of CCO Cost Template Verson 4 (effective May 23, 2012)

This section redacted
Per ORS 192.410 - 192.505

The member website includes Health Coach 4 Me which includes information on Diet and Nutrition, Exercise and Activity, Medicine, Smoking Cessation, Stress Management, Vaccination, Weight Management and chronic conditions such as Asthma, Breast Cancer, COPD, Diabetes, Heart Disease, and Migraine. Members with chronic conditions are encouraged by case managers to enroll in local Living Well with Chronic Conditions programs. Living Well with Chronic Conditions (the Chronic Disease Self-Management Program or CDSMP) is a six-week workshop that provides tools for living a healthy life with chronic health conditions, including diabetes, arthritis, asthma and heart disease. Through weekly sessions, the workshop provides support for continuing normal daily activities and dealing with the emotions that chronic conditions may bring about.

C.2.3.d. PSCS has experience in 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 PSCS. PSCS underwent review by the External Quality Review organization and were found to have Fully Met the ISCA requirements. PSCS has policies and procedures in place which will encourage and provide guidance for collection of necessary electronic data and other data. Experienced staff is able to produce reports from the data warehouse. Other PSCS Staff have experience in producing HEDIS reports and validating the results as well as producing measures from medical record collection. As noted above, PSCS has reporting systems that integrate member demographics, disease burden and claims history. This data is overlaid with Clinical Intelligence Rules which help to identify members meeting specific criteria. This reporting system will assist PSCS in collecting data to meet performance benchmarks.

C.2.3.e. PSCS has implemented other strategies to improve patient care outcomes, decrease duplication of services, and make processes more efficient as referenced above through current reporting capabilities and coordination of care processes.

In addition, PSCS has a weekly Integrated Care Management meeting (ICM). The ICM meeting is designed as a collaborative effort to address gaps in care and bring community partners and resources together to bring the appropriate care and utilization of health services. A care plan is then initiated and the case manager, care coordinator, pharmacist and/or behavioral health specialist works with the PCPs office, member and community partners such as the brokerage, transportation office, disability offices, member's state case worker, specialist's office, home health provider to develop a targeted, consistent approach. Once the member or member's representative is successfully engaged, the member is transitioned from the ICM workgroup to ongoing assessment and coordination with their nurse case manager. Six months after discharge from the ICM group, the member's prospective risk score is re-assessed and brought back to the ICM group if thresholds are again met.

Examples of Success with ICM:

1. Member had a stroke and had to be revived.

At first contact, member was very depressed and was unaware of available resources and having a very difficult time navigating the system.

Between the ENCC Transitional Care Coordinators and the Nurse Case Manager, working with the member, the member has been connected with several resources. Member complex issues were discussed in a weekly ICM meeting. Member was given American Blind Association information where member can order free books, other media choices and have access to other resources. PSCS worked with member and found providers in closer proximity to member. Member has been connected with a mental health (MH) provider. Member has been given information on how to obtain much needed dentures (nutrition issue) with this dental plan. Member has been given several other resources including transportation information.

2. When a member called Grievance and Appeals, staff referred the member to PSCS Care Coordinators. Upon calling the member, the Care Coordinator learned that member had been told the other pain clinic in town had a three month wait before next appointment. Knowing it was a Monday and member only had 2 more days of pain meds on hand (and the clinic the member had been dismissed from was not going to refill anymore), member was very frustrated and "ready to give up on insurance and doctors all together". Member was bed ridden after a failed back surgery and needed assistance with all ADL's. After Care Coordinator discussed with other staff, it was realized there was a pain clinic in town that was currently going through the credentialing process, but was not yet contracted. After calling and making arrangements, PSCS Care Coordinator was able to approve visits to the out-of-network provider to get the member the care needed. Member had an appointment that Friday morning which was four days out. Staff called and followed up that next Tuesday and member is able to move around and able to start caring for self and doing all ADL's independently.

C.2.3.f PSCS has 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 authorizations.

Care Coordination services may be requested by the member, the member's representative, physician, other medical personnel serving the member, or the member's agency case manager. Care coordination will be identified through wellness survey scoring as well as prospective risk scores generated by our claims analysis software, Ingenix & Thomson Reuters. Interpreter Services (including sign language) are covered for doctor visits for members who do not speak English or have a hearing impairment. These services are available by phone or in person.

Transitional Care Coordinators make outbound phone calls to all members meeting threshold criteria and ask a series of questions designed to identify gaps in care, barriers to access, educational need, and the need for referral to case management by an RN or BH specialist. Care Coordinators and case managers complete assessment forms that are based on NCQA standards. If members are not able to be contacted after two outbound phone calls, a "Cannot Reach" letter