Trillium Community Health Plan | P.O. Box 11756 Eugene, Oregon 97440-3956

ATTACHMENT 1 – Application Cover Sheet

Applicant Information - RFA # 3402

Applicant Name: Trillium Community Health Plan

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

State of domicile: Oregon

Primary Contact Person: Terry W. Coplin Title: CEO, Director/Secretary

Address: 1800 Millrace Drive

City, State, Zip: Eugene, Oregon 97403

Telephone: (541)345-9937 Fax: (541) 434-1109

E-mail Address: tcoplin@trilliumchp.com

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

Name: Terry W. Coplin Title: 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.

Trillium Community Health Plan
P.O. Box 11756
Eugene, Oregon 97440-3956

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: CEO Date: 04.23.12

(Authorized to Bind Applicant)

ATTACHMENT 6 – ATTESTATIONS, ASSURANCES AND REPRESENTATIONS

Applicant Name: **Trillium Community Health Plan**

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	Yes			

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
• Provider relations and network management, including credentialing • Health information technology and medical records • Privacy officer • Compliance officer				
Attestation A-2. Applicant will participate in the learning collaboratives required by ORS 442.210.	Yes			
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.	Yes			

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.	Yes			
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.	Yes			
Attestation B-3. Applicant will assure that all provider and supplier	Yes			

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
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 Covered Services throughout the requested service area.			Yes, Qualified	We will have such contracts executed by the readiness review date.
Attestation B-5. Applicant will have all provider contracts or agreements available upon request.			Yes, Qualified	We will have such contracts available once fully - executed.
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.	Yes			
Attestation B-7. Applicant's contracts for administrative and management services will contain the OHA required contract provisions.	Yes			
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.	Yes			
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.			Yes, Qualified	We will have such contracts executed by the readiness review date.
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:	Yes			

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
• 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; • 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.	Yes			
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.	Yes			
Attestation B-13. Applicant will provide all services covered by Medicaid and comply with OHA coverage determinations.	Yes			
Attestation B-14. Applicant, Applicant staff and its affiliated	Yes			

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
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 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.	Yes			No State or Federal government has brought any past actions listed herein.

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]	Yes			
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]	Yes			

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]	Yes			
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]	Yes			
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]	Yes			

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 1 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]	Yes			
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]	Yes			
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]	Yes			
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]	Yes			
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	Yes			

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]	Yes			
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]	Yes			
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	Yes			

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]	Yes			

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.	Yes			
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.			Yes, Qualified	We will have such a contract with delegated entity by the readiness review date.
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.			Yes, Qualified	We will have such a contract with delegated entity by the readiness review date.
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.			Yes, Qualified	We will have such a contract with delegated entity by the readiness review date.
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.		No		This function will be performed in-house.
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.			Yes, Qualified	We will have such a contract with delegated entity by the readiness review date.

Informational Representation	Yes	No	Yes, Qualified	Explanation
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.			Yes, Qualified	We will have such a contract with delegated entity(ies) by the readiness review date.
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.			Yes, Qualified	We will have such a contract with delegated entity(ies) by the readiness review date.
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.		No		This function will be performed in-house.
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.		No		This function will be performed in-house.
Representation B-11. 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.			Yes, Qualified	We will have such contracts in place by the readiness review date.
Representation B-12. 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.	Yes			

(Applicant Authorized Officer)

Signature: _____ Title: CEO Date: 04.29.2012

Terry Coplin

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).[1]

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).

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

Bethel School District # 52
4640 Barger Drive • Eugene, OR 97402 • Phone: (541) 689-3280
Fax: (541) 689-0719 • www.bethel.k12.or.us

Together we will reach, teach, and inspire each student to excellence

April 10, 2012

Dear Oregon Health Authority,

The Bethel School District supports the application being submitted by Trillium, on behalf of all of Lane County, to create a Lane Coordinated Care Organization. This organization will be built on the excellent existing organizational structures developed by Lipa and Lane County (LaneCare), thereby limiting the likelihood of new administrative costs.

School Districts have been closely following the development of Coordinated Care Organizations (CCO), from the initial concept through these final steps toward implementation. We have watched a substantial community engagement process that has incorporated input from providers, OHP members and their advocates, community members, and system partners, including schools. Along with the rest of the community, we strongly support a single application to form a CCO that provides integrated care for all residents of Lane County that are OHP members. As appropriate, in the future the CCO will incorporate Medicare and other funding streams and insurance products into an integrated health care system.

The CCO proposed by Lane County and Lipa will be a co-managed administrative organization that incorporates existing provider networks and supports the continuity of delivery system strengths. The new organization will also achieve administrative savings through the development of integrated and efficient management structures.

Our community continues to discuss strategies for enhancing person-centered primary care medical homes, integrating behavioral health and physical health and identifying high-risk high-cost patients where savings can be achieved through better care coordination. We look forward to the creation of the CCO Governance Board that will help guide the development of the CCO and, more importantly, will set policy and procedures for service delivery change strategies so that we can better meet the Triple Aim. We suggest school representation be invited into appropriate governance or advisory committees.

School Districts have long advocated for some essential strengths of the existing behavioral health delivery system that must be sustained in the future. These include:

1. An ongoing relationship with the County that incorporates the noteworthy success of LaneCare (the County-operated MHO) and supports for mental health services for kids and in schools, including day treatment and ICTS supports.

2. Ongoing financial support for prevention, education and outreach projects, particularly those that support school based family resource centers.

3. Support for the youth system enhancements that LaneCare currently funds, such as the Young Adults in Transition program and the Early Childhood mental health programs.

We strongly support this application and encourage the creation of the Lane CCO at the earliest possible opportunity.

Sincerely,

Mindy J. Le Roux
Assistant Director, Special Services

BETHEL
SCHOOL DISTRICT
Together we will reach, teach and inspire each student to excellence

April 20, 2012

Dear Oregon Health Authority,

Bethel School District recognizes the direct link between healthy children and their ability to learn, and in turn become more productive members of society. We seek to promote student health and help enable access to adequate and efficient health care, and that is why Bethel proudly opened its School -Based Health Center.

This is also why Bethel School District supports the application being submitted by Trillium on behalf of all of Lane County to create a Lane Coordinated Care Organization. With the Bethel Student Health Center included, this organization will be built on the excellent existing organizational structures developed by Lipa and Lane County (LaneCare), thereby limiting the likelihood of new administrative costs.

There has been a community engagement process incorporating input from the Bethel Student Health Center, a wide variety of other providers, OHP members and their advocates, community members and system partners. As a community we have agreed to support a single application to form a CCO that provides integrated care for all residents of Lane County that are OHP members. In the future the CCO will incorporate Medicare and other funding streams and insurance products into an integrated health care system.

Our students will receive more efficient and cost-effective medical care at the Bethel Student Health Center through an administrative organization co-managed by Lane County and Lipa. This would incorporate existing provider networks and continue supporting the strengths of our current delivery systems. Administrative savings would also be achieved through the development of integrated and efficient management structures.

The current discussion now includes creative strategies on how real savings can be achieved through better care coordination. It is the same type of resourceful approach that allows school districts such as ours to continually provide better educational opportunities at reduced costs. A single Lane CCO is truly an integrated and inclusive approach that will effectively support Bethel students and all of Lane County.

Bethel School District, through its Student Health Center, will eagerly participate in the CCO as a provider and a partner on the appropriate committees. On behalf of our students, the District supports this application and encourages the creation of the Lane CCO at the earliest opportunity possible.

Sincerely,

Colt Gill
Superintendent
Bethel School District

Capitol Dental Care, Inc.

3000 Market Street NE, Suite 228 • Salem, OR 97301 • (503) 585-5205 • Fax: (503) 581-0043

Dear Oregon Health Authority,

Capitol Dental Care, Inc.(CDC) is a current DCO and has been providing dental services to the Oregon Health Plan since its inception in 1994.

CDC supports the application being submitted by Trillium to create a Regional Coordinated Care Organization. This organization will be built on the excellent existing organizational capacities and structures developed over the past 15 years by Lipa and Lane County (LaneCare). Building from existing infrastructure will reduce the capital requirements for meaningful delivery system reform.

There has been a substantial community engagement process that has incorporated input from providers, OHP members and their advocates, community members, and system partners. The community has agreed to support a single application to form a CCO that provides integrated care for the residents of Lane County. As appropriate, in the future the CCO will incorporate Medicare and patient populations into an integrated health care system.

Lane County and Lipa will create a co-managed administrative organization that incorporates existing provider networks and supports the continuity of delivery system strengths. The new organization will also achieve administrative savings through the development of integrated and efficient management structures.

The CCO will form a Governance Board that will help guide the development of the CCO and, more importantly, will set policy and procedures for service delivery change strategies so that we can better meet the Triple Aim. The community is discussing strategies for enhancing person-centered primary care medical homes, integrating behavioral health and physical health and identifying high risk high cost patients where savings can be achieved through better care coordination.

My organization fully supports Trillium's application.

Sincerely,

William Hart Laws
President

cascade
HEALTH SOLUTIONS

2650 Suzanne Way
Suite 200
Eugene, OR 97408
p (541) 228-3000
f (541) 228-3180

Divisions

Home Care Services
- Home Health
- Hospice
- Lifeline

Occupational Health Services
- Occupational Medicine
- MedExpress
- Workers' Action Program
- DIRECTION
  - -Employee Assistance
  - -Behavioral Health Services
  - -COPES
- Corporate Health & Wellness

Community Services
- Active Lives, Active Minds
- Membership-Based Primary Care Clinic
- Nutrition Education
- Prescription Assistance Program

Cascade Health Foundation
- Festival of Trees

April 25, 2012

Dear Oregon Health Authority:

Cascade Health Solutions is a non-profit health care organization in Lane County that is dedicated to improving quality of life in our community by providing quality, charitable and compassionate health care. Our services are diverse but focus on providing health solutions at home, at work, and in the community. Our major services include an Occupational Medicine Clinic, a physical and occupational therapy department, a medic unit that responds to non-emergency injuries, wellness services for local employers, a primary care clinic for the uninsured, a prescription assistance program, a diabetic education program, a home health agency that has been recognized as one of the top in the nation, a transitions program for end of life care, a Lifeline alert system and an excellent hospice service. Cascade has plans to build and operate a hospice house to meet an unmet health need in our community. Our focus is to work in collaboration with referring physicians, the physician community as a whole, and other health care providers to positively impact health outcomes for our shared patients, to offer a superior patient experience, and to provide cost effective health care.

Cascade Health Solutions supports the application being submitted by Trillium to create a Regional Coordinated Care Organization. This organization will use as a foundation the existing organizational structures utilized by LIPA and Lane County. It will also incorporate community input with a strong emphasis on collaboration with community health care providers while utilizing existing provider networks. The community has agreed to support a single application to form a CCO that provides integrated care for the residents of Lane County and believes that the model that is proposed by Trillium is the best.

A major emphasis of the CCO will be to develop a governance structure, policies, and procedures that can achieve the Triple Aim. The community is currently engaged in discussions to enhance primary care medical homes, integration of behavioral health and physical health, and identifying high risk, high cost patients where savings can be achieved through better care coordination and support. These initiatives will be incorporated into the CCO.

Cascade Health Solutions fully supports Trillium's application.

Sincerely,

Cheryl Boyum, CEO

Center for Family Development
Serving the community since 1991

Mailing Address:
1258 High Street
Eugene OR 97401

Email: main@c-f-d.org
Website: www.c-f-d.org

Physical Locations:
CFD Main
1258 High Street
Eugene, OR 97401
Phone: (541) 342-8437
Fax: (541) 342-1639

CFD Central/Annex
1234 High Street
Eugene, OR 97401
Phone: (541) 342-8437
Fax: (541) 242-2999

CFD West
146 E. 12th Avenue
Eugene, OR 97401
Phone: (541) 342-4189
Fax: (541) 342-4231

Director
David Mikula, L.C.S.W.

Assistant Director
Shanti Rios

Center for Family Development
1258 High Street
Eugene, Oregon
97401

April 17, 2012

Dear Oregon Health Authority,

Center for Family Development is a Behavioral Health Provider in Lane County with a wide array of services for Medicaid and Medicare clients. Currently we have three outpatient chemical dependency programs, specially designed to address co-occurring disorders, outpatient mental health programs for children, adolescents, and adults, an intensive mental health program, programs specifically designed for Latino clients, a sex offender adult recovery program, and several programs designed and delivered in collaboration with the juvenile justice system.

Center for Family Development supports the application being submitted by Trillium to create a Regional Coordinated Care Organization. This organization will be built on the excellent existing organizational capacities and structures developed over the past 15 years by Lipa and Lane County (LaneCare). Building from existing infrastructure will reduce the capital requirements for meaningful delivery system reform.
There has been a substantial community engagement process that has incorporated input from providers, OHP members and their advocates, community members, and system partners. The community has agreed to support a single application to form a CCO that provides integrated care for the residents of Lane County. As appropriate, in the future the CCO will incorporate Medicare and patient populations into an integrated health care system.

Lane County and Lipa will create a co-managed administrative organization that incorporates existing provider networks and supports the continuity of delivery system strengths. The new organization will also achieve administrative savings through the development of integrated and efficient management structures.

The CCO will form a Governance Board that will help guide the development of the CCO and, more importantly, will set policy and procedures for service delivery change strategies so that we can better meet the Triple Aim. The community is discussing strategies for enhancing person-centered primary care medical homes, integrating behavioral health and physical health and identifying high risk high cost patients where savings can be achieved through better care coordination.
My organization fully supports Trillium's application.

Sincerely,

David J. Mikula

David J. Mikula, LCSW, CADC III, NCAC II
Director

Community Behavioral Health Consortium

April 5, 2012

Oregon Health Authority
500 Summer Street NE
Salem, OR 97301

Dear Reviewers,

The Lane County Community Behavioral Health Consortium (CBHC) and its member organizations strongly support the application being submitted to form a Lane County Coordinated Care Organization. The CBHC represents 17 community mental health and substance abuse treatment providers that serve Lane County. Together we have a combined budget of more than $76,000,000, serve over 46,000 clients (duplicated), and have 1,097 full-time equivalent employees. Over the past 15 years this group of provider organizations has joined together to serve the diverse needs of our community. The CBHC provides collaborative, accountable, cost-effective, and seamless service delivery.

There has been a community engagement process that has incorporated input from providers, OHP members and their advocates, community members, and system partners. The community has agreed to support a CCO that provides integrated care for all residents of Lane County that are OHP members.

A Governance Board will guide the CCO and set policy and procedures for service delivery strategies so that the group can better meet the Triple Aim. The CCO will enhance person-centered primary care medical homes; integrate behavioral health and physical health; and identify high risk/high cost patients where savings can be achieved through better care coordination.

The Community Behavioral Health Consortium believes that broad based community involvement and input will improve healthcare in Lane County. Our member organizations will participate in the CCO as providers and partners, ensuring a continuum of services that can improve the lives of the individuals who depend on us. We look forward to implementing the Lane County CCO.

Best Regards,

Marshall Peter, CBHC Chairperson

Craig Opperman, CBHC Representative
Lane County CCO Steering Committee

Center for Family Development - Centro LatinoAmericano - Direction Service - Emergence addiction and behavioral therapies Jasper Mountain - Lane County Behavioral Health - Laurel Hill Center - Looking Glass Youth & Family Services Options Counseling Services of Oregon - OSLC Community Programs - PeaceHealth Behavioral Health Outpatient Relief Nursery - ShelterCare - South Lane Mental Health - The Child Center - White Bird Clinic - Willamette Family, Inc.

Oregon
John A. Kitzhaber, MD, Governor

Department of Human Services
Eugene McKenzie Center
2885 Chad Drive
Eugene, OR 97408
Phone: 541-686-7878
FAX: 541-686-7641
TTY: 541-686-7528

DHS

Dear Oregon Health Authority,

The Department of Human Services District 5 which provides Child Welfare and Self Sufficiency services in Lane County supports the application being submitted by Trillium on behalf of all of Lane County to create a Lane Coordinated Care Organization. This organization will be built on the excellent existing organizational structures developed by Lipa and Lane County (LaneCare) thereby limiting the likelihood of new administrative costs.

There has been a substantial community engagement process that has incorporated input from providers, OHP members and their advocates, community members, and system partners. The community has agreed to support a single application to form a CCO that provides integrated care for all residents of Lane County that are OHP members. As appropriate, in the future the CCO will incorporate Medicare and other funding streams and insurance products into an integrated health care system.

Lane County and Lipa will create a co-managed administrative organization that incorporates existing provider networks and supports the continuity of delivery system strengths. The new organization will also achieve administrative savings through the development of integrated and efficient management structures.

The CCO will form a Governance Board that will help guide the development of the CCO and, more importantly, will set policy and procedures for service delivery change strategies so that we can better meet the Triple Aim. The community is discussing strategies for enhancing person-centered primary care medical homes, integrating behavioral health and physical health and identifying high risk high cost patients where savings can be achieved through better care coordination.

I believe that the development of the Lane CCO has and will continue to incorporate community input to assure the improvement of health care delivery in Lane County. DHS District 5 will participate in the CCO as a partner who serves low income families on the appropriate committees. We support this application and encourage the creation of the Lane CCO at the earliest opportunity possible.

Sincerely,

John Radich, Manager

DHS District 5

emergence
addiction and behavioral therapies

Dear Oregon Health Authority,

Emergence, *addiction and behavioral therapies*

Emergence supports the application being submitted by Trillium on behalf of all of Lane County to create a Lane Coordinated Care Organization. This organization will be built on the excellent existing organizational structures developed by Lipa and Lane County (LaneCare) thereby limiting the likelihood of new administrative costs.

There has been a substantial community engagement process that has incorporated input from providers, OHP members and their advocates, community members, and system partners. The community has agreed to support a single application to form a CCO that provides integrated care for all residents of Lane County that are OHP members. As appropriate, in the future the CCO will incorporate Medicare and other funding streams and insurance products into an integrated health care system.

Lane County and Lipa will create a co-managed administrative organization that incorporates existing provider networks and supports the continuity of delivery system strengths. The new organization will also achieve administrative savings through the development of integrated and efficient management structures.

The CCO will form a Governance Board that will help guide the development of the CCO and, more importantly, will set policy and procedures for service delivery change strategies so that we can better meet the Triple Aim. The community is discussing strategies for enhancing person-centered primary care medical homes, integrating behavioral health and physical health and identifying high risk high cost patients where savings can be achieved through better care coordination.

I believe that the development of the Lane CCO has and will continue to incorporate community input to assure the improvement of health care delivery in Lane County. My organization will participate in the CCO as a provider and or a partner on the appropriate committees. We support this application and encourage the creation of the Lane CCO at the earliest opportunity possible.

Sincerely,

Michael Bean
Executive Director
Emergence, Inc.
2149 Centennial Plaza #4
Eugene, Or 97401
541-393-0777 X301
mbean@4emergence.com

2149 Centennial Plaza, Suite 4
P.O. Box 7125
Eugene, Oregon 97401

541.687.8820
541.687.9279 fax

www.4emergence.com

eugene mission
Hope for the homeless since 1956

1542 West 1st Avenue | PO Box 1149
Eugene, OR 97440
Phone (541) 344-3251 | Fax (541) 344-7533
www.eugenemission.org

April 9, 2012

Dear Oregon Health Authority,

I am the Executive Director of the Eugene Mission, the largest homeless shelter in Lane County. Daily we serve approximately 600 men, women and children homeless guests.

The Eugene Mission supports the application being submitted by Trillium on behalf of all of Lane County to create a Lane Coordinated Care Organization. As I understand it, this organization will be built on the excellent existing organizational structures developed by Lipa and Lane County (LaneCare) limiting the likelihood of new administrative costs.

There has been a substantial community engagement process including input from providers, OHP members and their advocates, community members, and system partners. The community has agreed to support a single application to form a CCO that provides integrated care for all residents of Lane County that are OHP members. As appropriate, in the future the CCO will incorporate Medicare and other funding streams and insurance products into an integrated health care system. Many of our Mission guests have OHP so this will be a benefit to them.

As I understand it, Lane County and Lipa will create a co-managed administrative organization that incorporates existing provider networks and supports the continuity of delivery system strengths. The new organization will also achieve administrative savings through the development of integrated and efficient management structures.

I believe that the development of the Lane CCO has and will continue to incorporate community input to assure the improvement of health care delivery in Lane County. The Eugene Mission will participate in the CCO as a provider and or a partner on the appropriate committees. We support this application and encourage the creation of the Lane CCO at the earliest opportunity possible.

Sincerely,

Jack Tripp

Jack Tripp

Executive Director, Eugene Mission

School District 4J
Eugene Public Schools
200 North Monroe Street
Eugene, OR 97402-4295

April 11, 2012

Oregon Health Authority:

The Eugene School District 4J supports the application being submitted by Trillium, on behalf of all of Lane County, to create a Lane Coordinated Care Organization. This organization will be built on the existing organizational structures developed by LIPA and Lane County (LaneCare).

The Eugene School District 4J, as well as other school districts in our county, have been closely following the development of Coordinated Care Organizations. We have watched an inclusive community engagement process that has incorporated input from providers, OHP members and their advocates, community members, and system partners, including schools. Along with our community partners, we strongly support a single application to form a CCO that provides integrated care for all residents of Lane County that are OHP members. The CCO proposed by Lane County and LIPA will be a co-managed administrative organization that incorporates existing provider networks and supports the continuity of delivery system strengths. The new organization will also achieve administrative savings through the development of integrated and efficient management structures.

Our community continues to discuss strategies for enhancing person-centered primary care medical homes, integrating behavioral health and physical health, and identifying high-risk high-cost patients where savings can be achieved through better care coordination. We look forward to the creation of the CCO Governance Board that will help guide the development of the CCO and, more importantly, will set policy and procedures for service delivery change strategies so that we can better meet the Triple Aim. We suggest that school district representatives be invited into appropriate governance or advisory committees.

School Districts have long supported and advocated for the current behavioral health delivery system that must be sustained in the future. These include:

1. An ongoing relationship with the County that incorporates the success of LaneCare (the County-operated MHO) and supports for school-based mental health services as well as day treatment and ICTS supports.

2. Ongoing financial support for prevention, education and outreach projects, particularly those that support school-based family resource centers.

3. Support for the youth system enhancements that LaneCare currently funds, such as the Young Adults in Transition program and the Early Childhood mental health programs.

The Eugene School District 4J strongly supports this application. And, if you have any questions or need more information, please call me.

Sincerely,

Larry Sullivan PhD

Larry Sullivan, PhD
Director – Educational Support Services
School Psychologist
Eugene School District 4J
Member – Community Health Centers Advisory Committee
Member – Lane County Mental Health Advisory Committee

HEAD START of LANE COUNTY
221 B Street · Springfield OR 97477-4522
(541) 747-2425 · FAX (541) 747-6648 · http://www.hsolc.org
"Ensuring that our youngest children have a solid foundation for life."

April 18, 2012

Dear Oregon Health Authority,

Head Start of Lane County, a federal Head Start and Early Head Start grantee serving 1080 low-income families in 22 locations across Lane County Oregon is in support of the application being submitted by Trillium to create a Regional Coordinated Care Organization (CCO).

Head Start of Lane County had had many opportunities to engage with the existing medical care infrastructure that has been developed by Lipa and Lane County in our role of assisting low-income families with access to medicaid services. Building from this existing infrastructure will be far more cost effective in the long run; and will enable existing relationships with advocacy groups like ours to stay engaged in the process. It is our expectation that one CCO for Lane County will improve access to care for our clients; while also meeting and maintaining a standard of care that aligns with AAP and EPSDT guidelines for appropriate pediatric care.

Head Start of Lane County is appreciative of the opportunity to be involved in the unusual community engagement process that incorporated input from providers, OHP members and their advocates, community members, and system partners. We are part of a broader healthcare community in Lane County that has agreed to support a single application to form a CCO that provides integrated care for the residents of Lane County. Since Head Start of Lane County already has existing agreements with Lane County and Lipa regarding screening, assessment and referrals of Head Start children that are enrolled in Medicaid; we are pleased that Lane County and Lipa will create a co-managed administrative organization that incorporates existing provider networks and supports the continuity of delivery system strengths. It is likely that this new organization will allow for the development of even more integrated and efficient management structures.

Once the CCO has formed their Governance Board we will recruit Medicaid members for involvement in policy and procedure development and strategic planning as we all work in partnership to meet the Triple Aim of enhanced medical homes, integration of behavioral health and physical health and targeted care coordination for high risk patients.

Sincerely,

Annie Soto

Annie Soto
Executive Director
asoto@hsole.org

HIV ALLIANCE

1966 Garden Avenue
Eugene OR 97403

541-342-5088 office
541-342-1150 fax
www.hivalliance.org

April 25, 2012

Dear Oregon Health Authority,

HIV Alliance is a regional organization supporting individuals living with HIV and HCV and preventing new infections. We provide HIV care coordination in 10 counties, dental case management in 19 counties, HCV care coordination in 1 county,and education and prevention in 3 counties.

HIV Alliance supports the application being submitted by Trillium to create a Regional Coordinated Care Organization. This organization will be built on the excellent existing organizational and structures developed over the past 15 years by Lipa and Lane County (LaneCare). We have worked collaboratively with Lipa for many years to ensure that people living with HIV have access to life saving medical care and medication. LaneCare has also been an important partner, in supporting the social support services that help to combat isolation, stigma and mental health issues for people living with HIV. Building from existing infrastructure will reduce the capital requirements for meaningful delivery system reform.

There has been a substantial community engagement process that has incorporated input from providers, OHP members and their advocates, community members, and system partners. The community has agreed to support a single application to form a CCO that provides integrated care for the residents of Lane County. As appropriate, in the future the CCO will incorporate Medicare and patient populations into an integrated health care system.

Lane County and Lipa will create a co-managed administrative organization that incorporates existing provider networks and supports the continuity of delivery system strengths. The new organization will also achieve administrative savings through the development of integrated and efficient management structures.

The CCO will form a Governance Board that will help guide the development of the CCO and, more importantly, will set policy and procedures for service delivery change strategies so that we can better meet the Triple Aim. The community is discussing strategies for enhancing person-centered primary care medical homes, integrating behavioral health and physical health and identifying high risk high cost patients where savings can be achieved through better care coordination.

My organization fully supports Trillium's application.

Sincerely,

Diane B. Lang
Executive Director

LANE COUNTY BOARD OF COMMISSIONERS

25 April 2012

Oregon Health Authority (OHA)
500 Summer Street, NE, E-20
Salem, OR 97301-1097

Dear Oregon Health Authority:

Lane County supports the application being submitted by Trillium, on behalf of all of Lane County, to create a Lane Coordinated Care Organization. This organization will be built on the excellent existing organizational structures developed by Lipa and Lane County (LaneCare), thereby limiting the likelihood of new administrative costs. The Lane CCO will incorporate a contract between Trillium and Lane County to support continued County management and support of the behavioral health and public health systems with full, risk baring partnership in the CCO.

Lane County has participated in the development of Coordinated Care Organizations, from the initial concept through these final steps toward implementation. We have supported a substantial community engagement process that has incorporated input from providers, OHP members and their advocates, community members, and system partners, including schools. Along with the rest of the community, we strongly support a single application to form a CCO that provides integrated care for all residents of Lane County that are OHP members. As appropriate, in the future the CCO will incorporate Medicare and other funding streams and insurance products into an integrated health care system.

The CCO proposed by Lane County and Lipa will be a co-managed administrative organization that incorporates existing provider networks and supports the continuity of delivery system strengths. The new organization will also achieve administrative savings through the development of integrated and efficient management structures.

Our community continues to discuss strategies for enhancing person-centered primary care medical homes, integrating behavioral health and physical health and identifying high-risk high-cost patients where savings can be achieved through better care coordination. We have identified key members of the CCO Governance Board that will help guide the development of the CCO and, more importantly, will set policy and procedures for service delivery change strategies so that we can better meet the Triple Aim.

Lane County strongly supports this application and encourages the creation of the Lane CCO at the earliest possible opportunity.

Sincerely,

LANE COUNTY BOARD OF COMMISSIONERS

By: Sid Leiken, Chair

Lane County Medical Society
990 West 7th Avenue, Eugene, OR 97402
(541) 686-0995 || (541) 687-1554
lcms@riousa.com

April 25, 2012

Dear Oregon Health Authority,

Lane County Medical Society is a professional organization for physicians. Over 90% of Lane County physicians are members, totaling over 800 members.

Lane County Medical Society supports the application being submitted by Trillium to create a Regional Coordinated Care Organization. This organization will be built on the excellent existing organizational and structures developed over the past 15 years by Lipa and Lane County (LaneCare). Building from existing infrastructure will reduce the capital requirements for meaningful delivery system reform.

There has been a substantial community engagement process that has incorporated input from providers, OHP members and their advocates, community members, and system partners. The community has agreed to support a single application to form a CCO that provides integrated care for the residents of Lane County. As appropriate, in the future the CCO will incorporate Medicare and patient populations into an integrated health care system.

Lane County and Lipa will create a co-managed administrative organization that incorporates existing provider networks and supports the continuity of delivery system strengths. The new organization will also achieve administrative savings through the development of integrated and efficient management structures.

The CCO will form a Governance Board that will help guide the development of the CCO and, more importantly, will set policy and procedures for service delivery change strategies so that we can better meet the Triple Aim. The community is discussing strategies for enhancing person-centered primary care medical homes, integrating behavioral health and physical health and identifying high risk high cost patients where savings can be achieved through better care coordination.

Lane County Medical Society fully supports Trillium's application.

Sincerely,
Raymond N. Englander, MD

Raymond N. Englander, MD

President, Lane County Medical Society

Lane Community College SW

Office of the President

April 25, 2012

Dear Oregon Health Authority:

Lane Community College supports Trillium's application to create a Regional Coordinated Care Organization (CCO). This organization will be built on the excellent existing organizational and structures developed over the past fifteen years by Lipa and Lane County (LaneCare). Building from existing infrastructure will reduce the capital requirements for meaningful delivery system reform.

There has been a substantial community engagement process that has incorporated input from providers, OHP members and their advocates, community members, and system partners. The community has agreed to support a single application to form a CCO that provides integrated care for the residents of Lane County. As appropriate, in the future the CCO will incorporate Medicare and patient populations into an integrated health care system.

Lane County and Lipa will create a co-managed administrative organization that incorporates existing provider networks and supports the continuity of delivery system strengths. The new organization will also achieve administrative savings through the development of integrated and efficient management structures.

The CCO will form a Governance Board that will help guide the development of the CCO and, more importantly, will set policy and procedures for service delivery change strategies so that we can better meet the Triple Aim. The community is discussing strategies for enhancing person-centered primary care medical homes, integrating behavioral health and physical health and identifying high risk high cost patients where savings can be achieved through better care coordination.

Lane Community College fully supports Trillium's application.

Sincerely,

Mary Spilde

Mary Spilde, President

4000 East 30th Avenue ▪ Eugene, OR 97405-0640 ▪ Phone: (541) 463-5200 ▪ Fax: (541) 463-5201 ▪ Web: www.lanecc.edu

LANE ESD
Shaping the future:
Supporting excellence in education

LANE EDUCATION SERVICE DISTRICT

1200 Highway 99 North | 541.461.8200 | www.lesd.k12.or.us
Eugene, OR 97402 | 541.461.8298 (Fax)

EQUITY COMMITMENT LEADERSHIP COLLABORATION INTEGRITY

April 12, 2012

Dear Oregon Health Authority,

Lane ESD provides education serves to all 16 school districts in Lane County. Therefore, Lane ESD supports the application being submitted by Trillium on behalf of all of Lane County to create a Lane Coordinated Care Organization. This coordinated care will benefit all of our students and families. This organization will be built on the excellent existing organizational structures developed by Lipa and Lane County (LaneCare) thereby limiting the likelihood of new administrative costs.

There has been a substantial community engagement process that has incorporated input from providers, OHP members and their advocates, community members, and system partners. The community has agreed to support a single application to form a CCO that provides integrated care for all residents of Lane County that are OHP members. As appropriate, in the future the CCO will incorporate Medicare and other funding streams and insurance products into an integrated health care system.
Lane County and Lipa will create a co-managed administrative organization that incorporates existing provider networks and supports the continuity of delivery system strengths. The new organization will also achieve administrative savings through the development of integrated and efficient management structures.

The CCO will form a Governance Board that will help guide the development of the CCO and, more importantly, will set policy and procedures for service delivery change strategies so that we can better meet the Triple Aim. The community is discussing strategies for enhancing person-centered primary care medical homes, integrating behavioral health and physical health and identifying high risk high cost patients where savings can be achieved through better care coordination.

I believe that the development of the Lane CCO has and will continue to incorporate community input to assure the improvement of health care delivery in Lane County. My organization will participate in the CCO as a provider and or a partner on the appropriate committees. We support this application and encourage the creation of the Lane CCO at the earliest opportunity possible.

Sincerely,

Debbie Egan
Superintendent

Lane County Legal Aid and Advocacy Center
376 East 11th Avenue
Eugene, Oregon 97401-3246
Telephone (541) 485-1017
FAX (541) 342-5091
www.lclac.org

April 17, 2012

Dear Oregon Health Authority,

Lane County Legal Aid and Advocacy Center (LCLAAC) is a nonprofit organization providing legal assistance to low-income persons in Lane County, Oregon. LCLAAC provides assistance with family law, domestic violence cases, landlord-tenant disputes, consumer rights, public benefits issues such as Social Security and Supplemental Security Income, Medicaid/Medicare, welfare, food stamps, public housing and immigration cases.

LCLAAC supports the application being submitted by Trillium to create a Regional Coordinated Care Organization. LCLAAC has been particularly impressed with the last 7 years of services provided by Lipa and Lane County (Lane Care). Building from existing infrastructure will reduce the capital requirements for meaningful delivery system reform.

There has been a substantial community engagement process that has incorporated input from providers, OHP members and their advocates, community members, and system partners. The community has agreed to support a single application to form a CCO that provides integrated care for the residents of Lane County. As appropriate, in the future the CCO will incorporate Medicare and patient populations into an integrated health care system.

Lane County and Lipa will create a co-managed administrative organization that incorporates existing provider networks and supports the continuity of delivery system strengths. The new organization will also achieve administrative savings through the development of integrated and efficient management structures.

The CCO will form a Governance Board that will help guide the development of the CCO and, more importantly, will set policy and procedures for service delivery change strategies so that we can better meet the Triple Aim. The community is discussing strategies for enhancing person-centered primary care medical homes, integrating behavioral health and physical health and identifying high risk high cost patients where savings can be achieved through better care coordination.

My organization fully supports Trillium's application.

Ralph Saltus, Executive Director

Lane Independent Living Alliance (LILA)
99 West 10th Avenue, Suite 117
Eugene, OR 97401
541-607-7020 sthomas@lilaoregon.org

April 12, 2012

Dear Oregon Health Authority,

Lane Independent Living Alliance (LILA) - a Consumer Controlled Cross Disability Center for Independent Living

The Board of Directors of Lane Independent Living Alliance (LILA) supports the application being submitted by Trillium on behalf of all of Lane County to create a Lane Coordinated Care Organization. This organization will be built on the excellent existing organizational structures developed by Lipa and Lane County (LaneCare) thereby limiting the likelihood of new administrative costs.

There has been a substantial community engagement process that has incorporated input from providers, OHP members and their advocates, community members, and system partners. The community has agreed to support a single application to form a CCO that provides integrated care for all residents of Lane County that are OHP members. As appropriate, in the future the CCO will incorporate Medicare and other funding streams and insurance products into an integrated health care system.

Lane County and Lipa will create a co-managed administrative organization that incorporates existing provider networks and supports the continuity of delivery system strengths. The new organization will also achieve administrative savings through the development of integrated and efficient management structures.

The CCO will form a Governance Board that will help guide the development of the CCO and, more importantly, will set policy and procedures for service delivery change strategies so that we can better meet the Triple Aim. The community is discussing strategies for enhancing person-centered primary care medical homes, integrating behavioral health and physical health and identifying high risk high cost patients where savings can be achieved through better care coordination.

I believe that the development of the Lane CCO has and will continue to incorporate community input to assure the improvement of health care delivery in Lane County. My organization will participate in the CCO as a provider and partner on the appropriate committees. We support this application and encourage the creation of the Lane CCO at the earliest opportunity possible.

Sincerely,

Sheila Thomas, MA
Executive Director

LIPP

Lane Independent Primary Physicians

Dear Oregon Health Authority,

Lane Independent Primary Physicians Lane Independent Primary Physicians is an organization of over 60 practitioners working in independently owned clinics and practices throughout Lane County, Oregon. Specialties include pediatrics, family practice and internal medicine.

Lane Independent Primary Physicians supports the application being submitted by Trillium to create a Regional Coordinated Care Organization. This organization will be built on the excellent existing organizational and structures developed over the past 15 years by Lipa and Lane County (LaneCare). Building from existing infrastructure will reduce the capital requirements for meaningful delivery system reform.

There has been a substantial community engagement process that has incorporated input from providers, OHP members and their advocates, community members, and system partners. The community has agreed to support a single application to form a CCO that provides integrated care for the residents of Lane County. As appropriate, in the future the CCO will incorporate Medicare and patient populations into an integrated health care system.

Lane County and Lipa will create a co-managed administrative organization that incorporates existing provider networks and supports the continuity of delivery system strengths. The new organization will also achieve administrative savings through the development of integrated and efficient management structures.

The CCO will form a Governance Board that will help guide the development of the CCO and, more importantly, will set policy and procedures for service delivery change strategies so that we can better meet the Triple Aim. The community is discussing strategies for enhancing person-centered primary care medical homes, integrating behavioral health and physical health and identifying high risk high cost patients where savings can be achieved through better care coordination.
Lane Independent Primary Physicians fully supports Trillium's application.

Sincerely,

Rob Senger
Executive Director
Lane Independent Primary Physicians

April 10, 2012

State of Oregon
Oregon Health Authority
500 Summer St. NE
Salem, OR 97301-1079

RE: Letter in Support of a Lane Coordinated Care Organization

Dear Oregon Health Authority:

The Mental Health Subcommittee of the Lane County Mental Health Advisory/Local Alcohol & Drug Planning Committee (MHAC) supports the application being submitted by Trillium, on behalf of all of Lane County, to create a Lane Coordinated Care Organization. This organization will be built on the excellent existing organizational structures developed by Lipa and Lane County (LaneCare), thereby limiting the likelihood of new administrative costs.

Our subcommittee has been closely following the development of Coordinated Care Organizations (CCOs), from the initial concept through the steps toward implementation. We have watched a substantial community engagement process that has incorporated input from providers, OHP members and their advocates, community members, and system partners. Along with the rest of the community, we strongly support a single application to form a CCO that provides integrated care for all residents of Lane County that are OHP members. As appropriate, in the future the CCO will incorporate Medicare and other funding streams and insurance products into an integrated health care system.

The CCO proposed by Lane County and Lipa will be a co-managed administrative organization that incorporates existing provider networks and supports the continuity of delivery system strengths. The new organization will also achieve administrative savings through the development of integrated and efficient management structures.

Our community continues to discuss strategies for enhancing person-centered primary care medical homes, integrating behavioral health and physical health and identifying high-risk high-cost patients where savings can be achieved through better care coordination. We look forward to the creation of the CCO Governance Board that will help guide the development of the CCO and, more importantly, will set policy and procedures for service delivery change strategies so that we can better meet the Triple Aim.

As the committee that advises the County Commissioners and the Director of Health & Human Services (HHS), we have long advocated for some essential strengths of the existing behavioral health delivery system that must be sustained in the future. These include:

1. An ongoing relationship with the County that incorporates the noteworthy success of LaneCare (the County-operated MHO), Public Health, the FQHC, and other HHS divisions and programs.

2. Ongoing financial support for prevention, education and outreach projects supported by the MHAC.

3. Support for the system enhancements that the committee has promoted and that LaneCare currently funds, such as the Young Adults in Transition program, the nurse practitioner imbedded in Senior & Disabled Services, and the Early Childhood mental health programs.

We believe that the development of the Lane CCO will minimally disrupt contracted providers by maintaining the internet based payment system that LaneCare manages and the variety of reimbursement incentives that support the quality delivery system. We know that the Lane CCO will continue to incorporate community input to assure the improvement of health care delivery in Lane County. Our advisory committee expects to participate fully in the CCO as a system partner to support the County role and to assure attention to the principles and programs that we think are most important.

We strongly support this application and encourage the creation of the Lane CCO at the earliest possible opportunity.

Sincerely,

Charles R.B. Wright, Chairman
Lane County MHAC – Mental Health Subcommittee

Modern Midwifery Care, LLC

Providing comprehensive home birth services

Dear Oregon Health Authority, April 19, 2012

I am a Licensed Certified Professional Midwife and the owner of Modern Midwifery Care, LLC. We have been providing comprehensive home birth services, including prenatal and postpartum care since 2008, and have served many families in Lane and Benton counties that are enrolled with the Oregon Health Plan.

Modern Midwifery Care, LLC supports the application being submitted by Trillium to create a Regional Coordinated Care Organization. Because of the costs involved in creating a Regional CCO it is prudent to use the excellent existing organizational structures, reserving as much capital as possible for delivery and services. The responsible use of funds should be a top priority during system reform, and Modern Midwifery care, LLC believes this is an excellent way to achieve that end.

Modern Midwifery Care, LLC, like many community partners, has been involved in the input process regarding the creation of a Regional CCO. We support a single application to form a CCO that provides integrated care for the residents of Lane County. We believe that the efficiencies achieved by this system are highly desirable, as Lipa and Lane County will use existing administrative structures to co-manage the existing provider network and support the continuity of delivery system strengths.

Modern Midwifery Care, LLC fully supports Trillium's application.

Sincerely,

Sarah Macrorie, CPM, LDM
Owner and Clinical Director
Modern Midwifery Care, LLC

3575 Donald St., Suite 230, Eugene, OR 97405 • (541)359-6551 info@modernmidwiferycare.com • modernmidwiferycare.com

NAMI Lane County
76 Centennial Loop, Suite A, Eugene, Oregon 97401 (541) 343-7688
A United Way Agency

Dear Oregon Health Authority,

NAMI Lane County is dedicated to those persons concerned with mental health issues. NAMI Is the National Alliance on Mental Illness, the nation's largest grassroots organization for people with mental illness and their families. Founded in 1979, we offer help and hope and work to build better lives by providing support, education and advocacy to Eugene/Springfield Metro, and surrounding areas.

NAMI Lane County supports the application being submitted by Trillium on behalf of all of Lane County to create a Lane Coordinated Care Organization. This organization will be built on the excellent existing organizational structures developed by Lipa and Lane County (LaneCare) thereby limiting the likelihood of new administrative costs.

A substantial community engagement process has incorporated input from providers, community members, system partners, and OHP members and their advocates. The community has agreed to support a single application to form a CCO that provides integrated care for all residents of Lane County who are OHP members. It is our understanding that in the future the CCO will incorporate Medicare and other funding streams and insurance products into an integrated health care system.

Lane County and Lipa will create a co-managed administrative organization that incorporates existing provider networks and supports the continuity of delivery system strengths. The new organization will be able to promote administrative savings through the development of integrated and efficient management structures.

The CCO will form a Governance Board that will help guide the development of the CCO and, more importantly, will set policy and procedures for service delivery change strategies so that they can better meet the Triple Aim. Our community is already discussing strategies for enhancing person-centered primary care Health Hubs (aka medical homes), integrating behavioral health and physical health and identifying high risk high cost patients where savings can be achieved through better care coordination.

We believe that the development of the Lane CCO has and will continue to incorporate community input to assure the improvement of health care delivery in Lane County. NAMI Lane County will continue to participate in the CCO as a partner providing ongoing feedback and support on the appropriate committees. We support this application and encourage the creation of the Lane CCO at the earliest opportunity possible.

Sincerely,

Jose E. Soto III B.Ed
On behalf of NAMI Lane County & its Board of Directors

BRADLEY D. PALMEN, MD
BRIAN L. ROBINSON, MD
JAMES M. WHITMORE, MD
DAVID DONIELSON, MD
RICHARD FINKELSTEIN, MD
MARK N. BODILY, MD
J. GREGG MELTON, MD
RONALD D. SMITH, MD
DEBORAH W. BARNES, MD
BARRY J. PERLMAN, PhD, MD
DANIEL HAGENGRUBER, MD
TODD P. TRITCH, MD
LOU NGUYEN, MD
WALTER BERNARD, MD
DAVID BEARDSWORTH, MD
JOYCE SCHLICHTING, PhD, MD
PAUL A. THOMPSON, MD
DOMENICO CASTALDO, MD
BARBARA K. IRVING, MD
LESLIE C. PARKER, MD
STEPHEN R. AUFDERHEIDE, MD
SETIAWAN KAMARU, DO

NORTHWEST ANESTHESIA PHYSICIANS, P.C.

P.O. Box 7247
Springfield, OR 97475-0011
Office 541.686.9551
Fax 541.687.6716

MARK S. KRAUSE, MD
BRIAN ST. GEORGE, MD
ROBERT CARRICABURU, MD
ANDREW S. RUSHTON, MD
BRIAN P. JONES, MD
MARK E. HIBBARD, MD
PETER BISSONNETTE, MD
ALBERT R. CHO, DO
ALEX O. RAISKIN, MD
PATRICK J. SALISBURY, MD
KENNETH A. WOODWARD, MD
ROGER A. COLEMAN, MD
CHRISTOPHER B. HAGEN, MD
DOROTHY A. PENALOZA, MD
JOCELYN A. PARK, MD
LLOYD D. BIBY, MD
TRISHA J. MITCHELL, MD
SCOTT B. MYRICK, MD
STACIE H. OH, MD
JAMES W. HACKETT II, MD
REBECCA M. CARROLL, MD

Dear Oregon Health Authority,

April 20, 2012

Northwest Anesthesia Physician's P.C. supports the application being submitted by Trillium to create a Regional Coordinated Care Organization. We are confident that the organizational structures and physician relationships developed over the past 15 years by Lipa and Lane County (LaneCare) position Trillium to be a trusted steward in building from existing infrastructure and will reduce the capital requirements for meaningful delivery system reform.

There has been a substantial community engagement process that has incorporated input from providers, OHP members and their advocates, community members, and system partners. The community has agreed to support a single application to form a CCO that provides integrated care for the residents of Lane County.

Lane County and Lipa will create a co-managed administrative organization that incorporates existing provider networks and supports the continuity of delivery system strengths. The new organization also intends to achieve administrative savings through the development of integrated and efficient management structures.

Northwest Anesthesia Physicians fully supports Trillium's application.

Sincerely,

Luat Nguyen
President

Office Location: 939 Harlow Road, Suite 110 Springfield OR 97477-1190

OREGON MEDICAL GROUP

April 23, 2012

Oregon Health Authority
500 Summer Street SE
Salem, Oregon 97301

Re: Letter of Support for application submitted by Trillium

Dear Oregon Health Authority:

Oregon Medical Group is a primary care based multi-specialty group with more than 100 physicians and 16 neighborhood clinics throughout the Eugene and Springfield area.

Oregon Medical Group supports the application being submitted by Trillium to create a Regional Coordinated Care Organization. This organization will be built on the excellent existing organizational capacities and structures developed over the past 15 years by Lipa and Lane County (LaneCare). Building from existing infrastructure will reduce the capital requirements for meaningful delivery system reform.

There has been a substantial community engagement process that has incorporated input from providers, OHP members and their advocates, community members, and system partners. The community has agreed to support a single application to form a CCO that provides integrated care for the residents of Lane County. As appropriate, in the future the CCO will incorporate Medicare and patient populations into an integrated health care system.

Lane County and Lipa will create a co-managed administrative organization that incorporates existing provider networks and supports the continuity of delivery system strengths. The new organization will also achieve administrative savings through the development of integrated and efficient management structures.

The CCO will form a Governance Board that will help guide the development of the CCO and, more importantly, will set policy and procedures for service delivery change strategies so that we can better meet the Triple Aim. The community is discussing strategies for enhancing person-centered primary care medical homes, integrating behavioral health and physical health and identifying high risk high cost patients where savings can be achieved through better care coordination.

My organization fully supports Trillium's application.

Sincerely,

Cris Noah, CEO

TEL: 541.242.4000 • 1580 VALLEY RIVER DR. SUITE 200 • EUGENE OR 97

OREGON IMAGING CENTERS
PHYSICIANS & SURGEONS CENTER, SOUTH BUILDING, SUITE 330
1200 HILYARD STREET, EUGENE, OREGON 97401

April 25, 2012

Dear Oregon Health Authority,

Oregon Imaging Centers is a comprehensive multi-modality outpatient imaging center.

Oregon Imaging Centers supports the application being submitted by Trillium to create a Regional Coordinated Care Organization. This organization will be built on the excellent existing organizational and structures developed over the past 15 years by Lipa and Lane County (LaneCare). Building from existing infrastructure will reduce the capital requirements for meaningful delivery system reform.

There has been a substantial community engagement process that has incorporated input from providers, OHP members and their advocates, community members, and system partners. The community has agreed to support a single application to form a CCO that provides integrated care for the residents of Lane County. As appropriate, in the future the CCO will incorporate Medicare and patient populations into an integrated health care system.

Lane County and Lipa will create a co-managed administrative organization that incorporates existing provider networks and supports the continuity of delivery system strengths. The new organization will also achieve administrative savings through the development of integrated and efficient management structures.

The CCO will form a Governance Board that will help guide the development of the CCO and, more importantly, will set policy and procedures for service delivery change strategies so that we can better meet the Triple Aim. The community is discussing strategies for enhancing person-centered primary care medical homes, integrating behavioral health and physical health and identifying high risk high cost patients where savings can be achieved through better care coordination.

Oregon Imaging Centers fully supports Trillium's application.

Sincerely,

Rick Reeves
Practice Administrator
Oregon Imaging Centers

Every picture tells a story...™

Oregon Life Sciences

James W. Korfhage

April 25, 2012

Dear Oregon Health Authority,

I am writing as a principal of the Oregon Life Sciences group, an Oregon-based venture capital organization which for the past 20 years has focused on investment in the healthcare and medical technology sectors. For the past five years, I have been involved with Agate Resources, Inc. and their subsidiary companies, Trillium and Lipa, at the board level and as an advisor to Agate's management

Oregon Life Sciences supports the application being submitted by Trillium to create a Regional Coordinated Care Organization for the Lane County area. This CCO organization is being built upon the successful organizational and structural foundation created over the past fifteen years by Lipa and Lane County (LaneCare). We feel that by building from our successful existing infrastructure can only enhance the prospects for meaningful delivery system reform and integrated care for the population in the Southern Willamette Valley.

Over the past almost year and a half, I have observed the Agate organization being at the forefront of a significant community engagement process integrating input from providers, OHP members and their advocates, community members, and system partners. As a result of these efforts, our health delivery community has agreed to support this single application by Trillium to form a CCO for the residents of Lane County. And I know that in the future, this CCO is prepared and looks forward to incorporating Medicare and other patient populations into this successfully modeled integrated health care delivery system.

Lane County and Lipa have agreed and are excited to create a co-managed administrative organization that incorporates existing provider networks and supports the continuity of delivery system strengths that have been their history. The leadership of the new CCO organization is confident that it will also achieve administrative savings through the development of new generation efficient management structures with strong board guidance and oversight.

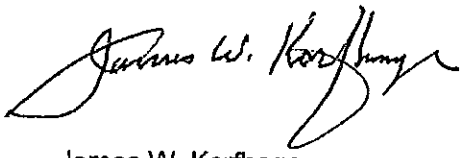
The CCO will form a Governance Board that will help guide the development of the CCO and, more importantly, will set policy and procedures for service delivery change strategies so that we can meet and exceed the tenants of the Triple Aim. At this writing, the region's medical

P.O. Box 51046 Eugene, OR 97405 541.683.2488

community is discussing strategies for enhancing patient-centered primary care medical homes, integrating behavioral health and physical health and identifying high risk, high cost treatment protocols where savings can be achieved through improved care coordination.

There is little disagreement that we are experiencing a very interesting transformation of our healthcare delivery system. But having observed our team's performance over the years and its commitment to building this CCO into an effectively-functioning entity based upon our well-documented successes to date, I fully support Trillium's CCO application and encourage you to do the same.

Sincerely,



James W. Korfhage

PEARL BUCK CENTER INCORPORATED

April 17, 2012

Dear Oregon Health Authority,

Pearl Buck Center's *mission is to enrich the lives of those affected by disabilities through vocational, educational and recreational programs.* Pearl Buck Center supports the application being submitted by Trillium on behalf of all of Lane County to create a Lane Coordinated Care Organization. This organization will be built on the excellent existing organizational structures developed by Lipa and Lane County (LaneCare) thereby limiting the likelihood of new administrative costs.

There has been a substantial community engagement process that has incorporated input from providers, OHP members and their advocates, community members, and system partners. The community has agreed to support a single application to form a CCO that provides integrated care for all residents of Lane County that are OHP members. As appropriate in the future, the CCO will incorporate Medicare and other funding streams and insurance products into an integrated health care system.

Lane County and Lipa will create a co-managed administrative organization that incorporates existing provider networks and supports the continuity of delivery system strengths. The new organization will also achieve administrative savings through the development of integrated and efficient management structures.

The CCO will form a Governance Board that will help guide the development of the CCO and, more importantly, will set policy and procedures for service delivery change strategies so that we can better meet the Triple Aim. The community is discussing strategies for enhancing person-centered primary care medical homes, integrating behavioral health and physical health and identifying high risk high cost patients where savings can be achieved through better care coordination.

I believe that the development of the Lane CCO has and will continue to incorporate community input to assure the improvement of health care delivery in Lane County. My organization will participate in the CCO as a provider and/or a partner on appropriate committees. We support this application and encourage the creation of the Lane CCO at the earliest opportunity possible.

Sincerely,

Jan Aho

Jan Aho
Executive Director
Pearl Buck Center

PEARL BUCK CENTER INCORPORATED, 3690 WEST 1ST AVE., EUGENE, OREGON 97402, PH/TDD 541.484.4066, FAX 541.484.0868

PINNACLE
HEALTHCARE INC.

Dear Oregon Health Authority,

Pinnacle Healthcare owns and operates ten nursing facilities in Oregon. We have Green Valley, Hillside Heights and South Hills in Lane County.

Pinnacle Healthcare supports the application being submitted by Trillium to create a Regional Coordinated Care Organization. This organization will be built on the excellent existing organizational capacities and structures developed over the past 15 years by Lipa and Lane County (LaneCare). Building from existing infrastructure will reduce the capital requirements for meaningful delivery system reform.

There has been a substantial community engagement process that has incorporated input from providers, OHP members and their advocates, community members, and system partners. The community has agreed to support a single application to form a CCO that provides integrated care for the residents of Lane County. As appropriate, in the future the CCO will incorporate Medicare and patient populations into an integrated health care system.

Lane County and Lipa will create a co-managed administrative organization that incorporates existing provider networks and supports the continuity of delivery system strengths. The new organization will also achieve administrative savings through the development of integrated and efficient management structures.

The CCO will form a Governance Board that will help guide the development of the CCO and, more importantly, will set policy and procedures for service delivery change strategies so that we can better meet the Triple Aim. The community is discussing strategies for enhancing person-centered primary care medical homes, integrating behavioral health and physical health and identifying high risk high cost patients where savings can be achieved through better care coordination.

My organization fully supports Trillium's application.

Sincerely,

Merlin Hart, CEO

1077 Gateway Loop • Springfield, Oregon 97477 • 541-746-1020 • Fax 541-746-1021

PINNACLE
HEALTHCARE INC.

Dear Oregon Health Authority,

Pinnacle Healthcare owns and operates ten nursing facilities in Oregon. We have Green Valley, Hillside Heights and South Hills in Lane County.

Pinnacle Healthcare supports the application being submitted by Trillium to create a Regional Coordinated Care Organization. This organization will be built on the excellent existing organizational capacities and structures developed over the past 15 years by Lipa and Lane County (LaneCare). Building from existing infrastructure will reduce the capital requirements for meaningful delivery system reform.

There has been a substantial community engagement process that has incorporated input from providers, OHP members and their advocates, community members, and system partners. The community has agreed to support a single application to form a CCO that provides integrated care for the residents of Lane County. As appropriate, in the future the CCO will incorporate Medicare and patient populations into an integrated health care system.

Lane County and Lipa will create a co-managed administrative organization that incorporates existing provider networks and supports the continuity of delivery system strengths. The new organization will also achieve administrative savings through the development of integrated and efficient management structures.

The CCO will form a Governance Board that will help guide the development of the CCO and, more importantly, will set policy and procedures for service delivery change strategies so that we can better meet the Triple Aim. The community is discussing strategies for enhancing person-centered primary care medical homes, integrating behavioral health and physical health and identifying high risk high cost patients where savings can be achieved through better care coordination.

My organization fully supports Trillium's application.

Sincerely,

Rebecca Conrad,

Director of Community Relations & Adhoc Member of the LTC Lane CCO Subcommittee

1077 Gateway Loop • Springfield, Oregon 97477 • 541-746-1020 • Fax 541-746-1021

Planned Parenthood®
of Southwestern Oregon

Dear Oregon Health Authority,

Planned Parenthood of Southwestern Oregon is a leading provider of reproductive health services and sexuality education in our region. Each year our expert team of dedicated nurses, nurse practioners, physician assistants, doctors, and family planning staff provide more than 41,000 visits to women, men, and teens.

Planned Parenthood of Southwestern Oregon supports the application being submitted by Trillium to create a Regional Coordinated Care Organization. This organization will be built on the excellent existing organizational and structures developed over the past 15 years by Lipa and Lane County (LaneCare). Building from existing infrastructure will reduce the capital requirements for meaningful delivery system reform.

There has been a substantial community engagement process that has incorporated input from providers, OHP members and their advocates, community members, and system partners. The community has agreed to support a single application to form a CCO that provides integrated care for the residents of Lane County. As appropriate, in the future the CCO will incorporate Medicare and patient populations into an integrated health care system.

Lane County and Lipa will create a co-managed administrative organization that incorporates existing provider networks and supports the continuity of delivery system strengths. The new organization will also achieve administrative savings through the development of integrated and efficient management structures.

The CCO will form a Governance Board that will help guide the development of the CCO and, more importantly, will set policy and procedures for service delivery change strategies so that we can better meet the Triple Aim. The community is discussing strategies for enhancing person-centered primary care medical homes, integrating behavioral health and physical health and identifying high risk high cost patients where savings can be achieved through better care coordination.

My organization fully supports Trillium's application.

Sincerely,

Cynthia Pappas

Cynthia Pappas
President and CEO

RAPC
RADIOLOGY ASSOCIATES PC
MEDICAL IMAGING SPECIALISTS

As one of the most prestigious radiology groups in the Northwest, Radiology Associates P.C. attracts and develops top professionals committed to and capable of improving the delivery of medical imaging now and into the future.

Radiology Associates, PC. supports the application being submitted by Trillium to create a Regional Coordinated Care Organization. This organization will be built on the excellent existing organizational and structures developed over the past 15 years by Lipa and Lane County (LaneCare). Building from existing infrastructure will reduce the capital requirements for meaningful delivery system reform.

There has been a substantial community engagement process that has incorporated input from providers, OHP members and their advocates, community members, and system partners. The community has agreed to support a single application to form a CCO that provides integrated care for the residents of Lane County. As appropriate, in the future the CCO will incorporate Medicare and patient populations into an integrated health care system.

Lane County and Lipa will create a co-managed administrative organization that incorporates existing provider networks and supports the continuity of delivery system strengths. The new organization will also achieve administrative savings through the development of integrated and efficient management structures.

The CCO will form a Governance Board that will help guide the development of the CCO and, more importantly, will set policy and procedures for service delivery change strategies so that we can better meet the Triple Aim. The community is discussing strategies for enhancing person-centered primary care medical homes, integrating behavioral health and physical health and identifying high risk high cost patients where savings can be achieved through better care coordination.

Radiology Associates, PC. fully supports Trillium's application.

Sincerely,

Rick Reeves
Practice Administrator
Radiology Assoc., PC

PO Box 482, Eugene, OR 97440 • 541-681-8586 (office) • 541-681-8587 (fax)

Sacred Heart Medical Center
PeaceHealth

April 23, 2012

Dear Oregon Health Authority,

PeaceHealth is a not for profit provider of Medicaid services in Lane County and has been since the beginning of the Medicaid program. We provide 85% of hospital services, we provide over a third of all physician services, virtually all of the inpatient behavioral health and a good portion of outpatient behavioral health, including psychiatric services, and numerous ancillary services. We consider provision of Medicaid services to our community as part of our mission.

We have been part of the substantial community engagement process that has incorporated input from providers, OHP members and their advocates, community members, and system partners. The community leadership has agreed to support a single application to form a CCO that provides integrated care for the residents of Lane County. **PeaceHealth supports the application being submitted by Trillium.**

We have a historically strong working relationship with LIPA/Trillium and Lane County (LaneCare), and believe it is vital to our community approach for coordinated care to build on the existing infrastructure. In addition, LIPA and LaneCare have a strong track record of collaborative and operational and fiscally responsible management of the Medicaid MCO and its risk relationships. We are optimistic about the potential for improving care coordination, particularly in the integration of behavioral and physical health, and in providing greater value to our community.

We believe PeaceHealth has a lot to offer, as we already have in place many of the medical home, care coordination, and physical/behavioral health integration components of promoting and delivering health improvement to vulnerable populations. Additionally, we are a significant provider and manager of current uninsured populations, some of whom will likely become insured through Medicaid expansion.

As the OHA has not yet made available information on the global budgets and their actuarial soundness, we are not prepared to comment on whether we think the return on the sizable redesign investment will meet budgetary goals, and have not entered into specific contractual discussions. We simply have no information to assess here. Despite this caveat, what we can say is that we currently have faith in the process, that we support the community engagement process and direction, and that PeaceHealth supports Trillium's application for the reasons cited above.

Sincerely,

Roger Saydack
Interim Chief Operating Officer
RiverBend Administration

Phone: 541-222-7300
3333 RiverBend Drive Springfield, OR 97477
PO Box 10905 Eugene, OR 97440
www.peacehealth.org

Dedicated to Exceptional Medicine and Compassionate Care

SENIOR & DISABLED SERVICES
A DIVISION OF LANE COUNCIL OF GOVERNMENTS

April 25, 2012

Dear Oregon Health Authority,

Lane Council of Governments Senior & Disabled Services (S&DS) is the Area Agency on Aging (AAA) and Disability Services for Lane County. S&DS works with community partners to provide easy access to a wide range of social, health, and support services to assist older adults and those with disabilities to live as independently as possible in the living situations of their choice. As a Type B Transfer Area Agency on Aging, S&DS is responsible for administration of the Medicaid and Food Stamp program for seniors and people with disabilities in Lane County. We also administer programs funded through the Older Americans Act that provide such services as support groups, training, volunteer recruitment, care management, transportation, options counseling and the Aging and Disability Resource Connection.

This letter is in support of the application submitted by Trillium to create a Regional Coordinated Care Organization. This organization will be built on the excellent existing organizational capacities and structures developed over the past 15 years by Lipa and Lane County (LaneCare). Building from existing infrastructure will reduce the capital requirements for meaningful delivery system reform.

Lipa and LaneCare have sponsored a substantial community engagement process that has incorporated input from providers, OHP members and their advocates, community members, and system partners. The community has agreed to support a single application to form a CCO that provides integrated care for the residents of Lane County. As appropriate, in the future the CCO will incorporate Medicare and patient populations into an integrated health care system.

Lane County and Lipa will create a co-managed administrative organization that incorporates existing provider networks and supports the continuity of delivery system strengths. The new organization will also achieve administrative savings through the development of integrated and efficient management structures.

The CCO will form a Governance Board that will help guide the development of the CCO and, more importantly, will set policy and procedures for service delivery change strategies so that we can better meet the Triple Aim. The community is discussing strategies for enhancing person-centered primary care medical homes, integrating behavioral health and physical health and identifying high risk high cost patients where savings can be achieved through better care coordination.

My organization fully supports Trillium's application.

Sincerely,

Kay Metzger, Director

SENIOR & DISABLED SERVICES • (541) 682-4498
1015 WILLAMETTE ST., EUGENE, OR 97401-3113 • FAX: (541) 682-2484

www.sdslane.org
1-800-441-4038 • TTY (541) 682-4567

slocum

55 Coburg Road, Eugene, OR 97401 • www.slocumcenter.com
(800) 866-7906 • (541) 485-8111 • Fax (541) 342-6379

center for
orthopedics &
sports medicine
Physicians & Surgeons

April 24, 2012

Orthopedic Surgery
Kenneth P. Butters, MD
Dennis K. Collis, MD
Daniel C. Fitzpatrick, MD
Rudolf G. Hoellrich, MD
Stanley L. James, MD
Brian A. Jewett, MD
Donald C. Jones, MD
Brick A. Lantz, MD
Thomas J. Macha, MD
Craig G. Mohler, MD
Steven N. Shah, MD
Matthew S. Shapiro, MD
Daniel V. Sheerin, MD
Kenneth M. Singer, MD
Timothy A. Straub, MD
Jason D. Tavakolian, MD
Christopher N. Walton, MD
Thomas K. Wuest, MD

Non-Operative Sports Medicine
Michael C. Koester, MD
Lisa M. Pomranky, MD
Denise D. Routhier, MD

Interventional Spine, Physical Medicine and Rehabilitation
Gregory M. Phillips, MD

Dear Oregon Health Authority,

Slocum Center for Orthopedics & Sports Medicine, located in Eugene Oregon, is Oregon's center for orthopedic excellence – a private practice that exists to help restore and enhance musculoskeletal health.

The 22 Physicians at Slocum Center support the application being submitted by Trillium to create a Regional Coordinated Care Organization. This organization will be built on the excellent existing organizational and structures developed over the past 15 years by Lipa and Lane County (LaneCare). Building from existing infrastructure will reduce the capital requirements for meaningful delivery system reform.

There has been a substantial community engagement process that has incorporated input from providers, OHP members and their advocates, community members, and system partners. The community has agreed to support a single application to form a CCO that provides integrated care for the residents of Lane County. As appropriate, in the future the CCO will incorporate Medicare and patient populations into an integrated health care system.

Lane County and Lipa will create a co-managed administrative organization that incorporates existing provider networks and supports the continuity of delivery system strengths. The new organization will also achieve administrative savings through the development of integrated and efficient management structures.

The CCO will form a Governance Board that will guide the development of the CCO and, more importantly, will set policy and procedures for service delivery change strategies so that we can better meet the Triple Aim. The community is discussing strategies for enhancing person-centered primary care medical homes, integrating behavioral health and physical health and identifying high risk high cost patients where savings can be achieved through better care coordination.

Slocum Center for Orthopedics & Sports Medicine fully supports Trillium's application.

Sincerely,

Keith Clark PTA, MBA
Administrator/COO
Slocum Orthopedics
55 Coburg Road
Eugene, OR 97401
541 868 3225

SPRINGFIELD
FAMILY PHYSICIANS

Comprehensive Healthcare Under One Roof

April 18, 2012

Dear Oregon Health Authority:

Springfield Family Physicians is a long-established, 10 provider family practice in Springfield, Oregon. Our providers collectively see about 3,200 patients per month.

Springfield Family Physicians supports the application being submitted by Trillium to create a Regional Coordinated Care Organization. This organization will be built on the excellent existing organizational capacities and structures developed over the past 15 years by LIPA and Lane County (LaneCare). Building from existing infrastructure will reduce the capital requirements for meaningful delivery system reform.

There has been a substantial community engagement process that has incorporated input from providers, OHP members and their advocates, community members and system partners. The community has agreed to support a single application to form a CCO that provides integrated care for the residents of Lane County. As appropriate, in the future the CCO will incorporate Medicare and patient populations into an integrated health care system.

Lane County and LIPA will create a co-managed administrative organization that incorporates existing provider networks and supports the continuity of delivery system strengths. The new organization will also achieve administrative savings through the development of integrated and efficient management structures.

The CCO will form a Governance Board that will help guide the development of the CCO and, more importantly, will set policy and procedures for service delivery change strategies so that we can better meet the Triple Aim. The community is discussing strategies for enhancing person-centered primary care medical homes, integrating behavioral health and physical health and identifying high risk cost patients where savings can be achieved through better care coordination.

My organization fully supports Trillium's application.

Sincerely,

Jane Conley
Administrator

2280 MARCOLA ROAD / SPRINGFIELD, OR 97477 / PHONE: 541.747.4300 / FAX: 541.747.0655 / BUSINESS OFFICE: 541.747.8576 / WWW.SPRINGFIELDFAMILYPHYSICIANS.COM

Every Student a Graduate Prepared for a Bright and Successful Future

Springfield Public Schools

Superintendent
Nancy Golden
525 Mill Street
Springfield, OR 97477
T: 541-726-3201
F: 541-726-3312
www.sps.lane.edu

April 13, 2012

Dear Oregon Health Authority,

Springfield Public Schools' enrollment of nearly 11,000 students includes an increasingly diverse and high-needs population. More than 62 percent of the district's students qualify for the Free and Reduced Lunch Program (used as an indicator of low-income or impoverished households), this figure represents an increase of 20 percent during the last five years. This increase has made our partnership with the Community Health Centers of Lane County more vital than ever before. In partnership with CHC, we are able to offer health services to students and their families at reduced rates or free-of-charge - making it possible for even the most vulnerable members of our community to access quality health care.

Springfield Public Schools supports the application being submitted by Trillium on behalf of all of Lane County to create a Lane Coordinated Care Organization. This organization will be built on the excellent existing organizational structures developed by Lipa and Lane County (LaneCare) thereby limiting the likelihood of new administrative costs.

There has been a substantial community engagement process that has incorporated input from providers, OHP members and their advocates, community members, and system partners. The community has agreed to support a single application to form a CCO that provides integrated care for all residents of Lane County that are OHP members. As appropriate, in the future the CCO will incorporate Medicare and other funding streams and insurance products into an integrated health care system. Lane County and Lipa will create a co-managed administrative organization that incorporates existing provider networks and supports the continuity of delivery system strengths. The new organization will also achieve administrative savings through the development of integrated and efficient management structures.

The CCO will form a Governance Board that will help guide the development of the CCO and, more importantly, will set policy and procedures for service delivery change strategies so that we can better meet the Triple Aim. The community is discussing strategies for enhancing person-centered primary care medical homes, integrating behavioral health and physical health and identifying high risk high cost patients where savings can be achieved through better care coordination.

I believe that the development of the Lane CCO has and will continue to incorporate community input to assure the improvement of health care delivery in Lane County. Our district will participate in the CCO as a provider and a partner on the appropriate committees. We support this application and encourage the creation of the Lane CCO at the earliest opportunity possible.

Sincerely,

Dr. Nancy Golden
Superintendent

April 16, 2012

Oregon Health Authority
500 Summer Street NE
Salem, OR 97301

Dear Oregon Health Authority,

I am writing to show support for the application being submitted by Trillium to create a Regional Coordinated Care Organization. This organization will be built on the excellent existing infrastructure and management structures developed over the past 15 years by Lipa and Lane County (LaneCare). Building from existing infrastructure will reduce the capital requirements for meaningful delivery system reform.

There has been a substantial community engagement process that has incorporated input from providers, OHP members and their advocates, community members, and system partners. The community has agreed to support a single application to form a CCO that provides integrated care for the residents of Lane County.

The CCO will form a Governance Board that will help guide the development of the CCO and, more importantly, will set policy and procedures for service delivery change strategies so that we can better meet the Triple Aim. The community is discussing strategies for enhancing person-centered primary care medical homes, integrating behavioral health and physical health and identifying high risk high cost patients where savings can be achieved through better care coordination.

I fully support Trillium's application.

Sincerely,

Jim Torrey
Owner, Total Communications Co.

United Way of Lane County

LIVE UNITED™
3171 Gateway Loop
Springfield, Oregon 97477

541.741.6000 Tel
541.726.4150 Fax
www.unitedwaylane.org

April 16, 2012

Oregon Health Authority
500 Summer Street, NE, E-20
Salem, OR 97301-1097

Dear Oregon Health Authority,

The 100% Access Healthcare Coalition formed as a result of the United Way of Lane County's 2004 Community Needs Assessment which found that for the first time, health care, affordable medications and health insurance were the top three needs of all people in Lane County regardless of socioeconomic status, age, or geography. The Coalition is comprised of Lane County's leading health care providers as well as private businesses and non-profit organizations who are committed to improving access to health care in Lane County – connecting more people to appropriate, quality health care at less cost. The Coalition is part of United Way of Lane County.

100% Access supports the application being submitted by Trillium on behalf of all of Lane County to create a Lane Coordinated Care Organization. Our Coalition is in agreement that there should be one single application to form a CCO that provides integrated care for all residents of Lane County who are OHP members. It is also important that the CCO in Lane County be lead by community partners, who have a long history of providing services to the residents of Lane County.

The CCO development effort in our county, spearheaded by Lane County and Lipa has included a substantial community engagement process that has incorporated input from providers, OHP members and their advocates, community members, and system partners. As appropriate, in the future the CCO will incorporate Medicare and other funding streams and insurance products into an integrated health care system.

Lane County and Lipa will create a co-managed administrative organization that incorporates existing provider networks and supports the continuity of delivery system strengths. The new organization will also achieve administrative savings through the development of integrated and efficient management structures.

The CCO will form a Governance Board to guide the development of the CCO and, more importantly, will set policy and procedures for service delivery change strategies to better meet the Triple Aim. The community is discussing strategies for enhancing person-centered primary care medical homes, integrating behavioral health and physical health and identifying high risk high cost patients where savings can be achieved through better care coordination.

I believe that the development of the Lane CCO has and will continue to incorporate community input to assure the improvement of health care delivery in Lane County. My organization will participate in the CCO as partner on the appropriate committees and we support this application.

Sincerely,

Kellie DeVore

Kellie DeVore
Director, 100% Access Coalition

100% ACCESS
HEALTHCARE COALITION

Women's Care
OBSTETRICS & GYNECOLOGY

DOUGLAS AUSTIN, MD
SUSAN ARMSTRONG, CNM
590 Country Club Pkwy.
Suite A
Eugene, OR 97401
Phone (541) 683-1559
Fax (541) 683-1709

BRANT COOPER, MD
MELISSA EDWARDS, MD
MATTHEW HAUGEN, MD
TINA SCHNAPPER, MD
JENNIFER TUFARIELLO, MD
HEATHER YORK, MD
590 Country Club Pkwy.
Suite B
Eugene, OR 97401
Phone (541) 686-2922
Fax (541) 683-1709

KEITH BALDERSTON, MD
VERN KATZ, MD
3355 RiverBend Drive
Suite 210
Springfield, OR 97477
Phone (541) 349-7600
Fax (541) 686-8330

CRISTIN BABCOCK, MD
KIMBERLY BOCK, MD
FREDERICK GREEN, MD
PAULA JEWETT, MD
BROOKE KYLE, MD
GARY LECLAIR, MD
SUZANNE TEMPLE, MD
CATHERINE YORK, MD
SUSAN TREZONA, CNM
3100 MLK Jr. Pkwy.
Springfield, OR 97477
Phone (541) 868-9700
Fax (541) 485-7392

April 24, 2012

Dear Oregon Health Authority,

Women's Care is an independent group of Obstetricians and Gynecologists in Eugene and Springfield, Oregon, with 17 partners and 4 clinic locations. We offer obstetrics, gynecology, infertility, maternal fetal medicine, reproductive endocrinology and urogynecology. We believe that all women have a right to quality health care before, during and after their childbearing years. It is our goal to offer convenient, high-quality, patient-centered care.

Women's Care supports the application being submitted by Trillium to create a Regional Coordinated Care Organization. This organization will be built on the excellent existing organizational and structures developed over the past 15 years by Lipa and Lane County (LaneCare). Building from existing infrastructure will reduce the capital requirements for meaningful delivery system reform.

There has been a substantial community engagement process that has incorporated input from providers, OHP members and their advocates, community members, and system partners. The community has agreed to support a single application to form a CCO that provides integrated care for the residents of Lane County. As appropriate, in the future the CCO will incorporate Medicare and patient populations into an integrated health care system.

Lane County and Lipa will create a co-managed administrative organization that incorporates existing provider networks and supports the continuity of delivery system strengths. The new organization will also achieve administrative savings through the development of integrated and efficient management structures.

The CCO will form a Governance Board that will help guide the development of the CCO and, more importantly, will set policy and procedures for service

Women's Care
OBSTETRICS & GYNECOLOGY

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delivery change strategies so that we can better meet the Triple Aim. The community is discussing strategies for enhancing person-centered primary care medical homes, integrating behavioral health and physical health and identifying high risk high cost patients where savings can be achieved through better care coordination.

Women's Care fully supports Trillium's application.

Sincerely,

Melissa Edwards, MD
Women's Care Obstetrics & Gynecology
590 Country Club Pkwy, Ste. B
Eugene, OR 97401
www.womenscare.com

Terry W. Coplin

SUMMARY

Healthcare executive with extensive background in health plan management, medical group practice and physician networks. Experience with mergers, company startups, and corporate development. Understanding of technological issues, especially regarding information systems, health plan products and corporate finance. Strong expertise in government insurance products, including managed Medicaid and Medicare Advantage.

EDUCATION

M.B.A., Gonzaga University, Spokane, WA
Major: Accounting, Information systems

B.S., University of Alabama, Tuscaloosa, AL
Major: Mathematics
Minor: Physics

MT(ASCP) Degree and certificate
School of Medical Technology, University of Alabama

MLT(ASCP), U.S. Army School of Medical Laboratory Science
Fort Sam Houston, TX

PROFESSIONAL EXPERIENCE

AGATE HEALTHCARE (Agate) **1999-Present**

CEO
CEO of this parent company and its subsidiaries, with health care related subsidiary companies and products. Top to bottom P&L responsibility. Products include: 1) Medicare and Medicaid insurance products, 2) Medical coordinated care and case management programs, 3) Medical billing services and claims payments, 4) Health plan benefits management, and 5) Physician credentialing program.

Corporate Officer – Secretary (2004 - present)

Agate Resources/Lane Individual Practice Association (Lipa)

Lipa is a wholly owned subsidiary of Agate Resources, Inc. Chief executive of 3rd largest Oregon Medicaid Managed Care company. Covers approximately 47,000 Medicaid members. Managed this program from Oregon contract application in 1999 to present.

Agate Resources/Trillium Community Health Plan, Inc. (TCHP)

TCHP is a wholly owned subsidiary of Agate Resources, Inc. Managed the creation and market introduction of this MA-PD insurance company whose scope includes Medicare Specials Needs Plan, Institutional SNP, and Commercial Medicare. Market introduction, January 1, 2007. Currently covers approximately 3,600 Medicare members, mostly dual eligible.

Board of Directors – Secretary (2006-present)
Director and officer

CASCADE MEDICAL GROUP, INC./ CASCADE PHYSICIANS, PC 1993 - 1999

CEO/ Administrator (1993 - 1999)
Reported to the Board of Directors of this physician Management Service Organization (Inc.) and medical group practice (PC). Manage all business aspects, including practice mergers, withdrawals, and financing.

- Built MSO and acquired contracts with HMOs for capitated lines of business.
- Developed a claims department, expanded accounting and billing services.
- Lead the team to purchase and install central computer systems.

Board of Directors - Treasurer (1995 - 1998)
CMG was partner and part owner in Northwest Physician's Alliance and Northwest Group Practices Association. Served on the Board of both organizations. The Northwest Physician's Alliance was a corporation whose partners were BlueCross BlueShield of Oregon, Legacy Health Systems (5 hospitals), Cascade Medical Group, MedPartners, and HealthFirst Medical Group.

WENATCHEE VALLEY CLINIC, PC 1984 - 1993

Associate Administrator (1988 - 1993)
Reported to the Administrator of this 120 physician, 600 employee medical group practice.

Laboratory Manager (1984 - 1988)
Responsible for the general and business management of group's medical laboratories. Approximately 45 employees (Pathologists, technologists, technicians, and Ph.D. level scientists).

YUKON-KUSKOKWIM DELTA REGIONAL HOSPITAL 1980 - 1984
ALASKA AREA NATIVE HEALTH SERVICES

Laboratory Manager (1980 - 1984)
52 bed general hospital in the Yukon-Kuskokwim delta region of Western Alaska.

COLLEGE OF COMMUNITY HEALTH SCIENCES 1976 - 1980
UNIVERSITY OF ALABAMA

Laboratory supervisor/ Lecturer (1976 - 1980)

Family Practice Residency program and clinics.

DCH HOSPITAL **1974 - 1977**

Medical Technologist (1974 - 1977)
600 bed community hospital

NATO/ SHAPE **1971 - 1974**
SUPREME HEADQUARTERS OF ALLIED POWERS IN EUROPE
U.S. ARMY

Honorable Discharge (1971 - 1974)
International Military Headquarters, Belgium

COMMUNITY and BOARDS

Coordinated Care Organization (CCO) Criteria Workgroup (2011-present)
Workgroup formed by Oregon Health Policy Board to review criteria and provide recommendations on the creation of Oregon CCO's to be presented by Oregon Health Authority as proposal for legislation.

Health System Transformation Team (Oregon Health Authority) (2010-2011)
Work chartered by Oregon Health Policy Board at the request of the Governor. Work products: 1) define elements for a successful delivery system including benefits and service integration, 2) budget/value proposition, 3) draft legislation recommendation, resulting in HB 3650

ACO Steering Committee (2010-present)
Community leader efforts to form a community base model for an ACO and identify methods of integration.

United Way of Lane County Board of Directors (2010 – Present)
Executive Committee (2010 – Present)

US Bank Advisory Board (2009 – Present)
Member

Health Policy Research Northwest (2005 – Present)
Board of Directors

Statewide Children's Wraparound Initiative Advisory Committee (2008 – 2009)
Governor's appointment: community based, coordinated system of services and supports for Oregon children with complex behavioral health needs and their families.

Lane County Medical Society, Presidential Citation (05-06-2008)
Award for work with Oregon Health Fund Board toward comprehensive health care for all Oregonians.

Lane Community College Foundation (2008 – Present)
Board of Trustees – Legal authority for the Lane Community College Foundation.

Oregon Health Fund Board, Finance Committee (2007 – 2008)
OHFB was created by SB 329 to create a plan to provide health care for all Oregonians; present that plan to the Governor for legislative action in 2009.

Advisory Board for Community Health Centers of Lane County (2004 - 2009)
Advisory Council member to this Federally Qualified Health Center (FQHC).

Birth To Three (2006 – 2009)
Board of Directors – Non-profit organization to assist with parenting education and support for families with infants and young children.

100% Access of Lane County (2004 - Present)
Executive Committee and Board – Community Collaboration around access for the uninsured.
Executive Committee Chair (2011 – 2012)

LIPA Community Advisory Committee (2007 - Present)
A committee of community advocates and other health plan stakeholders whose purpose is to provide community input into the administration of the health plan.

Oregon Health Plan Contractors (2000 - Present)
A monthly forum for Oregon Health Plan contractors, including CEO's, to exchange information with the Department of Medical Assistance Program, including mental health and dental organizations.

Archimedes Project Insurance Advisory Committee (2006 - 2007)
Member of the insurance advisory committee to Governor Kitzhaber regarding the Archimedes project.

Coalition for a Healthy Oregon (COHO) (2000 - 2007)
Chair (2006-2007) --Association of Oregon Health Plan organization, represented by the CEO's from each participating organization.

PUBLICATIONS

Pieroni RE, Coplin TW, Leeper JD: Tetanus and Diphtheria Immune Status of Patients in a Family Practice. J. Family Practice 11:403-406, 1980.

Pieroni RE, Coplin TW, Leeper JD: Survey of Tetanus Immunity. J Med Assoc. St. Al.: P. 38, July 1981.

Pieroni RE, Coplin TW, Leeper JD, Thames CT: the Changing Status of Diphtheria Immunity. J Med Assoc. St. Al.: P. 41, Feb 1981.

DAVID L. COLE, C.P.A.

SUMMARY

Certified Public Accountant currently the Vice President of Finance and Chief Operating Officer (COO) for Agate Healthcare, Inc. Experience with company startups, and corporate development. Participated at executive and board level in the creation and continuing operations of corporations. The Chairperson of the Agate Healthcare, Inc. Finance Committee. Understanding and quick grasp of issues, especially regarding corporate finance and information systems.

EDUCATION

B.S., University of Oregon, Eugene, OR
Major: Accounting

CERTIFICATIONS

CPA Certified Public Accountant, State of Oregon

PROFESSIONAL EXPERIENCE

AGATE HEALTHCARE INC. (1997-Present)

Executive VP of Finance and Chief Operating Officer
Reports to CEO of Agate Healthcare. Manage Finance Department and IS Department. Played integral role in the creation of Agate Healthcare. Responsible for all Financial and Contractual issues involved in the start-up. Agate Healthcare is a for-profit company which began operation in Janaury of 2004. Agate Healthcare is responsible for providing administrative services for various healthcare related companies.

LANE INDIVIDUAL PRACTICE ASSOCIATION (Lipa)

Chief Financial Officer
Reports to CEO of Lipa. Manage Finance Department and IS Department. Responsible for all phases of financial reporting for the organization, including, annual audit of organization, monthly interim financial statements, annual budget, risk management of organization, and cash management of organization. Oversee the day to day operations of IS, including, rewriting of claims and referral software, upgrading and maintaining all computer equipment.

- Integral piece of company turnaround from losses in '97 to profit in all succeeding years.
- Negotiated favorable risk contracts for physicians.
- Negotiated Re-insurance contracts resulting in hundreds of thousands in savings.
- Negotiated settlements with health plans that resulted in annual savings over $300,000.
- Oversaw the in-house rewrite of claims software resulting in $200,000 annual savings.

Financial Analyst/Contracts Coordinator
Preparing and analyzing contract data. Working with physicians to negotiate and implement contracts. Negotiating and implementing reinsurance contracts. Supervising staff and overseeing financial operations. Working with physician community to problem solve contract issues.

TRILLIUM COMMUNITY HEALTH PLAN, INC.
Executive VP of Finance
Reports to CEO of Trillium Community Health Plan, Inc. Manages the Finance Department. Played integral role in the creation of Trillium Community Health Plan, Inc. Responsible for all Financial and Contractual issues involved in the start-up. Trillium is a for-profit company which began operation in February of 2006.

SELECTCARE (1995-1997)

Manager Specialty Transactions Department (1996-1997)
Negotiation, tracking and filing of Reinsurance, ($1.5 million recoveries yearly). Third Party Liability-Subrogation, ($700,000 recoveries yearly). Oversee Coordination of Benefits. Claimcheck (claims auditing software that results in $700,000 in savings yearly). Risk Manager for SelectCare. Managing the Copy Center for LIPA was also in my portfolio of duties.

Senior Financial Analyst (1995-1996)
Contract reconciliation for Lane County Contracts, including SelectCare Plus, Oregon Health Plan, Senior Plus, and the LIPA Contract. LIPA Contract negotiation team. Physician Incentive paybacks for Lane County Contracts and Non-Lane County Contracts. Preparation of Incurred But Not Reported (IBNR) monthly reports. Preparation of Mental Health Match Off-System Capitation payments.

THOMAS R. GRIGGS C.P.A. (1991-1995)
Certified Public Accountant
Prepare Interim and Year-end Financial Statements, Prepare Income Tax Returns, Business and Personal Financial Consulting, Municipal Auditing.

ORGANIZATIONS

Oregon Society of Certified Public Accountants	1994- Present
State of Oregon Member - Certified Public Accountant	
HIV Alliance Board Member - Treasurer	2007-Present
Chair-State of Oregon Financial Solvency Committee	2004-2010

John E. Sattenspiel, M.D.
2120 W 27th Avenue
Eugene, OR 97405
503-881-3787 (Mobile)

Medical Practice: Private Family Practice in Salem Oregon – 1982 to 2006

Current Employment
Chief Medical Officer Agate Healthcare, Eugene Oregon – 2006 to present
Chief Medical Officer LIPA Medicaid Managed Care – 2006 to present
Chief Medical Officer Trillium Community Health Plan – 2006 to present
Chief Medical Officer Apropo Benefits Management – 2006 to present

Education
Family Practice Residency – 1979-1982
Oregon Health Sciences University
Portland, Oregon

Dr. of Medicine – 1979
University of Arizona
Tucson, Arizona

Certification
Advanced Life Support in Obstetrics (ALSO)
Certified – 1994
Certified Instructor – 1995

American Board of Family Medicine
Certified – 1982
Recertified – 1989, 1995, 2001, 2007

National Board of Medical Examiners
Certified – 1979

Licensure
Oregon – 1980

Hospital Affiliations:
Salem Hospital
Chief Family Medicine Section 2006
Chief of Family Practice Department – 1987 and 1988
Executive Committee Member – 1987 and 1988
Active Staff – 1982 to 2006
Committees
Multiple hospital committees including:
OB Performance Improvement
Family Practice Committee
Executive Committee
Chairman of Bylaws Committee
OB Patient Care Review
Patient Care Review
Utilization Review

Pediatric Committee
Alternate Delegate AMA/HMSS

Professional Societies and Activities

American Medical Association
Member – 1976 to present

American Academy of Family Physicians
Director – 2002 to 2005
Board of Directors Strategic Planning Subcommittee 2002-2005
Board Liaison Commission on Legislation and Governmental Affairs 2004 to 2005
Board Liaison Commission on Health Care Services 2003-2004
Board Liaison Commission on Continuing Medical Education 2002 to 2003
Board Liaison Committee on Scientific Program 2002 to 2003
Commission on Quality and Scope of Practice 1999 to 2002
Chairman of Commission on Quality and Scope of Practice 2001 to 2002
AAFP representative to AMA Physicians Consortium Working Group on Osteoarthritis Performance Measures 2002-2004
AAFP representative to NCQA Practicing Physicians Advisory Committee 2002 to 2005

American Board of Family Medicine
Standard Setting Committee for Certification/Recertification Examination, 2008

Mid-Valley IPA
EHR Selection and Implementation Steering Committee 2004 to 2006

Marion-Polk County Medical Society
Member – 1982 to 2006

OMPAC
Board member – 1986 to 1990

Oregon Academy of Family Physicians
Alternate Delegate to AAFP – 2000 to 2002
President – 1998 to 1999
Chairman External Affairs Commission – 1999 to 2002
Risk Management Committee – 1989 to 2002
Public Policy Committee – 1987 to present, Chairman – 1991 to 2002
Financial Committee – 1989 to present
Board Member – 1985 to 2005
Scientific Assembly Committee – 1989 to 1996
Speaker, Congress of Delegates – 1990 to 1992
Member – 1979 to present

Oregon Medical Association
Legislative Committee – 1992 to 2004
Professional Assessment Committee – 1990 to 2007
Member – 1979 to present

Regence HMO Oregon (formerly Capital Health Care)
Quality Improvement Committee – 1992 to 2002

Primary Care Committee – 1989 to 1990
Pharmacy Advisory Committee – 1987 to 1988

University of Arizona College of Medicine
Admissions Committee – 1979 to 1981

Oregon Health Care Quality Corporation
Member Board of Directors 2006-2007
Member Measurement and Reporting Team for Oregon Aligning Forces for Quality initiative (multi-year project funded by Robert Wood Johnson Foundation)

University Appointments

University of Oregon Health Sciences Center
Clinical Assistant
Professor of Family Medicine – 1982 to present

Awards

Master Teacher Award – 2001
Department of Family Medicine, OHSU

Alumni Association Meritorious Achievement Award – 2002
Department of Family Medicine, OHSU

PATRICE KORJENEK
Health Economist

Passion: to maximize safe, high quality, affordable healthcare by USING performance information created through data analysis

Superior analysis skill finds what others miss
Connects everyday actions to the big picture
Generates priorities, innovative solutions, practical recommendations
Implements systematically, effectively, efficiently
Communicates successfully with diverse individuals

EXCERPTS FROM PERFORMANCE REVIEWS
"Immensely practical"
"...questions traditions and considers new, innovative alternatives."
"Has a great deal of personal credibility."
"Recognizes readily where her limits are."
"Knows how to listen, ask questions, and lead you to a conclusion..."
"A fantastic public speaker"
"Wonderful laugh...reminds us all jobs can be fun and rewarding."

Highlights

- More than 15 yrs in health insurance, provider performance, clinical processes and outcomes, data analysis & systems improvement
- Scholarly trained; real world applied
- Successfully managed multi-million dollar health systems projects
- Familiar with performance of primary, specialty, ancillary providers, hospitals, disease & and case managers
- Prioritized and coordinated insurer operations by using clinical data to align consumer and provider strategies.
- Saved the insurer over $8 M by negotiating terms & analyzing data to reconcile performance-based patient management contracts.

EDUCATIONAL BACKGROUND

- **Post Doctoral Fellow**, University of North Carolina, Carolina Population Center, USA, 1989 – 1991. Research: The Microeconomic Effects of Macroeconomic Adjustment in Cebu, Philippines
- **PhD Economics**, University of Oregon, USA, 1989. Dissertation: The Effect of Health on Worker Productivity in Bicol, Philippines
- **MA International Studies; BA Government**

PROFESSIONAL EXPERIENCE SUMMARY

- **Chief Performance Officer, Agate Healthcare, 2012-present**
  Measures, manages, and improves the performance of the Agate family of companies including Lipa and Trillium
- **Independent Health Economics Consultant, World Bank, Abt Associates-USAID,Various Country Governments, 2004-present**
  Provides technical support for health system reform and strengthening
- **Assistant Vice President Health Services- Health Economics and Medical Informatics, Regence BlueCross BlueShield of Oregon, 2001-2004**
  Led multidisciplinary team of analysts and programmers conducting clinical and financial analyses to make recommendations for action
- **Manager Actuarial and Underwriting-Provider Performance, Regence BlueCross BlueShield of Oregon, 1995-2000** MANAGEMENT LEADERSHIP AWARD

Created a team to monitor and evaluate provider clinical and financial performance, identify and promote best practices

- **Manager Actuarial and Underwriting- Resource Allocation Specialist, Regence BlueCross BlueShield of Oregon, 1994-1995**
  Assessed business processes and IS for efficient and effective allocation of company resources

PROFESSIONAL EXPERIENCE DETAILS

Independent Health Economist Consultant **2004-Present**

Republic of Kazakhstan, Ministry of Health
Supported the State Healthcare Development Program for 2011-2015 in developing a performance rating system for healthcare organizations within the Uniform National Health Care System
Republic of Georgia, Abt Associates-USAID, World Bank
Supported USAID Health System Sustainability Project, private insurers and providers with privatizing healthcare financing and insurance
Albania, Ministry of Health, World Bank
Evaluated national health insurance organization's readiness for hospital performance analysis
Bulgaria, Council of Ministers, World Bank
Evaluated legislation proposing to expand the role of private health insurers in Bulgaria
Serbia, Ministry of Health, World Bank
Supported National Insurance Fund and hospitals in measuring a baseline for analyzing the effects of case-based payment reform
Lebanon, World Bank
Developed and monitored implementation of a hospital performance measurement action plan, data analysis, performance indicators, reports
Philippines, DAMPA NGO
Worked with community organizers to strengthen community savings funds and family health programs
Bosnia- Herzegovina, Republika Srpska, Ministry of Health, World Bank
Led a team of Health Insurance Fund staff to create comparable hospital performance reports for strategic purchasing
Finland Institute for Research and Development, Luxembourg Ministry of Health
Reviewed Sustain Health Care Project for Helsinki Conference on the sustainability of healthcare financing in Europe
Poland, National Health Fund, World Bank
Collaborated with National Health Fund staff to assess the insurer's data strategy, functions, and operations
Egypt, Jordan, Abt Associates-USAID
Developed and implemented pilot programs for alternative methods of national healthcare financing and delivery

Other Consultancies: **1989- 2001**
Oregon Research Institute, World Bank, Abt Associates, Urban Institute, USAID Health Financing and Sustainability Project, Inovise Medical
Burden of disease /cost effectiveness of interventions in East Africa;

equity/efficiency implications of changes to the social insurance system in Kenya; Ministry of Health adjustments to fiscal austerity policies in Kenya; MCH, family planning, nutrition and other services costs of World Summit Health Goals in Latin America and the Caribbean; cost effectiveness analysis of smokeless tobacco use cessation, domestic violence; pricing of new diagnostic technology in Oregon.

Regence Blue Cross BlueShield of Oregon **1994-2004**
Assistant Vice President, Health Services Division, Health Economics and Medical Informatics 2001-2004 **USA**
Manager, Actuarial and Underwriting Division, Provider Performance 1995-2000
Resource Allocation Specialist, Actuarial and Underwriting Division 1994-1995
MANAGEMENT LEADERSHIP AWARD
The Regence Group began in the late 1990s as a holding company for four separate Blues plans in Washington, Idaho, Utah, and Oregon that integrated to form a regional alliance.

Data/Research Analysis/HMIS

- Improved the accuracy, appropriateness and timeliness of priority data and deliverables by evaluating and changing work flow systems
- Created a forum for routinely sharing actionable, high impact clinical and financial information with senior leaders
- Improved system support for current operations while allowing for future flexibility by integrating systems, identifying business requirements, making recommendations, standardizing analyses practices
- Brought functional consistency and reduced operating costs (est. $10M savings) by leading four health plans in selecting a common HMIS
- Co-directed installation of HMI systems, the largest a warehouse combining data from four health plans with a $15M project budget
- Worked with a wide variety of clinical, non-clinical data (claims/utilization, membership, provider, financial) to develop routine and ad hoc reports, metrics, indicators, targets, benchmarks

Medical/Quality Management

- Reduced evaluation disparities and inconsistencies by leading development of corporate guidelines for calculating returns on medical management investments
- Improved the effectiveness of clinical intervention programs by evaluating processes and outcomes (high risk pregnancy, CAD, CHF, diabetes, low back surgery, tobacco cessation, radiology utilization, physical therapy utilization, child and adult immunizations, preventive screenings, behavioral health)
- Increased the effectiveness of medical management operations and the rigor of savings reporting by evaluating processes and negotiating changes; example: retrospective claims reviewers found $6M in provider overpayments that were never collected
- Saved over $10M by formulating, negotiating, and reconciling performance-based contracts

- Provided analysis support for clinical quality and patient safety including "Excellent-top 10%" NCQA accreditation, HEDIS, member satisfaction surveys, risk appraisals, disease studies, customer service studies
- Led work with HEDIS auditors and analysis support for Medicare audits

Provider Performance

- Started and matured the plan's provider performance reporting process; profiled providers; worked with medical groups to improve performance
- Developed and implemented the plan's first performance-based method for tiering provider networks
- Strengthened provider contracts by analyzing data, identifying opportunities, recommending actions; modeled provider reimbursement alternatives; established and reconciled provider budgets and performance incentives
- Contributed to state and national work groups developing provider rankings
- Familiar with diverse reimbursement methods
- Familiar with diverse clinical reporting systems, clinical groupers, and risk adjustment methods

Actuarial/Underwriting/ Marketing/ Finance

- Enhanced the cost control and marketability of group products by using clinical information to align medical and benefit management strategies
- Informed the design of new products by monitoring the clinical risk of market segments over time
- Increased the success of new benefit designs by modeling their clinical and financial impacts
- Improved timeliness of problem identification and resolution by analyzing monthly trends, anomalies, and opportunities for cost control in plan spending ($175M); prepared and oversaw department ($1.2M), division ($7M) budgets
- Supported external and internal audits

General Administration

- Started, grew a multidisciplinary analysis department
- Recruited, reviewed, coached, trained, disciplined/discharged staff
- Directed work of consultants, contractors, vendors, affiliate plan personnel
- Led and participated in collaborative teams
- Developed and maintained strategic partnerships with internal and external collaborators

University of Oregon, University of N. Carolina, Portland State University, Clark College, Lane Community College, Linfield College, Pittsburg Unified School District, El Jay, Inc. **1980-2003**

Educator

- Taught Micro/Macro Principles, Intermediate Micro/Macro, Undergraduate and Graduate Health Economics, Graduate and Undergraduate Development Economics, Political Economy
- Successfully negotiated two collective bargaining agreements; participated in arbitration, grievance hearings
- Taught junior high school; ESL and Special Ed

WORK PRODUCTS & PAPERS:

Available upon request

OTHER RECENT ACTIVITIES:

Smart Health Decisions, LLC
Independent advocate helps users navigate the health care system, especially Medicare choices
Internal Review Board, Peace Health Southwest Washington Medical Center
Board member reviews clinical research for adherence to FDA patient protection and data integrity standards
Kaiser Permanente and OHSU Resident Seminars
Works with physician residents to better understand healthcare financing

Shannon Conley

188 E Anchor Avenue
Eugene, Oregon
(541)461-0535
conx4@comcast.net

Summary

Highly motivated, results driven professional with 17 years experience in the health care industry. Thrive on innovation and change in business strategy. Experienced in building work teams and startups with long term business goals.

Community

2006-2010 North Eugene Dance Team Fundraising
2008-2010 Medical Access Program Committee
2009-present Senior Companions and Successful Aging Institute Council
2009-present Aging & Disability Resource Center Advisory Council

Experience

10/2010 – Present Agate Healthcare / Lipa / Trillium
Senior Vice President of Medicare and Medicaid Services

- Director of Medicare programs including Dual Special Needs Plan
- Interface with CMS, DMAP and Agate, Trillium and Lipa Board of Directors
- Management of Marketing and Sales activities
- Participation in all facets of Medicare program management including introduction of new regulatory requirements, benefit design, quality improvement and bid development
- Participate in consideration of product development and acquisitions

08/06-10/2010 Agate Healthcare / Lipa / Trillium
Medicare Program Director and Associate VP of Claims Administration

- Successful participation in launch of new Medicare program
- Management of implementation teams
- Responsible for oversight of the Operations Department Managers for Lane Individual Practice Association and Trillium Community Health Plan.
- Responsible for oversight of the Marketing Department Manager and marketing activities.
- Development of policies, procedures and process in accordance with URAC, DMAP and CMS.
- Contributed toward preparation and development of documentation for URAC accreditation.
- Participation in benefit design and annual bid process with CMS

03/01-08/06 Agate Healthcare / Lipa / Trillium
Operations Manager

- Successful transition of health plan membership from 15,000 to 30,000 members over two months

- Development of training manuals, policies, procedures and work flow including auditing materials intended to ensure claims and customer service operated in accordance with DMAP rules.
- Oversight of the Lane Individual Practice Association and Employers Health Alliance Operations activities including claims payment and customer service.
- Development of claims queue processing which increased accuracy and productivity.
- Collaboration in creation and launch of Apropô; a durable benefits management company. Including strategic planning, operational development, and participation in health plan needs assessments.
- Contributed toward development of the Trillium Community Health Plan Medicare application.
- Supervision of all Operational staff for Lane Individual Practice Association and Employers Health Alliance in excellence in professionalism, productivity and customer service.

11/99-02/01 Agate Healthcare / Lipa / Trillium

Claims Analyst

- Processing of primary care, specialty and hospital claims for Lane Individual Practice Association.
- Provided back-up assistance for the Provider Payment Specialist on weekly claims processing check run.
- Collaboration with the IS department in concept development of the Docustream claims scanning process.
- New employee training claims auditing and error recovery.

08/90-09/95 Junction City Medical Clinic

Medical Office Assistant and Limited x-ray technician

- Assisted physician in busy rural medical practice
- Preparation of patients for exams, preparation and administration of injections, EKG, and Holter monitors. Assistance with minor surgeries and examinations
- Performed x-rays, phlebotomy, and basic lab tests while maintaining OSHA standards.
- Ordered supplies, maintained medical records, insurance referrals, prior authorizations and phone triage.
- Successfully assisted physicians in maintaining an extremely busy medical practice.

Education

1990 Medical Office Assistant Certificate Program and General Studies
Lane Community College

1990 Limited x-ray permit in upper and lower extremities, chest and ribs, radiation use and safety. Oregon x-ray Institute

CASSANDRA C. SKINNERLOPATA
1800 Millrace Drive•Eugene, OR 97403•(541) 790-1441•cass@agatehealthcare.com

PROFESSIONAL EXPERIENCE

Agate Healthcare/Lipa/Trillium Community Health Plans • Eugene, Oregon
General Counsel, Medicaid Program Director, Contracting Department Manager • January 2011 to present

- Provide in-house legal counsel and legislative review to parent company, its subsidiaries, and all relevant boards of directors and executive management.
- Manage and oversee contracting department and staff.
- Collaborate with senior and mid-level management and state officials to implement all aspects of the Medicaid/OHP state contract within Lane County.
- Represent Lipa in monthly statewide stakeholder meetings.

Cassandra C. SkinnerLopata, SkinnerLopata Harris LLC • Eugene, Oregon
Attorney • December 2007 to January 2011

- Founding partner of three-attorney law firm with emphasis in general civil practice including family law, domestic partnership planning, and litigation.

Career Services, University of Oregon School of Law • Eugene, Oregon
Interim Career Counselor • January 2008 to June 2008

- Counseled law students regarding short-term and long-term career goals.
- Reviewed and edited students' job application materials.
- Facilitated mentorships between students and practicing attorneys.

Cassandra C. SkinnerLopata, SkinnerLopata Law LLC • Eugene, Oregon
Attorney • August 2007 to December 2007

- Civil practice, both transactional and trial based, with emphasis in family law, estate planning, general civil litigation and contract work.

Lane County Legal Aid Services, Inc., Domestic Violence Clinic • Eugene, Oregon *Contract Attorney* • June 2007 to September 2007

- Counseled, represented, and appeared in court on behalf of clients in contested restraining order, stalking order, and custody cases.

Margaret J. Wilson, Wilson Law Office • Eugene, Oregon
Associate Attorney • April 2007 to August 2007

- Civil practice with emphasis in employment law, estate planning, family law, and general civil litigation.

Honorable Charles D. Carlson, Lane County Circuit Court • Eugene, Oregon
Judicial Clerk • May 2006 to April 2007

- Researched and drafted memoranda on a variety of legal issues.
- Coordinated courtroom procedures and the administration of criminal and civil proceedings.

APPOINTMENTS

Oregon Liquor Control Commission • Oregon
Chair of the Board of Commissioners • July 2011 to present

- Appointed by Governor John Kitzhaber.

Commissioner • July 2009 to March 2013

• Nominated by Governor Kulongoski and confirmed by the Oregon State Senate.

Governor's Council on Domestic Violence • Oregon
Member • June 2006 to October 2009
• Appointed by Governor Kulongoski.

Oregon State Bar Association • Oregon
Co-Grader, Board of Bar Examiners • January 2008 to present; *Member, Quality of Life Committee* •2007-10

LEADERSHIP • COMMUNITY SERVICE

National Alcohol Beverage Control Association (NABCA), Arlington, Virginia
Board Member • July 2011 to present

Survivors Justice Center/Stop Violence Against Women Clinic Project, Eugene, Oregon
Advisory Board Member • 2009 to present; *Domestic Violence Clinic Supporter* • 2003 to present

Oregon State Bar Association, Leadership College
Fellow • 2009

Lane County Bar Association, Mentorship Program
Mentor Attorney • 2007 to present

Head Start of Lane County, Board of Directors
Secretary 2009-10; *Member, Negotiating Team* 2008-10; *Board Member* 2007-11

Legal Research and Writing Program, University of Oregon School of Law
Judge for First Year Appellate Brief Oral Arguments • 2007-11

Loan Repayment Assistance Program, University of Oregon School of Law
Community Board Member • October 2007 to August 2008

SB 269 Forms Implementation Workgroup
Member • October to December 2007

Women's Law Forum, University of Oregon School of Law
Co-Director 2005-06; *Conference Co-Director* 2004-05; *1L Representative* 2003-04

Lane County Human Rights Advisory Committee
Associate Member • October 2003 to August 2006

OUTLaws (LGBTQA Student Association), University of Oregon School of Law
Member • September 2003 to May 2006

Womenspace, Eugene, Oregon
Volunteer Legal Advocate; *Domestic Violence Crisis Line Volunteer* • January to September 2004

University Health Center, University of Oregon
Peer Health Education Program, Domestic Violence Guest Speaker 2003 to present; *Student Health*
Advisory Committee Member 2002-05; *Peer Health Education Intern* 2002

INTERNSHIPS • OTHER EXPERIENCE

Lane County Legal Aid Services, Inc., Domestic Violence Clinic • Eugene, Oregon *Legal Intern* • August 2005 to November 2005

Honorable Robert D. Durham, Oregon Supreme Court • Salem, Oregon *Legal Extern* • Summer 2005

Phyllis Barkhurst, Attorney General's Sexual Assault Task Force (SATF) • Eugene, Oregon • *Volunteer Legal Intern* • February 2005 to May 2005

Professor Caroline Forell, University of Oregon School of Law • Eugene, Oregon *Research Assistant* • July 2004 to May 2006

PROFESSIONAL MEMBERSHIPS • LICENSES

Oregon State Bar Association • Oregon *Member: Business, Diversity, Elder, Estate Planning, Family Law, Health Law Sections* • May 2007 to present

Lane County Bar Association • Oregon *Member: Family Law Committee* • May 2007 to present

Oregon Women Lawyers • Oregon *Board Member* • May 2010 to May 2012 *Member* • July 2005 to present

Lane County Women Lawyers • Oregon *Member* • May 2007 to present

Oregon Minority Lawyers Association • Oregon *Member* • July 2006 to present

Multnomah County Bar Association • Oregon *Member* • 2008-09

Oregon Gay and Lesbian Law Association •Oregon *Member* • July 2006 to present

Oregon State Bar • #072036

United States Bar • District of Oregon

American Bar Association • Health Law Section *Member* • February 2011 to present

American Health Lawyers Association • *Member* • February 2011 to present

EDUCATION

***University of Oregon School of Law,* J.D.** • Eugene, Oregon • May 2006
Certificate in Public Interest and Public Service Law

- *Honors*: National Association of Women Lawyers Outstanding Law Student Award 2006; University of Oregon Nontraditional Student Award 2006; University of Oregon Diversity- Building Scholarship 2005-06; Journal of Environmental Law and Litigation (JELL), *Senior Editor* 2005-06; *Staff Editor* 2004-05
- *Scholarships*: Charles G. Howard Law Scholarship Fund 2006; Wayne Morse Memorial Scholarship 2005-06; Barnett Memorial Scholarship 2005-06, 2004-05; Leslie Harris Scholarship 2005-06, 2004-05; Kathryn Fenning Owens Scholarship 2004-05

***University of Oregon*, Post-Baccalaureate Studies** • Eugene, Oregon • September 2001 to June 2003 • Pre-Medical Sciences Track/Biology

***University of Colorado*, B.A., Anthropology** • Boulder, Colorado • May 1999

***University of South Florida*, A.A.** • Tampa, Florida • May 1995

AWARDS • PUBLICATIONS

A recipient of the 2010 "20 Under 40" Rising Business Star Award from the Register-Guard/Blue Chip Monthly Business Magazine.

Cassandra C. SkinnerLopata, *From "The Victim's Situation": A Hypothetical Opinion By A "Reasonable Woman,"* 8 J.L. & SOC. CHALLENGES 111 (Fall 2006).

BRUCE ABEL, D.S.W., L.C.S.W.
2452 Lawrence Street; Eugene, Oregon 97405
(503) 344-7221

EXPERIENCE:

1997-Present **Lane County Health and Human Services, Eugene Or.**
LaneCare Manager, Eugene Or.

LaneCare is the County operated Oregon Health Plan Mental Health Organization with a $32,000,000 budget, 55,000 members and over 60 contracts with community providers.

Responsibilities: *Budget, policies and procedures, hiring and supervision, contracting, provider relations, service system oversight, and public relations*

2000-2010 **Chair, OHP-MHO State Contractor Committee**

2003-2004 **Lecturer, Portland State School of Social Work**

1995-2001 **Lane County Health and Human Services, Eugene Or.**
Project Director, New Opportunities Program

New Opportunities was a CMS funded, child system integration grant that created enhanced community partnerships, blended funds, and developed a wraparound approach to care.

Responsibilities: *Reporting, grant management, budget, policies and procedures, hiring and supervision, contracting, provider relations, service system oversight, and public relations*

1995-1998 **Lane County Health and Human Services, Eugene Or.**
Child and Adolescent Behavioral Health Manager

Responsibilities: *Budget, policies and procedures, hiring and supervision, contracting, provider relations, service system oversight, and public relations*

1988-1995 **Looking Glass Counseling Center, Eugene, Oregon Director of Outpatient Services, (Mental Health, Substance Abuse Treatment, and Family Preservation)**

Responsibilities: *Program management and development, grant writing, budget, hiring and supervision, service coordination.*

1985 - 1987 **University of Pennsylvania, School of Social Work, Philadelphia, Pennsylvania; Lecturer**

1985-1988 **Family and Community Service of Delaware County, Media, Pennsylvania; Supervisor of Special Services**

Responsibilities: *Program management and development of seven clinical programs, grant writing, budget, service coordination, intern training, and community education program.*

1983-1985 **University of Pennsylvania, School of Social Work, Family Maintenance Organization, National Institute of Mental Health, Adolescent Mental Health Grant**

Responsibilities: *Support to community for refugee families in Philadelphia, focus on family and adolescent issues.*

1982-1983 **Catholic Family Services, Bellingham, Washington; Day Treatment Program Manager, Out Patient Therapist**

Responsibilities: *Management of a day treatment program for school age youth; out-patient therapist providing community based treatment.*

1980-1982 **Waverly Children's Home, Portland, Or.; Program Supervisor**

Responsibilities: *Supervisor of a residential treatment program for 12 youth, provided individual, group and family therapy.*

1979-1980 **Deaconess Children's Home, Everett, Washington; Director**

Responsibilities: *Supervisor of a residential treatment program for 6 youth, provided individual, group and family therapy.*

LICENSURE:

Licensed Clinical Social Worker, Oregon

EDUCATION:

D.S.W. **University of Pennsylvania, Philadelphia, Pennsylvania; 1989. Social Work**

Focus: Management through change; system (family) adjustment to crisis

Dissertation; Impact of First Time Parenthood on a Marital Relationship

M.S.W. **University of Washington, Seattle, Washington; 1979. Social Work**

Focus: Child and family mental health

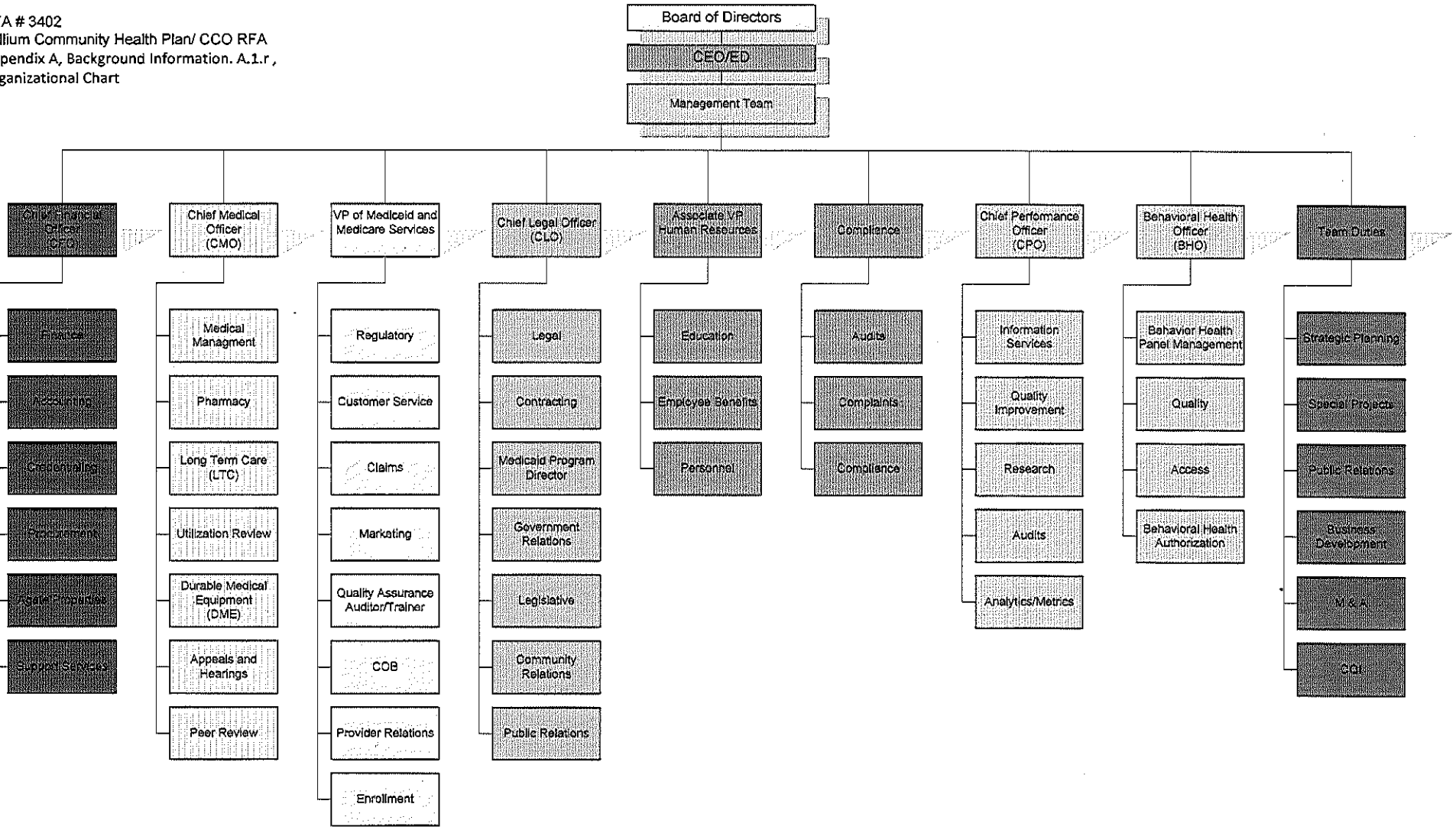
B.A. **Vassar College, Poughkeepsie New York; 1975. Bio-psychology**

COMMUNITY BOARDS and COMMITTEES currently participating on

Senior and Disabled Services Advisory Committee

Senior and Disabled Services Budget Committee
District 5, Department of Human Services Advisory Committee
Trillium Board of Directors
Lane County Mental Health Advisory Committee
Lane County Behavioral Health Consortium
Oregon OHP Mental Health Organization Contractor Committee
AMH-CAF System of Care Steering Committee
AMH Adult Mental Health Initiative Implementation Committee
Lipa Community Advisory Committee
Person Centered Primary Care Medical Home Committee

RFA # 3402
Trillium Community Health Plan/ CCO RFA
Appendix A, Background Information. A.1.r ,
Organizational Chart



Trillium Community Health Plan
RFA#3402
Appendix B, Section 1, Service Area and Capacity

Service Area Description	Zip Code(s)	Maximum Number of Members- Capacity Level
Eugene	97401	Unlimited
Eugene	97402	Unlimited
Eugene	97403	Unlimited
Eugene	97404	Unlimited
Eugene	97405	Unlimited
Eugene	97408	Unlimited
Alvadore	97409	Unlimited
Blachly	97412	Unlimited
Blue River	97413	Unlimited
Cheshire	97419	Unlimited
Cottage Grove	97424	Unlimited
Creswell	97426	Unlimited
Culp Creek	97427	Unlimited
Deadwood	97430	Unlimited
Dexter	97431	Unlimited
Dorena	97434	Unlimited
Elmira	97437	Unlimited
Fall Creek	97438	Unlimited
Florence	97439	Unlimited
Eugene	97440	Unlimited
Junction City	97448	Unlimited
Lorane	97451	Unlimited
Lowell	97452	Unlimited
Mapleton	97453	Unlimited
Marcola	97454	Unlimited
Pleasant Hill	97455	Unlimited
Noti	97461	Unlimited
Oakridge	97463	Unlimited
Saginaw	97472	Unlimited
Springfield	97477	Unlimited
Springfield	97478	Unlimited
Swisshome	97480	Unlimited
Thurston	97482	Unlimited
Veneta	97487	Unlimited
Vida	97488	Unlimited
Walterville	97489	Unlimited
Walton	97490	Unlimited
Westfir	97492	Unlimited
Westlake	97493	Unlimited

APPENDIX A – CCO Criteria Questionnaire

APPLICANT MUST RESPOND TO EACH ITEM IN THE QUESTIONNAIRE ADDRESSING THE HEALTH SERVICES TRANSFORMATION AND CCO CRITERIA REQUIREMENTS

Part I: Background Information about the Applicant
Part II: Community Engagement

Section 1: Governance and Organizational Relationships
Section 2: Member Engagement and Activation
Section 3: Transforming Models of Care
Section 4: Health Equity and Eliminating Health Disparities
Section 5: Payment Methodologies that Support the Triple Aim
Section 6: Health Information Technology

For background and guidance, see the CCO Implementation Proposal. Additional information is located in ORS Chapter 414 related to CCOs and the CCO administrative rules.

The information requested in this questionnaire should be provided in narrative form, answering specific questions in each section and providing enough information for the OHA to evaluate the response. Include reasons why your organization is able to effectively complete the CCO service delivery and program design requirements, and how this will be accomplished in time to meet the needs of Members on implementation.

While HB 3650 excludes DHS Medicaid-funded LTC services and supports from being directly provided by CCOs, CCOs will still be responsible for providing physical and behavioral health services for individuals receiving DHS Medicaid-funded Long Term Care (LTC), and will be responsible for coordinating with the DHS Medicaid-funded LTC system. The requirements for coordinating with the DHS Medicaid-funded LTC system are integrated throughout this section of the Application.

A.I. Background Information about the Applicant

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

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

The applicant entity is Trillium Community Health Plan (Trillium). Currently, Agate Resources, Inc. (Agate), a for-profit C-Corporation with approximately 310 shareholders (96.6% of the ownership is controlled by physicians), is the sole shareholder of a subsidiary holding company called Trillium Holdings, Inc. and is domiciled in Eugene, Lane County, Oregon.

Trillium Holdings, Inc. owns 100% of Lipa (Lane Individual Practice Association), the Fully Capitated Health Plan (FCHP) contracted with the Oregon Department of Medical Assistance Programs to administer and manage the Medicaid Oregon Health Plan (OHP) for Lane County. Trillium, (the applicant CCO) is a subsidiary owned 40% by Trillium Holdings and 60% by Lipa. Trillium has a current Certificate of Authority issued by the Oregon Insurance Division of

DCBS and a Medicare Advantage Plan contract with CMS and offers three Medicare Advantage Plans and three Special Needs Plans.

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

Trillium's collaborative partnership between Lane County and Lipa will bring together the resources and expertise of the current MCO and MHO and transform Trillium into the CCO with potential risk partnerships from organizations such as, McKenzie-Willamette Medical Center, Lane County Community Behavioral Health Consortium, PeaceHealth, and individual provider organizations. Additionally, Trillium will be working in close partnership with Senior & Disabled Services (S&DS), and other community service organizations.

c. What is the Applicant's intended effective date for serving Medicaid popnlations?

Intended effective date: August 1, 2012.

d. Is the Applicant invoking alternative dispute resolution with respect to any provider (*see* OAR 410-141-3268). If so, describe.

No, Trillium is not invoking any alternative dispute resolution proceedings with respect to any provider, or for any other issue.

e. Does the Applicant request changes to or desire to negotiate any terms and conditions in the Core Contract, other than those mandated by Medicaid or Medicare? If so, set forth (in a separate document, which will not be counted against page limits) the alternative language requested.

Trillium does not request changes to the Core Contract.

f. What is the proposed service area by zip code?

Trillium is applying for all of Lane County. The zip codes are: 97419, 97408, 97424, 97472, 97426, 97401, 97427, 97424, 97430, 97431, 97434, 97437, 97403, 97401, 97402, 97403, 97404, 97405, 97408, 97412, 97440, 97455, 97438, 97488, 97439, 97430, 97438, 97448, 97489, 97451, 97452, 97453, 97454, 97413, 97413, 97413, 97409, 97412, 97413, 97461, 97463, 97455, 97405, 97455, 97451, 97472, 97404, 97477, 97477, 97477, 97478, 97482, 97480, 97482, 97412, 97487, 97487, 97488, 97424, 97426, 97489, 97490, 97492, 97493.

g. What is the address for the Applicant's primary office and administration located within the proposed service area?

1800 Millrace Drive
Eugene, OR 97403

h. What counties or portions of counties are included in this service area? Describe the arrangements the Applicant has made to coordinate with county governments and establish written agreements as required by ORS 414.153.

The service area will encompass Lane County. Lane County has been fundamental in establishing the CCO and developing the plan to coordinate services. The contract required in ORS 414.153 is currently being finalized and includes Lane County managing the behavioral health services, providing funding for required reserves, as well as coordination of services for public health and mental health point-of-contact and population health services.

i. Prior history as a managed care organization with the OHA: Did this Legal Entity have a contract with the OHA as a managed care organization as of October 1, 2011 (hereinafter called "current MCO")? If so, what type of managed care organization?

- **Fully Capitated Health Plan**
- **Physician Care Organization**
- **Mental Health Organization**
- **Dental Care Organization**

Trillium does not have a managed care organization/FCHP contract with OHA and is not considered to be a "current MCO." Trillium's majority owner, Lipa, does contract with OHA and is considered to be a "current MCO," with an effective contract as of October 1, 2011. Trillium has a current HealthyKids Connect contract which was in force on October 1, 2011. Lipa is an FCHP whose members will move from Lipa to Trillium on August 1, 2012. Additionally the CCO includes Lane County to manage the behavioral health benefit, and currently Lane County contracts with OHA as a Mental Health Organization.

j. Is this the identical organization with a current MCO contract, or has that entity been purchased, merged, acquired, or otherwise undergone any legal status change since October 1, 2011?

No, this is not an identical organization with a current MCO contract. Lipa, the current holder of the MCO contract with the state, is a majority owner of Trillium. Trillium holds the HealthyKids Connect contract but it does not currently have the OHP contract. The two entities, Lipa and Trillium, are under common management and share administrative and medical management resources for both products as well as an MA-PD (Medicare Advantage) contract with CMS. Neither organization has undergone any legal status change since October 1, 2011.

k. Does the Applicant include more than one current MCO (e.g., a combination of a current FCHP and MHO)? If so, provide the information requested in this section regarding each applicable current MCO.

Yes, Trillium includes more than one MCO, Lipa (FCHP/MCO) and LaneCare (Lane County MHO). Lipa is a Fully Capitated Health Plan (FCHP) contracted with the Oregon Department of Medical Assistance Programs to administer and manage the Medicaid Oregon Health Plan (OHP) for Lane County. Lipa is an FCHP whose members will move from Lipa to Trillium on August 1, 2012. LaneCare is the Lane County MHO and administers all mental health services. Lipa and LaneCare will be coordinating and integrating administrative and other services.

l. Does the current MCO make this Application for the identical Service Area that is the subject of the current MCO's contract with OHA? Does this Application propose any change in the current Service Areas?

The service area proposed within this application includes Lane County zip codes only. Zip codes outside of Lane County are not included in this application, and additional zip codes in Lane County that are not covered in the current MCO contract are included.

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

- **Oregon Medical Insurance Pool**
- **Healthy Kids Connect**
- **Public Employees Benefit Board**
- **Oregon Educators Benefit Board**
- **Adult Mental Health Initiative**
- **Other**

Trillium is a current contractor with OHA's Office of Private Health Partnerships for its Healthy Kids Connect product. Trillium has a current Medicare Advantage Plan contract with CMS and offers three Medicare Advantage Plans in addition to three Special Needs Plans. Trillium has a current Certificate of Authority issued by the Oregon Insurance Division of DCBS. LaneCare is a current OHA contractor for the Adult Mental Health Initiative.

n. Does the Applicant have experience as a Medicare Advantage contractor? Does the Applicant have a current contract with Medicare as a Medicare Advantage contractor? What is the service area for the Medicare Advantage plan?

Trillium has had a contract with CMS since 2007 to provide both Medicare Advantage, Dual SNP, ISNP and ISNP E plans. Currently, Trillium provides services in Lane County.

o. Does the Applicant hold a current certificate of insurance from the State of Oregon Department of Consumer and Business Services, Insurance Division?

Yes, Trillium has a certificate of authority as a health care services contractor.

p. Applicants must describe their demonstrated experience and capacity for:

(1) Developing and implementing alternative payment methodologies that are based on health care quality and improved health outcomes.

Trillium has experience with risk-based fee-for-service, case rates and capitation payments. There are efforts in the planning stages to implement episode of care based payments as well.

Quality, performance and outcome based payments to support the Triple Aim are also in development.

(2) Coordinating the delivery of physical health care, mental health and chemical dependency services, oral health care and covered DHS Medicaid-funded LTC services.

The organizations coming together in Trillium are currently administering the delivery of physical health care through Lipa. Lipa contracts for the administration of chemical dependency services with LaneCare (a department of Lane County government). LaneCare is the County MHO and administers all mental health services, including the Children's Wraparound Initiative and the Adult Mental Health Initiative. Both Lipa and LaneCare currently coordinate health services for the LTC populations separately, working with case management at the County Developmental Disabilities Services (DDS) office and the Senior & Disabled Services (S&DS) office. Under the CCO, the coordination of these services will be unified and the delivery system will be more efficiently managed to deliver coordinated care.

The CCO has experience working in community collaboratives aimed at improving coordination of care. Examples of those include: 1) Lane Transitional Care Collaborative, in sponsorship with Oregon DHS that focused on transitions from hospitals to community based care; 2) Collaborative between S&DS and LaneCare to provide psychiatric nurse practitioner intervention for adult foster care residents at risk of eviction; 3) Combined chemical dependency and mental health services into a single behavioral health benefit design resulting in improved coordination of care.

(3) Engaging community members and health care providers in improving the health of the community and addressing regional, cultural, socioeconomic and racial disparities in health care that exist among the entity's enrollees and in the entity's community.

Trillium, as the applicant organization, has broad experience in engaging community members. This experience is apparent in the breadth of partners who have signed the letters of support that accompany this application and in the representatives serving on the governance and advisory boards formed to assist in the application process and the formation of the CCO. Trillium has grown out of the local IPA, effectively engaging physicians in achieving important health outcomes. Various cultural/ethnic/tribal organizations will inform our processes to ensure that services provided are linguistically appropriate, culturally competent, and designed to reduce disparities in health care. Lipa and LaneCare currently engage community members through a joint consumer advocacy council. The strong engagement of Lane County brings expertise and a focus on population health, prevention, and improving health disparities. Additionally, work is ongoing to develop increased capacity in the community to address cultural differences including increased numbers of Spanish speaking providers and support for the local CAWEM project.

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

Resumes will be uploaded for the following personnel via the instructions listed in Attachment 7 of the RFA.

- Chief Executive Officer, Terry Coplin
- Chief Operations Officer, Executive Vice President, David Cole
- Chief Medical Officer, Dr. John Sattenspiel
- Chief Performance Officer, Patrice Korjenek
- Senior VP of Medicaid & Medicare Services, Shannon Conley
- General Counsel, Cassandra SkinnerLopata
- Chief Behavioral Health Officer, Bruce Abel

r. Provide an organizational chart showing the relationships of the various departments.

Trillium's organizational chart will be uploaded via the instructions listed in Attachment 7 of the RFA.

s. Is Applicant deferring submission of any supporting documents, tables, or data that are part of its Technical Application until its readiness review under Section 6.7.1? Please list all deferred submission documents.

The following documents will be deferred until the Readiness Review:

Appendix A
- A.1.3.b LTC MOU
- A.1.4.a Mental Health Services Contract
- A.3.1.e DCO or Oral Health Contract

Appendix B
- Table B-1 Participating Provider
- Section 2, Standard 3(b) contract deferred

Attestations
- B-4
- B-5
- B-9

Representation
- B-2
- B-3
- B-4
- B-6
- B-7
- B-8
- B-11

A.II. Community Engagement in Development of Application

Applicant is encouraged to obtain community involvement in the development of the Application. The term "community" is defined in ORS 414.018 for this purpose:

"Community" means the groups within the geographic area served by a CCO and includes groups that identify themselves by age, ethnicity, race, economic status, or other defining characteristic that may impact delivery of health care services to the group, as well as the Governing Board of each county located wholly or partially within the CCO's service area.

Describe the process used for engaging its community in the development of this Application.

The community has been involved in an extensive planning process in Lane County that began in early 2011 with monthly meetings between LaneCare (MHO) and Lipa (FCHP). The progress of these meetings was shared with providers and community partners through the summer and fall of 2011, with several organized lunches and public meetings contributing to the community knowledge about coordinated care. In October, 2011 Lipa and LaneCare convened the first Consumer Advocacy Council (CAC) with four community advocates, two staff from Lipa, and two from LaneCare. This group has met monthly since then and has been a full participant in the planning of the CCO. The CAC has since grown to 12 consumer members with great diversity (with representation from populations of Latino, disabled, youth, mental health and substance use, and family and peer recovery partners) and has provided excellent feedback and support to the planning team.

In addition, the CCO Steering Committee sponsored a series of ten open forums in March and April, 2012 that involved over 100 consumers, community members, health care providers, and human services leaders to discuss the planning underway for the new CCO and to hear people's thoughts about key design features. There are numerous examples in the CCO design that reflect the input from these sessions. For example, following the input at the community meeting in Florence regarding the challenges with access to services for rural communities, the Steering Committee added a Rural Advisory Council to the CCO's governance structure. A representative from this council will sit on the CCO's Governing Board to represent the interests and needs of individuals in the many rural parts of Lane County.

Section 1 – Governance and Organizational Relationships

A.1.1. Governance

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

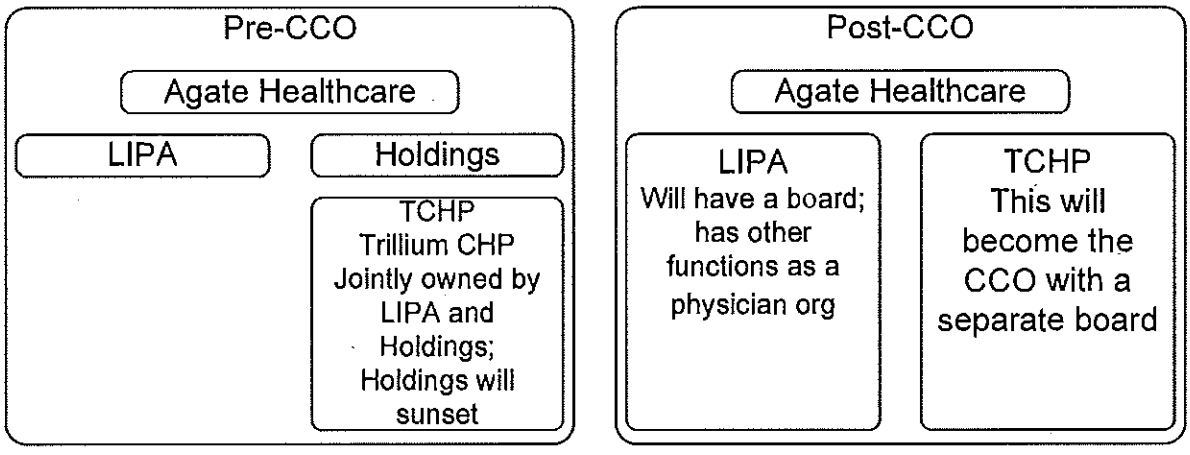
A.1.1.a. Provide a description of the proposed Governance Structnre, consistent with ORS 414.625.

In early March 2012, a group of local stakeholders came together to form the Lane County CCO Steering Committee. The Steering Committee membership includes representatives from Lane County primary care practices, specialty practices, hospitals, behavioral health organizations, long term care, health plans, Lane County government, consumers, and community leaders. The goal of the Steering Committee has been to define the best possible model for developing a county wide CCO that would transform the health care for Oregon Health Plan members in Lane County and lay the groundwork for transformation of care for other populations in the future.

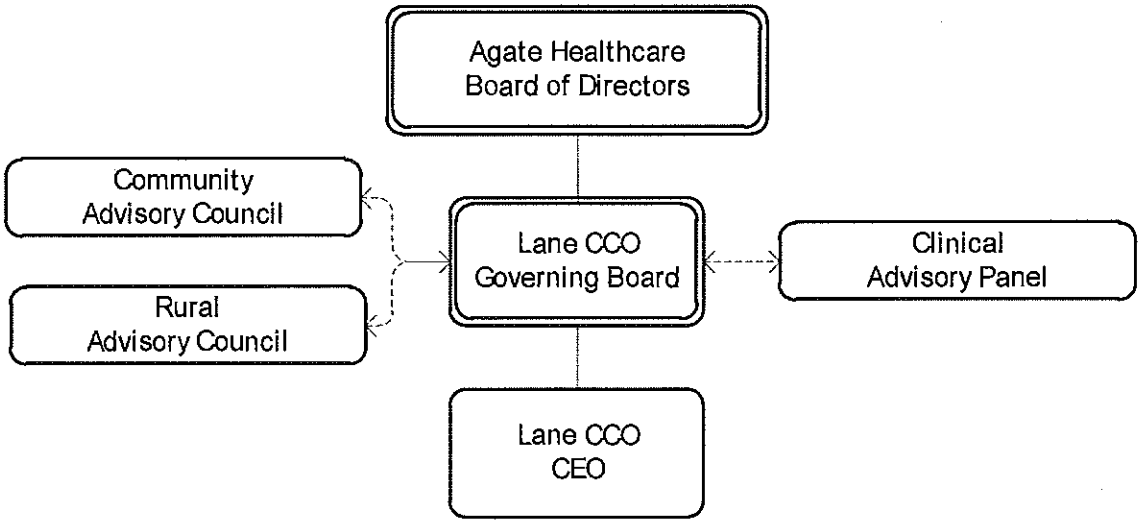
Working collaboratively, the Steering Committee identified the legal entity as Trillium that would apply to become the CCO. Additionally, they formulated the composition of the CCO Governing Board, and developed a process for recruiting Board members. To guide its work, the Steering Committee developed the following set of principles: 1) take a phased approach; 2) take a collaborative approach that provides opportunities for multiple payers to participate; 3) develop governance and infrastructure approaches that move the most funding to the service delivery level, i.e., that are the least top heavy and use the fewest resources carrying out non-service delivery functions; 4) identify a CCO structure that enables the community to focus most of its transformation energy on improving the service delivery system, not on reorganizing administrative systems; 5) establish the goal of developing an integrated health system that brings together the different services and system people need to be healthy; and 6) build on the strengths of the current medical and behavioral health service delivery systems.

The Steering Committee decided that the conversion of Trillium Community Health Plan would be the most effective approach to creating the legal entity for the CCO. Trillium, a corporation within Agate Healthcare (along with the Lane Independent Practice Association or Lipa), offered the infrastructure and Oregon Health Plan experience necessary to launch the CCO in a timely manner. In addition, the Agate leadership is deeply committed to the care of the OHP population and viewed the creation of the CCO as an opportunity to improve care delivered and outcomes achieved while reducing costs.

The CCO will fit into the Agate Healthcare corporate structure as depicted in the figure below:



Agate Healthcare is privately owned by physicians and employs staff and administrative systems. Currently, Lipa and Trillium Community Health Plan (TCHP) buy services from Agate. Trillium will convert to the CCO with its own Governing Board and Chief Executive Officer, as depicted below.



As the Steering Committee developed the Governing Board for the CCO, the group paid close attention to the requirements of ORS 414.625: a majority interest consisting of the persons that share in the financial risk of the organization; 1) representation by the major components of the health care delivery system; and 2) participation by the community at large, to ensure that the organization's decision-making is consistent with the values of the members and the community.

The composition of the CCO Governing Board, summarized below, meets these requirements:

Category	Risk*	Delivery System	Total Seats	Notes
Agate Healthcare	y	y	3	
Lane County	y	y	3	Admin = 1; LaneCare = 1; Public Health Officer = 1
Primary Medical Care	y	y	3	Oregon Medical Group = 1; Lane Independent Providers = 1; Peace Health Medical Group = 1
Specialty Medical Care	y	y	2	
Hospitals	y & n	y	3	Peace Health = 2; McKenzie Willamette = 1
Behavioral Health Care	y	y	2	Providers' goal is to have both mental health and drug/alcohol expertise and representation
Community Advisory Council	n	n	2	Community leader as chair = 1; consumer = 1
Rural Community Advisory Council	n	n	1	Could be a consumer, but not necessarily
Long Term Care	n	y	1	
Total			20	

Required Board Representation per RFA (Seats are counted in all applicable requirements; therefore numbers add to more than 100% and 20)		%	#
§Seats that bear risk (>50%)		75%	15
§ Seats that represent components of the health care delivery system		85%	17
§ Seats for consumer/community members		15%	3
§ Seats for behavioral health and LaneCare		15%	3
§ Seats for long term care		5%	1

***Risk = organizations that assume risk for Medicaid health care expenses or service delivery either through contractual agreements or resulting from the administration of a global budget.**

The Governing Board reflects the composition necessary to develop and sustain an effective organization that can work collaboratively with the community to transform the health care system in Lane County and achieve significant progress toward the Triple Aim. The presence of risk-

bearing organizations at 75% of the Governing Board ensures that the fiscal due diligence essential to operation of a cost-effective system is in place.

In addition, most (14 out of 17) of the Board seats held by members of the health care system are at-risk. This combination of diverse representation by essential components of the system, linked to the presence of financial risk, adds a critical element of investment and responsibility to the Governing Board.

Consumers and community members are also a vital component of the Governing Board. The representation on the Board of community members and/or consumers from two Community Advisory Councils provides a critical link between consumers and community members and the Governing Board. This is particularly true as the Governing Board will include three Community Council representatives: two from the county-wide council and one from a Rural Advisory Council developed specifically to weigh in on the health care transformation challenges impacting Lane County's rural residents.

Representation by behavioral health care provider organizations is also an essential feature of the CCO Governing Board. The importance of integrating medical care and behavioral health care as part of the system's transformation required that the Governing Board have sufficient involvement of behavioral health care organizations. This representation will allow for the participation of both mental health and drug/alcohol provider organizations on the board. Given the impact of both mental illness and substance abuse on the OHP population, these components of the system are vital. In addition to the two behavioral health provider organizations on the Board, LaneCare, the Mental Health Organization (MHO) operated by Lane County, is also represented.

The integration of health care services for individuals residing in long term care facilities is a transformational element that also calls for Governing Board representation. The involvement of a long term care representative will ensure that the Governing Board is providing leadership and oversight to the transformation of all the participating components of the health care system.
In addition to identifying the composition of the Governing Board, the Steering Committee also developed a set of competencies Governing Board members should possess. These characteristics will guide the selection of individuals who will serve as the founding Board of the CCO:

- ✓ **Leadership**, e.g., proven track record as person responsible for bringing about significant improvement in a service delivery system
- ✓ **Understanding of health care issues**, e.g., experience working with finance, delivery, evaluation, and management of one or more components of the health care system
- ✓ **Strategic thinking**, e.g., experience leading or participating in transformational efforts in Lane County
- ✓ **Communication**, e.g., ability and willingness to share information that supports the success of a collaborative effort involving multiple organizations and systems
- ✓ **Interpersonal skills**, e.g., a history of effective participation in coalitions, collaboratives, boards, and other activities that require working effectively with other people and organizations

- ✓ **Analytical and critical thinking,** e.g., experience using data to formulate conclusions and support development of strategies
- ✓ **Knowledge of and experience with Medicaid-funded services,** e.g., from a provider and from a consumer prospective
- ✓ **Reliability,** e.g., a solid history of fulfilling responsibilities, particularly related to board experience
- ✓ **Financial and business acumen,** e.g., experience managing resources to meet both program and financial goals

The Steering Committee also developed a draft job description for the Governing Board members. This job description will be finalized by the Governing Board when the group convenes in May 2012. The Steering Committee will hold its final meeting on April 30, 2012. At this session, the group will develop a proposed Governing Board slated for approval by the Agate Healthcare Board of Directors. Following approval by the Agate Board, the CCO Governing Board will convene for its first meeting during the week of May 7, 2012.

A.1.1.b. Provide a description of the proposed community advisory council (CAC) in each of the proposed services areas and how the CAC will be selected consistent with ORS 414.625.

The Steering Committee recognized the critical role the Community Advisory Council will play in the success of the CCO. The implementation of the needs assessment will be conducted in partnership with Lane County Public Health, PeaceHealth, the United Way, and others. The development of the health improvement plan is important to assist the CCO in achieving the Triple Aim. In addition, the Community Advisory Council's role in determining the CCO's effectiveness in providing quality services that are accessible to all OHP members will be essential.

Similar to its development of the Governing Board for the CCO, the Steering Committee paid close attention to ORS 414.625 as it developed the composition for the Community Advisory Council: consumers must make up a majority of the members; county government must be represented; and representatives must include members of the community. In addition, the Steering Committee took the following optional criteria into account: the geographic, age, and cultural/linguistic diversity of Lane County; the importance of expertise in compiling and analyzing data for the community health assessment; the need for representation from the physical and behavioral health care delivery systems; and the role of representatives from the education, criminal justice, housing and human services systems.

The Community Advisory Council proposed composition outlined below will be finalized by the CCO Governing Board once the Board is convened in May 2012.

Category	#	Sources for Council Members	OHP Member
Rural Advisory Council	3	Consumer reps from Florence, Oak Ridge, Cottage Grove	Y
At-large consumers that reflect geographic, ethnic, linguistic diversity of county	3	Individuals covered by OHP who have been active in related advocacy efforts	Y
Advisory groups and commissions	5	OHP Member reps from Disability Services Advisory Council, Senior Services Advisory Council, Commission on Children and Families, Community Health Council, Community Action Advisory Committee, Mental Health Advisory/Local Alcohol and Drug Planning Committee, Public Health Advisory Committee, Housing Policy Board, Tribal Governments	Y
Lane County representation	3	Staff reps from County Health and Human Services divisions linked to health care transformation, including prevention, community health centers, behavioral health, human services, public health	N
Health, human service, education, housing, and criminal justice coalitions and agencies that can represent the broader CCO safety net	2	Staff reps from school districts, Human Services Network, Head Start, Family Resource Centers, Housing and Community Service Agency of Lane County, Legal Aid, Health care Safety Net Providers	N
Community Leadership	1	A recognized leader from outside the health care system	N
Research/Evaluation Technical Expert Representative	1	Such as United Way Research and Evaluation Team, University of Oregon, Oregon Research Institute, and Health Policy Research Northwest	N
Representatives from public relations/media	1	To assist the council in engaging the community	N
Representative from Clinical Advisory Panel	1	For connection to CCO system transformation priorities	N
Council size	20		
Required Representation (seats are counted in all applicable requirements, therefore, numbers add to more than 100%.) Consumers (>50%) County Community	 11 3 11		

In addition to the Community Advisory Council, the Steering Committee identified a Rural Advisory Council as an important CCO feature. This advisory council will include representatives from the many rural areas of the county, including Florence, Oakridge, and Cottage Grove. This Rural Advisory Council will work collaboratively with the Community Advisory Council and the Governing Board to transform the health care delivery system in rural parts of the county as well as ensure that the care provided in the urban area is responsive to the needs of rural residents. The

Governing Board and the Community Advisory Council will work together to identify the composition of the Rural Advisory Council and convene the group in June or July 2012.

A.1.1.c. Provide a description of the relationship of the Governance Structure with the CAC, including how the Applicant will ensure transparency and accountability for the governing body's consideration of recommendations from the CAC.

The Trillium Governing Board will have three representatives from community advisory councils, two from the county-wide CAC and one from the Rural Advisory Council. This representation on the Governing Board will ensure that the input and recommendations from the CAC and Rural Advisory Council are treated seriously and acted upon by Trillium. One option for achieving this is to build in specific agenda items into each Governing Board meeting for the CAC and the Rural Advisory Council. Trillium staff will attend council meetings to ensure direct communication with administrators and governance. In addition, Governing Board representatives will regularly attend CAC and Rural Advisory Council meetings to answer questions and address concerns the members may have about Trillium's performance.

A.1.1.d. Describe how the CCO Governance Structure will reflect the needs of Members with severe and persistent mental illness and Members receiving DHS Medicaid-funded LTC services and supports through representation on the Governing Board or CAC.

The Trillium Governing Board will include three representatives from Behavioral Health, one from Long Term Care, and at least one OHP consumer. The representation on the Governing Board reflects one of the initial transformations planned by Trillium; the integration of primary and behavioral health care for OHP members. The CAC will have a majority membership of OHP consumers (at least 11/20). Some of those consumers will have a history of severe and persistent mental illness and/or a history of receiving long term care services. Many of the consumers may be drawn from the existing Consumer Advocacy Council. This group has been vocal about the needs of both of these populations, and they see great hope that Trillium will provide better care for these conditions.

A.1.2. Clinical Advisory Panel

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

A.1.2.a. If a CAP is established, describe the role of the CAP and its relationship to the CCO governance and organizational structure.

The Clinical Advisory Panel (CAP) and sub-committees will be advisory to Trillium and to the Governance Board. Trillium staff will participate at all committee meetings and will assure direct communication with administrators and governance. The CAP will have broad representation from providers, organizations, and facilities representing the spectrum of behavioral, social, and physical health services available in the community. The CAP will be responsible for identifying and developing clinical guidelines and pathways to care with a special focus on integrating care across clinical domains and accomplishing the Triple Aim. Another responsibility of the CAP

will be to submit recommendations regarding the best mix of services, behavioral/social/physical/oral, required to meet the needs of members receiving services through Trillium; and to communicate those recommendations to the CCO board. The CAP will have oversight responsibility for quality and performance improvement projects.

A.1.2.b. If a CAP is not established, the Applicant should describe how its governance and organizational structure will achieve best clinical practices consistently adopted across the CCO's entire network of providers and facilities.

A.1.2.b is not applicable to Trillium.

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

While DHS Medicaid-funded LTC services are legislatively excluded in HB 3650 from CCO responsibility, and will be paid for directly by the Department of Human Services, CCOs will still be responsible for providing physical and behavioral health services for individuals receiving DHS Medicaid-funded LTC services, and will be responsible for coordinating with the DHS Medicaid-funded LTC system. To implement and formalize coordination and ensure relationships exist between CCOs and the local DHS Medicaid-funded LTC providers, CCOs will be required to work with the local type B AAA or DHS' APD local office to develop a Memorandum of Understanding (MOU) or contract, detailing their system coordination agreements regarding Members receiving DHS Medicaid-funded LTC services. Guidance for an MOU with the Type B AAA or with the DHS local APD office is available at http://www.oregon.gov/DHS/hst/apd-cco-info.shtml.

A.1.3.a. Describe the Applicant's current status in obtaining MOU(s) or contracts with Type B AAAs or DHS local APD office.

Trillium has been collaborating with the Type B Area Agency on Aging Office (Senior & Disabled Services) for over a year on the CCO project. Trillium and S&DS are fully committed to establishing a mutually acceptable MOU based on the recommendations from the state designed to coordinate care for those in Long Term Care (LTC).

A.1.3.b. If MOUs or contracts have not been executed, describe the Applicant's good faith efforts to do so and how the Applicant will obtain the MOU or contract.

Trillium and the Type B Area Agency on Aging (S&DS) are in the process of reviewing a proposed template provided by DHS and customizing it to the unique needs of the Lane County community.

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

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

A.1.4.a. Describe the Applicant's current status in establishing working relationships with the Local Mental Health Authorities (LMHAs) and Community Mental Health Programs (CMHPs) operating in the service area to maintain a comprehensive and coordinated mental health delivery system and to ensure member access to mental health services, which are not provided under the global budget. A sample LMHA MOU is in Attachment 10 to this RFA.

Trillium has been collaborating with the LMHA and CMHP's for over a year on the CCO project. Trillium represents an integration of the two existing OHP health plans in Lane County, Lipa and LaneCare. Lane County Behavioral Health Services (LMHA/CMHP) is a division of Health and Human Services and Lane County will be a contracted, risk-bearing partner in the CCO. Lane County will contract with Trillium to form the CCO and will incorporate in the contract a relationship with the Local Mental Health Authority including coordination plans for services and funds not covered under the global budget. LaneCare has managed the OHP mental health contracts for 15 years and will continue in this role in the CCO.

A.1.4.b. How will Applicant ensure that members receiving services from extended or long-term psychiatric care programs (e.g., secure resideutial facilities, PASSAGES projects, state hospital) shall receive follow-up services as medically appropriate to ensure discharge within five working days of receiving notification of discharge readiness?

LaneCare currently manages the AMHI system for Lane County. They have met and exceeded all contract performance goals established by the State, and will continue to do so as a part of the CCO. Two LaneCare ENCCs work with residential and long term care providers to develop transition plans, community placements, and medically appropriate treatment plans. Staff will continue in this role through the CCO. Lane County currently has two contracted Assertive Community Treatment (ACT) teams and two contractors that provide supported housing. The County also has 24 Mental Health Adult Foster Home providers.

A.1.4.c. How will Applicant coordinate with Community Emergency Service Agencies (e.g., police, courts and juvenile justice, corrections, and the LMHAs and CMHPs) to promote an appropriate response to members experiencing a mental health crisis?

Trillium will contract with Lane County to coordinate with the Community Emergency Service Agencies. Trillium will partially fund the Manager of Lane County Behavioral Health who represents the County on Community Emergency Service issues. The manager also chairs the Lane Acute Care Council which includes representatives of all area emergency departments, crisis services, police agencies, secure transport companies, detox and sobering facilities, inpatient psychiatry, Eugene Mission, NAMI, and others.

LaneCare covers mental health emergency services and this will continue with the CCO. LaneCare currently funds emergency services at White Bird, Royal Avenue Program and through the Youth Crisis Network, as well as emergency department based crisis evaluation and

next day crisis referrals from the ER to outpatient providers to avoid acute hospitalizations. Each outpatient contracted provider is required to have an emergency service procedure for open clients covered by OHP and their response is validated annually through unannounced phone calls.

As Trillium develops IT resources, such as shared care plans and problem lists, these will, within HIPAA guidelines, be made available for Emergency Services Personnel, Mental Health Crisis Workers along with other CCO participant providers to access and coordinate care more effectively during emergencies.

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

A.1.5.a. In order to carry out the Triple Aim, it will be important for CCOs to develop meaningful relationship with social and support services in the services area. Describe how the Applicant has established and will maintain relationships with social and support services in the service area, such as:

- **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**

Lipa and LaneCare will bring to Trillium extensive relationships with social and support services, built on a strong commitment to support members through a variety of services to meet their needs. Some examples include but are not limited to the following:

- DHS Children's Adults and Families: The Lane County DHS District Manager has served on LaneCare's Operations committee for many years, and LaneCare provides an extensive array of services all children in foster care and to their families.
- Lane County Youth Services: LaneCare participates in weekly joint meetings and supports several corrections programs focused on mental health.
- Lane County Adult Corrections: Lipa supports treatment in drug courts and DUII programs and an extensive array of behavioral health services.
- Lane County School districts participate in LaneCare's monthly community meetings and Lane County supports several school-based health clinics in Eugene and Springfield.

- The Lane County Developmental Disabilities Department is a collaborative partner in the Long Term Care system and has been supportive of the CCO model of care.
- Lane County is home to the Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians; the CCO will continue contact with this Tribal organization and works with schools and other organizations to meet the health needs of Tribal members on OHP.
- Lane County's Human Services Commission is at the heart of the community's response to homelessness and housing needs; the County works with the State HUD, urban centers, and local nonprofit community based organizations, and faith based organizations to meet the housing needs of OHP members.

Lipa case managers and ENCCs frequently work with the above organizations to coordinate and manage care and services.

LaneCare has extensive relationships with local peer and family based community supports, including the local OFSN (Oregon Family Support Network) office, YouthMove program, LILA (Lane Independent Living Alliance), and NAMI (National Alliance on Mental Illness) Lane County.

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

This section should detail the Applicant's anticipated process for developing a community health assessment, including conducting the assessment and development of the resultant Community Health Improvement Plan. Applicants should include information on approaches to coordinate care across the spectrum of services, as well as to encourage preventiou and health promotion to create healthier communities.

The Applicant is required to work with the OHA, including the Office of Equity and Inclusion, to identify the components of the community health assessment. Applicant is encouraged to partner with their local public health authority, hospital system, type B AAA, APD field office, local mental health authority.

The community health assessment is expected to be analyzed in accordance with OHA's race, ethnicity and language data policy.

While developing the initial Community Health Assessment CCOs are encouraged to draw on existing resources. The OHA has assembled relevant resources used in current community health assessments performed by local pnblic health agencies, mental health agencies, hospitals, etc., to be fouud at the following web site: http://public.health.oregon.gov/ProviderPartnerResources/HealthSystemTransformation/Documents/9623B_phaHAssessment.pdf. Additionally, CCOs are expected to collaborate with community partners to provide additional relevant perspectives and information to help identify health disparities in the CCO's service area.
In order to avoid duplication the community health assessment should build upon, coordinate with or take the place of the community health assessments required of community mental/behavioral health, community public health and hospital system community benefit reporting.

A.1.6.a. The Applicant should describe:

- **Applicant's community health assessment process, and a strategy to update periodically according to Administrative Rules**
- **Applicant should describe the mechanisms by which the CAC will meaningfully and systematically engage diverse populatious as well as individuals receiving DHS Medicaid-funded LTC and individuals with severe and persistent mental illness, in the community health assessment process.**

Historically, a number of agencies in Lane County conduct their own community needs assessments and improvement plans. Recent needs assessments are available from Senior & Disabled Services, United Way of Lane County, Lane County Public Health, Lane County Mental Health and Addictions, along with others—all providing important data about the health status of Lane County. Creation of the Trillium CCO presents an excellent opportunity to bring together the various community health assessment processes that currently happen (or are soon scheduled to happen) in Lane County, to build a comprehensive picture of health in Lane County, and create a community-wide plan for achieving the Triple Aim. Beginning this year, a collaborative Community Health Assessment process is being conducted using the Mobilizing for Action through Planning and Partnerships (MAPP) process, providing the opportunity for Lane County Public Health, PeaceHealth, and Trillium to work together both to assess health needs and create a Community Health Improvement Plan. This process will allow for the assessment required by the IRS of PeaceHealth hospitals, the Public Health Accreditation, and Trillium. A team of community health leaders recently returned from a training on the MAPP process, and plan to complete the MAPP process in the next 12-18 months.

The MAPP process, supported by the federal Centers for Disease Control and Prevention, provides a framework for meaningful engagement of representatives of critical populations and community stakeholders to create a health improvement plan for addressing community needs that builds on community resources and skills. By working closely with Lane County Public Health and PeaceHealth, the needs assessment will include Trillium members in the context of the larger community, and guide Trillium's efforts at improving population health. The process includes a quantitative assessment, where the community will examine data from a variety of sources, including data on health disparities available through the OHA Office of Equity and Inclusion. The assessment also includes a qualitative assessment process to engage the community through community meetings and surveys. Lane County will build on its strong history of engagement, including targeted outreach to engage representatives of our diverse communities in large community meetings, smaller focus groups, and opportunities for on-line input.

One of the first assignments for the newly created Community Advisory Council (CAC) will be to learn about the MAPP Process and to engage in the assessment workgroups. The timing is excellent, as the qualitative data gathering process is due to begin in early fall, so Trillium can be a full participant in the process. As part of the engagement process, the CAC will work closely with the Clinical Advisory Panel and the existing Consumer Advocacy Council that includes representatives of physical health, behavioral

health, and long-term care services to ensure meaningful input in both the assessment phase and the Health Improvement Plan. Additionally, the planning process will coordinate with the community needs assessments completed by Lane County as the Local Mental Health Authority, United Way of Lane County, and Senior & Disabled Services. These agencies use a combination of client surveys and community meetings to specifically solicit input from consumers in those systems, and that input will also be part of the larger Community Needs Assessment.

In January, the data gathering should be complete and work will begin on development of the strategies for the Health Improvement Plan that will serve as a strategic population health and health care system service plan for Lane County. The Council will publish the results of the plan, and an annual progress report. The plan will be updated every three years.

Section 2 – Member Engagement and Activation

A.2.1. Member and Family Partnerships

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

A.2.1.a. Describe the ways in which Members (and their families and support networks, where appropriate) are meaningfully engaged as partners in the care they receive as well as in organizational Quality Improvement activities.

Trillium will, by policy and program, design and facilitate meaningful member engagement. Strategies include the following:

- Promotion of Motivational Interviewing as a core competency
- The use of Personal Health Records that includes member health goals
- Promotion of shared decision making between members and providers
- Promotion of health literacy
- The use of The Patients Activation Measure to promote member engagement
- Promotion of the Chronic Disease Self-Management Program
- Promotion of Feedback Informed Treatment
- Member Satisfaction Surveys

A.2.1.b. Describe how the Applicant will ensure a comprehensive communication program to engage and provide all Members, not just those Members accessing services, with appropriate information related to benefits and accessing physical health, behavioral health and oral health services, including how it will:

- **Encourage Members to be active partners in their health care, understanding to the greatest extent feasible how the approach to activation accounts for the social determinants of health;**

- **Engage Members in culturally and linguistically appropriate ways;**
- **Educate Members on how to navigate the coordinated care approach and ensure access to advocates including peer wellness and other non-traditional healthcare worker resources;**
- **Encourage Members to use effective wellness and prevention resources and to make healthy lifestyle choices in a manner that is culturally and linguistically appropriate;**
- **Provide plain language narrative that informs patients about what they should expect from the CCO with regard to their rights and responsibilities; and**
- **Meaningfully engage the CAC to monitor and measure patient engagement and activation.**

All members enrolled in Trillium will receive a culturally and linguistically appropriate informational package about the scope of their benefits and how to access care from organizations and providers, including community wellness advocates and peer support workers. Materials will explain responsibilities of both providers and members. Member newsletters and the Trillium website will serve as part of Trillium's communications plan. The website will contain a listing of Trillium providers along with a brief description of the scope of services they provide. Trillium will also inventory current informational materials for cultural and linguistic appropriateness. A guide and index of those materials will be published to the Trillium website for access by participating providers, other organizations, and members. Trillium will promote specific prevention practices to all members with an initial focus on immunizations, tobacco prevention and chronic disease prevention. These specific strategies will be evidence-based and supported by the Community Advisory Council. Member satisfaction surveys and other measures of engagement will be periodically reported to the CAC for review. As a result of that review, the CAC will assist Trillium in identifying areas where member engagement can be improved and developing programs to accomplish the desired improvement. The CAP and CAC will monitor and review utilization rates of appropriate and inappropriate services.

Section 3 – Transforming Models of Care

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

A.3.1. Patient-Centered Primary Care Homes

A.3.1.a. Describe Applicant's plan to support the provider network through the provision of:

- **Technical assistance.**
- **Tools for coordination.**
- **Management of Provider concerns.**

- **Relevant Member data.**
- **Training and tools necessary to communicate in a linguistically and culturally appropriate fashion with Members and their families.**

Trillium will make its current shared care plan available to participating providers across multiple sites of care. Trillium will link providers to existing community resources through community health workers, local 211, and other registries. Care Coordination staff at Trillium will function as a knowledge resource for providers. Staff will be able to help providers identify Trillium's programs, services and resources available to members, as well as facilitate referral to and access of those benefits. Trillium will utilize multiple methods to identify high risk members and communicate that information to a member's providers as appropriate. Wherever necessary, Trillium staff will help providers and members identify and access any services needed to reduce linguistic and cultural barriers to care. Programs to help providers recognize and address special linguistic and cultural needs will also be developed.

Trillium will partner with primary care groups to:

- Support the existing learning collaborative for primary care practice staff to share best practices in support of PCPCH implementation.
- Collect PCPCH outcomes data from primary care practices consistent with OHA and/or NCQA data reporting requirements and use this outcomes data to drive CCO quality improvement initiatives.
- Establish annual goals for the percentage of CCO enrollees who are assigned to PCPCH certified practices.
- Use outcomes data to identify areas for improvement and to enhance and improve community outcomes.
- Develop coordinated problem lists
- Utilize shared care plans for all members which include input from all Trillium participants providing care and services to a member.
- Maintain a data base of verified contact information on all participants
- Provide access to translators or phone based translation services for all members with language barriers to care
- Provide training opportunities in conjunction with the CAC to enhance cultural competency among the provider community.

A.3.1.b. Describe Applicant's plan for engaging Members in achieving this transformation.

Integral to transformation is the patient-centered primary care home (PCPCH), as currently defined by Oregon's statewide standards in OAR. These standards advance the Triple Aim goals of better health, better care, lower costs by focusing on effective wellness and prevention, coordination of care, active management and support of individuals with special health care needs, a patient and family-centered approach to all aspects of care, and an emphasis on whole-person care in order to address a patient's physical and behavioral health care needs.

Trillium will ensure that all members have access to a PCP. Active efforts will be made to ensure that members are educated about the scope and breadth of services available through and coordinated by their PCP's and PCPCH centered care team.

The engagement strategies listed in A.2.1.a will be central to Trillium's efforts to engage members in achieving this transformation.

Enhancements to the PCPCH would be aimed at improving communication with members, prevention, and coordination of services across care settings. Any modifications used for special needs populations will be monitored for effectiveness.

A.3.1.c. Demonstrate how the Applicant will use PCPCH capacity to achieve the goals of Health System Transformation, including:

- **How the Applicant will partner with and/or implement a network of PCPCHs as defined by Oregon's standards to the maximum extent feasible, as required by ORS 414.655, including but not limited to the following:**

  - **Assurances that the Applicant will enroll a significant percentage of Members in PCPCHs certified as tier 1 or higher according to Oregon's standards; and**
  - **A coucrete plan for increasing the number of enrollees that will be served by certified PCPCHs over the first five years of operation, including targets and benchmarks; and**
  - **A concrete plan for tier 1 PCPCHs to move toward tier 2 and 3 of the Oregon standard over the first five years of operation, including targets and benchmarks.**

- **How the Applicant will require two-way communication and coordination between the PCPCH and its other contracting health and services providers to in a timely manner for comprehensive care management.**

Most of the PCP's participating in Trillium have implemented electronic health records capable of meeting meaningful use criteria. Many of the PCP's already have the systems in place to be recognized as PCPCH consistent with Oregon standards, and some are already so recognized.

Trillium will increase the percentage of members served by PCPCHs by at least 10% in each of the first five years. Strategies to support this include:

- Facilitating incentive payments from state and federal sources.
- Continued support to the primary care learning collaborative.
- Initiatives to raise awareness, promote, and recognize advancement through the tiered process.
- Work to devise payment systems that reflect the value of the comprehensive services and outcomes.

Through policy, Trillium will require two-way communication and coordination between the PCP's, PCPCH's and all other providers and organizations delivering services to Trillium members. Area hospitals are currently entering into agreements with primary care groups that outline communication expectations and processes for admission referrals and post hospital coordination of care. These agreements also include assurances to access to post hospital follow-up care within clinically indicated time frames.

A.3.1.d. Describe how the Applicant's PCPCH delivery system will coordinate PCPCH providers and services with DHS Medicaid-funded LTC providers and services.

Current infrastructure and processes used to coordinate Institutional Special Needs Plan (ISNP) and behavioral health services will be adapted and applied to a broader range of long term care providers. The communications infrastructure anticipated for Trillium will allow all Trillium participants to receive consistent and accurate member information and to access current information about the conditions and needs around which services are being provided. Since DHS and local Medicaid funded Long Term Care (LTC) providers are also among the broad scope of community partners forming the CCO, they will have access to effective communications infrastructure allowing for efficient and accurate coordination of care between them and a member's PCPCH.

A.3.1.e. Describe how the Applicant will encourage the use of federally qualified health centers, rural health clinics, migrant health clinics, school-based health clinics and other safety net providers that qualify as patient centered primary care homes.

Lipa and LaneCare have contracts in place with the two FQHCs in Lane County: the Community Health Centers of Lane County (CHCLC) operated by Lane County and White Bird Clinic. Those contracts will continue in the CCO. The CHCLC currently is a Level 2 PCPCH serving one fifth of the OHP members in Lane County.

In addition, Lipa has a strong and well established relationship with the school-based health clinics already operating in Lane County. Trillium has a clear understanding of the value of the services provided by the FQHC, the rural health clinics, and the school-based health clinics. The CHCLC provides services to the migrant population in Lane County as part of its FQHC grant, as well as services through a school-based health center.

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

A.3.2.a. If the Applicant proposes to use other models of patient-centered primary health care in addition to the use of PCPCH, describe how the Applicant will assure Member access to Coordinated Care Services that provides effective wellness and prevention, coordination of care, active management and support of individuals with special health care needs, a patient and family-centered approach to all aspects of care, and an emphasis on whole-person care in order to address a patient's physical and behavioral health care needs.

Trillium is adopting the PCPCH model and this section is not applicable.

A.3.2.b. Describe how the Applicant's use of this model will achieve the goals of Health System Transformation.

Trillium is adopting the PCPCH model and this section is not applicable.

A.3.2.c. Describe how the Applicant will require two-way communication and coordination between its patient-centered primary health care providers and other contracting health and services providers in a timely manner for comprehensive care management.

Trillium is adopting the PCPCH model and this section is not applicable.

A.3.2.d. Describe how the Applicant's patient centered primary health care delivery system will coordinate with PCPCH providers and services with DHS Medicaid-funded LTC providers and services.

This question is not applicable to Trillium.

A.3.3. Access

Applicant's network of providers will be adequate to serve Members' health care and service needs, meet access to care standards, and allow for appropriate choice for Members, and include non-traditional health care workers including Community Health Workers, Personal Health Navigators and certified, qualified interpreters.

A.3.3.a. Describe the actions taken 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 delivery of a service array and mix comparable to the majority population.

The organizations participating in Trillium have providers throughout urban and rural locations in Lane County, including co-located mental and physical health services, FQHC's, and school based clinics. Careful attention is paid to ensuring that, regardless of service location, culturally appropriate approaches and materials are used. Where possible the native culture of community health workers is aligned with that of the members to whom they are providing services. Translation services, already utilized in Lane County, will continue to be available. An increasing number of providers in the network are Spanish speaking which helps meet the needs of a growing population. Ongoing data analysis will monitor the service mix provided in all areas of Lane County. Inappropriate disparities will be detected and addressed.

Trillium's Community Advisory Council and Rural Advisory Council will have oversight responsibility to ensure that the concerns and needs of Lane County's diverse communities are being heard and met by Trillium. It will be a challenge to effectively address the comprehensive needs of members in rural communities where many services are scarce. It will also be a challenge to extend the CCO model to communities not previously served by an MCO. The

Rural Advisory Council will be created to ensure appropriate focus on outlying communities. A key strategy for engagement and re-engagement is the community health workers, the first group of which completed training in April 2012.

Trillium will continue contracts with a network of providers currently serving OHP members. The existing LaneCare provider panel serves 50% more clients per 1000 members than other MHO's in the state. Members are assured access to a variety of different behavioral health services with a contracted provider in most communities in our service area. Members are allowed to choose mental health providers as they are available. Trillium will contract with non-traditional health workers such as Peer Support Specialists, Personal Health Navigators and Community Health Workers as needed.

Behavioral health providers are located in the urban core and in the rural communities throughout Lane County. Trillium supports behavioral health services being provided in offices and in non-traditional settings. Trillium will support alternative services through contracts to serve under-served populations (transition age youth) and will maintain a comprehensive array of services for people with a severe and persistent mental illness.

Through the CACs, Trillium will convene periodic meetings with members and community-based organizations in order to provide opportunities to share concerns about access, cost, and quality and to make recommendations about how Trillium can better serve them and the populations they represent.

A.3.3.b. What barriers are anticipated with having sufficient access to coordinated care services for all covered populations by Contract Start Date? What strategies would the Applicant employ to address these barriers?

The most significant barrier to access to care is inadequate reimbursements that would ensure provider participation. Together, this collaboration that involves providers and local community members is best positioned to share resources and contain costs. If funding drops below a certain threshold, then access will suffer.

The formation of the CCO will not create any barriers to access that are not already present, or perceived to be present, in the community. Between longstanding presence and support within the community and the collaboration involving Lane County and other key affiliates, Trillium has been successful in obtaining the support of the local provider community as well as other community partners. Collaborative efforts aligned with the common Triple Aim goals of the CCO have been the focus of meetings and community discussions over the past two years. Trillium will build upon existing provider networks in order to meet the access needs for all members. Providing access to psychiatric providers is a challenge as there are an insufficient number of psychiatrists in the community. Significant recruitment efforts have been underway by mental health providers for the past six months and will continue.

To address lack of timely access to mental health services LaneCare has sponsored a process to promote rapid access to behavioral health services and anticipates service contracts that require an outpatient contractor to meet new referrals within five days of the initial contact. Some providers are negotiating same day referrals with medical homes. In the event that unanticipated barriers to obtain required contract services arise, Trillium is prepared to obtain those services

through non-contracted and out of area provider services. Required services outside of Trillium's service area will include procedures such as one-time contract agreements.

It will be a challenge to maintain the sustainability of services in rural communities, including Critical Access Hospital care, that have required cost-based reimbursement. Trillium will carefully monitor the situation and work with the provider network to ensure access.

A.3.3.c. Describe how the Applicant will engage their Members of all covered populations to be fully informed partners in transitioning to this model of care.

There are multiple published models for facilitating member (patient) engagement in the many processes of health care. Those models will be reviewed by Trillium to identify which concepts, programs, and specific tools are most relevant to informing the population and subpopulations of Lane County about the formation and structure of the CCO. As part of the process by which the CCO itself is being formed, many of the identifiable constituencies in Lane County have been invited into discussion to ensure that Trillium meets their needs and that they are engaged.

Trillium will develop and distribute to all enrollees a member handbook that describes system changes and the benefits of the new delivery system. Trillium will make printed materials available in all DHS and S&DS offices.

A.3.4. Provider Network Development and Contracts

A.3.4.a. Describe how the Applicant will build on existing provider networks that delivery coordinated care and a team based approach, including how it will arrange for services with providers external to the CCO service area, to ensure access to a full range of services to accommodate member needs.

Lipa and LaneCare have complete provider panels able to meet the current demand of the OHP population and will build on this experience, through Trillium, to deliver coordinated care using a team based approach. Arranging for access for required services outside of the Lane County service area will be achieved by using a defined referral process and utilizing one time contracts when needed, Trillium will ensure that members will have access to and receive a full range of services accommodating any covered health care needs that may occur.

A.3.4.b. Describe how the Applicant will develop mental health and chemical dependency service alternatives to unnecessary inpatient utilization for children and adults, including those with addictive disorders. Discuss strategies the Applicant has used to develop services that divert members from non-medically necessary inpatient care, decrease length of stay, and prevent readmissions.

LaneCare has been managing the integrated OHP mental health and chemical dependency benefit and will continue to develop approaches that help divert members from high cost hospital based services and reduce the length of stay. Examples include:

- 24/7 Youth Crisis Network which provides in home crisis supports for members under the age of 21
- Next day crisis assessments for all members diverted from the ER

- Suicide hospital diversion program at Royal Avenue Program
- Transition Team program that accepts acute hospital discharge patients
- First Episode Psychosis Program (under review)

Trillium will work with a continuing care model and coordination of care, with a full range of American Society of Addiction Medicine (ASAM) detoxification services, residential services, intensive outpatient services, and follow up aftercare to support recovery for those with addiction disorders.

Trillium also supports the need for co-occurring treatment of both mental health and substance abuse disorders, particularly for those with a history of trauma and/or high relapse rates. LaneCare has provided technical assistance and support to providers to encourage them to become licensed to provide both interventions, and education and training has focused on effective evidence based practices for this population.

LaneCare has also worked with the detoxification providers to address the high relapse rates following detox for opiate users who do not enter ongoing care following their detox stay. Trillium also is encouraging PCPs to train in understanding addiction issues, including the use of medications for the disorders. For example, buprenorphine may be used to treat opiate addiction, as well as chronic pain; many members with that addiction are also suffering from chronic pain and could benefit from that medication.

A.3.4.c. Describe how the Applicant 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.

Trillium will prioritize options for least restrictive care for those with chronic behavioral health disorders and already has a vast behavioral health provider network. Trillium will continue LaneCare's current practice of behavioral health supports to protect independent living and person centered care approaches:

- Peer support specialist services and Community Health Workers
- Peer drop in center
- Community based and in-home intensive services for youth paid at a higher rate
- Assertive Community Treatment teams and supported housing programs
- Adult foster homes

A.3.5. Coordination, Transition and Care Management

<u>Care Coordination</u>:

A.3.5.a. Describe how the Applicant will support the flow of information between providers, including DHS Medicaid-funded LTC care providers, mental health crisis services, and home and community based services, covered under the State's 1915(i) State Plan Amendment (SPA) for Members with severe and persistent mental illness, in order to avoid duplication of services, medication

errors and missed opportunities to provide effective preventive and primary care.

Trillium plans to develop an electronic communication system that will be utilized by all of Trillium participants. The system will incorporate Trillium shared health information and care plans to support a coordinated care team approach. Pending deployment of the communication system Trillium will support information sharing through the development of virtual "teams," use of standardized care transition forms, medication reconciliation, and data sharing between health and social service providers.

The physical and behavioral health ENCCs will assure that information is exchanged between all providers for members with a severe and persistent mental illness (or other conditions that limit benefit from a higher level of care coordination). The ENCCs currently have experience performing this to a high level of effectiveness. Trillium will cross train these staff so they are more proficient in areas in which they are not yet experts by expanding their skill sets to incorporate both physical and behavioral health. Developmental Disabilities brokerage systems and self-sufficiency offices will be included in the systems changes as well.

Trillium recognizes that these members are particularly vulnerable and they often lack the ability to self manage their health effectively. ENCCs will work closely with the S&DS, Developmental Disabilities, Foster Home Providers, residential service providers and others to assure services are managed, preventative and primary care is provided compassionately, and that supports are provided to reduce medication errors. There is a monthly interdisciplinary team meeting (called the LTC3) that brings together staff from the LTC service delivery systems to analyze and support the transition under Trillium and to ensure adequate communication between departments.

A.3.5.b. Describe how the Applicant will work with its providers to develop the partnerships necessary to allow for access to and coordination with social and support services, including crisis management services, and community prevention and self-management programs.

Trillium will continue to provide regular opportunities for its providers to be educated about social and support services within Lane County and to engage the social service network. The County will support a monthly meeting of community partners to share information, address concerns and barriers to access, and recommend approaches to address community issues particularly related to the social determinants of health. Providers will have tools to assist with these partnerships including community health workers, resource information on chronic disease, self management, crisis management and other evidence based practices.

A.3.5.c. Describe how the Applicant will develop a tool for provider use to assist in the culturally and linguistically appropriate education of Members about care coordination, and the responsibilities of both providers and Members in assuring effective communication.

Trillium will develop member information materials that describe its function in a culturally and linguistically appropriate fashion. An early joint assignment to the CAC and the CAP will be to develop these tools with support from consultants as necessary for content and design.

A.3.5.d. Describe how the Applicant will work with providers to implement uniform methods of identifying Members with multiple diagnoses and who are served with multiple healthcare and service systems. Describe how Applicant will implement an 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.

Members with multiple diagnoses, complex care needs, and who are served by multiple health care and service systems will be identified using multiple standardized approaches including provider identification, needs assessment by S&DS at the time of plan enrollment, claims-based prospective risk scoring, and others. Once identified, members will be assigned to a care coordination nurse who will be responsible for oversight to ensure that care is coordinated across all CCO providers working on behalf of the member.

Level of services provided will be based upon medical needs assessment performed by the PCPCH as well as social/behavioral needs assessments performed by other involved CCO participants. Trillium will support education of providers regarding program parameters, eligibility and service packages for social service programs available to its members, including the Community Developmental Disability Programs. Standardized instruments (such as the LOCUS and ASAM assessments) will be shared with PCPCHs and medical providers will receive education on the use of these instruments and their assistance in understanding member health issues.

Trillium will maintain a level of care approach for members receiving behavioral health services.

- Level 1: hospital, sub-acute and residential care.
- Level 2: outpatient care for members identified with a serious mental health condition that requires significant community support and care management and health care coordination may be through behavioral health medical homes with care teams that incorporates CHWs, physical and behavioral health.
- Level 3: behavioral health care that requires some longer term supports and care coordination and significant coordination with medical homes by using CHWs.
- Level 4: brief behavioral health treatments with a goal of having this level of care provided in medical homes.

Trillium will be responsible for coordination of complex supports with other service providers such as Developmental Disabilities, S&DS, brokerages, nursing homes, etc.

Deployment of Trillium's planned communications infrastructure will greatly facilitate coordination of care through the use of shared health information and the development of care plans shared across multiple providers, facilities and organizations delivering services to high need members.

A.3.5.e. Describe how the Applicant will meet state goals and expectations for coordination of care for Members with severe and persistent mental illness

receiving home and community based services covered under the State's 1915(i) SPA and Members receiving DHS Medicaid-funded LTC services, given the exclusion of DHS Medicaid-funded LTC services from global budgets.

Trillium will coordinate care for members with severe and persistent mental illness receiving home and community based services in partnership with Lane County Behavioral Health, S&DS, DD and CMHPs. Immediately upon enrollment in Trillium, members with severe and persistent mental illness will be assigned to an ENCC who will be responsible for ensuring that care coordination occurs. In addition, LaneCare currently funds a psychiatric nurse practitioner based in the S&DS office that works with long term care providers and case managers to prevent unnecessary transitions to higher levels of care or hospitalizations. For members receiving DHS Medicaid-funded LTC services, Trillium and S&DS will establish the following:

- Protocols for information sharing regarding common clients (i.e. lists of clients and the type of LTC service)
- Joint staffing to problem solve complex cases
- Joint evaluation of current processes for improvements and efficiencies.

A.3.5.f. Describe the evidence-based or innovative strategies the Applicant will use within their 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.

<u>Assignment of responsibility and accountability:</u> The Applicant must demonstrate that each Member has a primary care provider or primary care team that is responsible for coordination of care and transitions.

Trillium will employ multiple strategies to ensure coordinate care. Lane County has invested in the training of 24 Community Health Workers who are being deployed throughout the delivery system. There are more than 30 peer specialists employed by mental health contractors who work with members with intensive support and care coordination needs. Family and peer service providers are supported by Trillium and participate in provider meetings and access training and education opportunities.

The County also supported the creation earlier this year of a health outreach center at the Eugene Mission, providing health screening and referral to the Community Health Centers of Lane County for over 300 homeless adults nightly. The County supports four FQHC clinics and several school-based health clinics, as well as a Homeless Health clinic located at a community based organization. Many of these are eligible Trillium members with serious health conditions who do not access care due to mental health and substance use issues.

A key strategy is the emphasis on primary care and the PCPCH as a way to coordinate care. Each member within 30 days of enrollment will be encouraged to choose a PCP. If the member does not choose a PCP, one will be assigned to them.

A.3.5.g. Describe the Applicant's standards that ensure access to care and systems in place to engage Members with appropriate levels of care and services beginning not later than 30 days after Enrollment with the CCO.

When members are enrolled in Trillium, each member within 30 days of enrollment will be encouraged to choose a PCP. If the member does not choose a PCP, one will be assigned to them. Additionally, Phase 2 members are identified and assigned within one week of enrollment to an ENCC. The ENCC will be responsible for ensuring that the member has timely access to all necessary services.

A.3.5.h. Describe how the Applicant will provide access to primary care to conduct culturally and linguistically appropriate health screenings for Members to assess individual care needs or to determine if a higher level of care is needed.

Comprehensive transitional care: The Applicant must ensure that Members receive comprehensive transitional care so that Members' experience of care and outcomes are improved. Care coordination and transitional care should be culturally and linguistically appropriate to the Member's need.

All members in Trillium will be assigned to a PCP. Trillium will encourage agreements with providers, outlining expectations and processes during care hand-offs. Trillium will support the use of standardized care transition communication tools and processes, for example, follow-up telephone calls, medication reconciliation, and Teach Back.

Where alignment of language is not possible, Trillium will provide necessary translation services. Cultural competency in its providers will be an explicit focus for Trillium. Larger organizations will be expected to provide cultural competency training to their staffs and Trillium will identify and deploy resources to ensure that smaller organizations and individual providers will have access to similar training. Language Lines will be employed as necessary, to meet linguistic needs when contacting members for health risk assessments.

A.3.5.i. Describe the Applicant's plan to address appropriate transitional care for Members facing admission or discharge from hospital, hospice or other palliative care, home health care, adult foster care, skilled nursing care, residential or outpatient treatment for mental health or chemical dependency or other care settings. This includes transitional services and supports for children, adolescents and adults with serious behavioral health conditions facing admissions or discharge from residential treatment settings and the state hospitals.

Trillium recognizes the importance of continuity and coordination of care for members transitioning between levels and/or locations of care. The Care Coordinators for both mental health and physical health have an important role working with members leaving intensive care settings for community settings, assisting in finding placements for members in the community, setting up PCPCHs, coordinating CHW services when needed, supporting family and peer activities, and initiating entry into outpatient care as needed, among other duties.

The communications infrastructure being developed for Trillium will be critical to ensure that during transitions, all providers caring for a member have access to the same information set and care plan to reduce the likelihood of unmet needs and adverse outcomes. Portions of Trillium's

transitions system will be modeled on the program already developed by several of the CCO participants, including local hospitals, S&DS, Trillium, and others.

A.3.5.j. Describe the Applicant's plan to coordinate and communicate with Type B AAA or APD to promote and monitor improved transitions of care for Members receiving DHS Medicaid-funded LTC services and supports, so that these Members receive comprehensive transitional care.

The local S&DS office is one of the primary stakeholders in the CCO and as such it has committed to integrating its care planning and service delivery processes with the communications infrastructure of the CCO. This integration will allow for seamless, real-time, sharing of care plans and service needs among all of the CCO participant providers, facilities, and organizations. With this system in place comprehensive transitional care will be facilitated. This system will also allow for better monitoring of transitions and their outcomes allowing Trillium to optimize processes wherever necessary.

A.3.5.k. Describe the Applicant's plan to develop an effective mechanism to track Member transitions from one care setting to another, including engagement of the Member and family Members in care management and treatment planning.

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

Please see A.2.1.a and A.3.5.i responses above. Member and family member engagement is an important component of the PCPCH model and Trillium's plan for improvement of member transitions keeps the PCPCH at the center of the process. It is anticipated that this will ensure their engagement in the necessary care management and treatment planning that accompanies any care transition.

When notifications of transitions occur, it is entered into a care coordination program which will generate notification to the treating and service providers.

A.3.5.l. Describe the Applicant's standards and procedures that ensure the development of individualized care plans, including any priorities that will be followed in establishing such plans for those with intensive care coordination needs, including Members with severe and persistent mental illness receiving home and community based services covered under the State's 1915(i) SPA.

Members with a severe and persistent mental illness will receive comprehensive mental health assessments, overseen by a LMP, that result in a diagnosis and a person-centered treatment plan. Trillium will implement an Internet based provider-authorization system where the provider will identify the treatment and care coordination needs of the individual, develop an individual service and support plan, and provide the appropriate services. Trillium will provide technical

support and oversight to assure provider accountability. For members receiving Level 1 or 2 care, the ENCC will become involved in reviewing plans and authorizing care to ensure appropriate services are being provided and care coordination needs are being met.

A.3.5.m. Describe the Applicant's universal screening process that assesses individuals for critical risk factors that trigger intensive care coordination for high needs Members; including those receiving DHS Medicaid-funded LTC services.

Trillium will utilize the list of Medicaid enrollees, including the LTC members, provided weekly by the State of Oregon, as the initial information to identify the Phase 2 exceptional needs and complex, high needs members. Trillium will utilize collected administrative, electronic, referral and member reported data. Employing priority health care analytics systems data and incorporating data gleaned from self-reported Health Risk Assessments (HRA s), episodic trigger events and information gained from direct interface with our members. Members will be assessed for critical risk factors that drive intensive care coordination.

Additionally, changes in functional status, health care needs, socio-economic status, access to care, etc., serve as triggers for activation of intensive care coordination services. The coalesced assessment information will lead Trillium in a member-centric, member-participatory fashion that is as pro-active as possible, while meeting the high complex care needs of our members. Trillium will utilize a multi-dimensional, prioritizing, risk stratification process with the goal of having no members with complex intensive care coordination needs unmet.

A.3.5.n. Describe how the Applicant will factor in relevant referral, risk assessment and screening information from local type B AAA and APD offices and DHS Medicaid-funded LTC providers; and how they will communicate and coordinate with type B AAA and APD offices.

Trillium will share relevant referral, risk assessment, and screening information with CCO participating providers facilities and organization via a secure website. This portal is currently being successfully utilized by Trillium, LaneCare and Trillium medical providers. The access will be expanded to include all members of the CCO. Joint staffing models of Trillium and S&DS transition staff will be designed to support better coordination during transitions. The sharing of risk factor tools and triggers for intensive care coordination will allow for more comprehensive shared care planning. Research and development of technological tools to support shared care planning will be ongoing. Communication of shared care plans will initially be through the electronic portal, face-to-face or telephonic care plan meetings, and the Complex Case Management Committee meetings.

A.3.5.o. Describe how the Applicant will reassess high-needs Members at least semi-annually or when significant changes in status occur to determine whether their care plans are effectively meeting their needs in a person-centered, person-directed manner.

Complex, high needs members will be assessed semi-annually and when significant changes in status trigger events to determine whether their care plans require revision. The assessment will include reviewing the care plan to ensure there remains a person-centered, person-directed focus.

The assessment will include reviewing the care plan to determine if the transition is an indication of previous unmet needs. The care plan review will also serve to identify any new service needs.

Trillium will require that all behavioral health assessments and ISSP plans are updated annually and when conditions or changes in status of the member change significantly. Trillium will conduct site visits to assure this standard is met and that care plans are person-centered and person-directed, providing the supports and services desired and medically appropriate for the patient. Trillium ENCCs will review authorizations submitted for Level 2 services and will review these assessments and plans prior to entering and approved authorization.

A.3.5.p. Describe how individualized care plans will be jointly shared and coordinated with relevant staff from type B AAA and APD with and DHS Medicaid-funded LTC providers.

Technological tools will be pursued to support real time, continually updated data incorporated into care plans based on member contact information from all Trillium service providers. The information will populate a constantly up-to-date community shared care plan encompassing all aspects of the member's care. Use of joint staffing and inter-disciplinary meetings will support sharing of individualized care plans with S&DS and LTC providers. A model of virtual integrated care teams will be explored.

A.3.6 Care Integration

Mental Health and Chemical Dependency Services and Supports

A.3.6.a. Describe how the Applicant has or 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 includes Members in all age groups and all covered populations.

LaneCare and Lipa currently maintain a provider panel of mental health and chemical dependency providers, including some that provide culturally specific services. There are five contractors that are certified as both mental health and chemical dependency providers. Trillium will continue to support the following:

- 22 mental health provider contracts
- Nine chemical dependency provider contracts
- Residential mental health providers for children, youth, adults and seniors
- Two Adolescent and four adult chemical dependency providers
- One mental health/chemical dependency contractor that specializes in serving Spanish speaking members

A.3.6.b. Describe how the Applicant 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. This includes Members with limited social support systems. Describe also how the Applicant will transition Members out of hospital, including state hospitals and residential care settings into the most appropriate, independent and integrated community-based settings.

Care Coordination: ENCCs will assure that coordination occurs for high cost, high risk members by supporting care transitions, coordinating care across physical and behavioral health providers, and reviewing and authorizing level 1 and 2 care. Contractors will be funded to provide care coordination, case management and follow-up services for patients.

Treatment Engagement: LaneCare currently measures engagement through a performance assessment process, assessing the time period between the first and second treatment appointment. The standard of care expected is that the second appointment occurs within 14 days of the first. LaneCare is also supporting clinician use of tested instruments that assess client functioning as well as clinician engagement with the client. This can be used administratively, by clinical supervisors and by clinicians with their clients.

Preventive Services: LaneCare currently has over 20 consumer, prevention, and carve-out contracts that address the social determinants of health, improve natural support systems, offer alternative treatments to reduce dependence on medications, and provide parenting and living supports. Trillium will support ongoing community efforts for mental health promotion and substance abuse prevention. Specific evidence based efforts target suicide prevention, early childhood mental health, and high risk drink prevention. Trillium will continue to work with post partum depression and other prevention related to both physical and behavior health.

Transition to community based care: Trillium ENCCs specialize in transitioning adult members from the State and acute hospital settings into residential or community settings. The ENCCs will participate in hospital discharge meetings. LaneCare has managed AMHI transitions for two years and is experienced with working with all local and state residential providers including secure, non-secure residential settings, adult foster homes, supported housing programs and ACT teams. Trillium will facilitate monthly provider meetings, track vacancies, review LOCUS scores, negotiate placements and approve necessary supports. Trillium ENCCs will specialize in working with youth served by ISA programs including state hospital, residential services, BRS programs, day treatment programs, and intensive community programs. Weekly meetings with child welfare, providers, DYS, and family members allow for review of each child, assessment of progress, and planning for discharge and community reintegration. Trillium will be responsible for authorizations, utilization review, and discharge planning.

A.3.6.c. Describe how the Applicant has integrated 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.

LaneCare has managed both the chemical dependency and the mental health benefit for OHP members for the past year. LaneCare has programs that serve different age groups, in different communities, and that serve different cultural groups. All CD treatment providers are now certified as mental health providers. Behavioral health assessments must screen and assess for both chemical dependence and a mental health conditions. Trillium will support providers in developing integrated treatment programs, single authorizations for behavioral health services, single case records, and blended funding.

Providers complete crisis plans for both children and adults who have experienced a crisis that resulted in a hospitalization or an ER presentation. These are developed in partnership with the patient and family. They can be shared with a signed release with the hospital or with other providers, long term care facilities, Developmental Disabilities (DD), child welfare and foster care providers. We will make these an integral component of medical home processes.

A.3.6.d. Describe how the Applicant has organized a system of services and supports for mental health and chemical dependency, including:

- **Integrated prevention services at the clinical and community level**
- **Integration of primary care across systems**
- **Qualified service providers and community resources designed and contracted to deliver care that is strength-based, family-focused, community-based, and culturally competent;**
- **Network of crisis response providers to serve members of all ages; and**
- **Recognized evidence-based practices, best emerging practices and culturally competent services that promote resilience through nationally recognized integrated service models**

Integrated prevention services at the clinical and community level: Lane County Health and Human Services employs a Prevention Program Supervisor and has a long history of developing and supporting clinical and community prevention activities that include: Mental Health First Aid, Suicide Prevention Training, Tobacco use reduction, Public Health Initiatives, Family Resource Centers, Early Intervention programs, and hospital diversion programs.

Integration of primary care across systems: Lane County will develop and expand PCPCH in physician offices and behavioral health clinics. Community Health Workers will serve as service integration links. LaneCare has distributed health transformation funds to contractors to help them develop infrastructure and skilled staff to work more effectively with primary care. Many physical health and behavioral health providers have developed EMRs and Trillium intends to facilitate cross EMR communication.

Qualified service providers and community resources designed and contracted to deliver care that is strength based, family focused, community based, and culturally competent: Providers in Lane County have been trained to provide these services for over 15 years and this philosophical approach is integral to all levels and types of behavioral health treatment. Child providers have been trained in this strength based approach since the New Opportunities program and family engagement is essential in child programs, particularly the ICTS programs. Adult service providers embrace the person-centered approach with flexible, community-based services

offered through intensive outpatient and ACT team services. Continued training and support for these approaches will be provided by Trillium.

Network of crisis response providers to serve members of all ages: Trillium will continue to support the following services:

The Youth Crisis Network is a collaboration of three child mental health contractors that provides 24/7 phone and mobile supports across the entire county for families where a child is experiencing a mental health crisis.

White Bird Clinic provides in phone and drop in crisis supports and operates CAHOOTS, a mobile crisis response team. White Bird also manages a 24/7 phone line that screens individuals for next day mental health assessments to avoid a psychiatric hospital admission.

Emergency Department Crisis Services including safety assessment and safety planning hospital admission or diversion and rapid access to same day or next day treatment.

Royal Avenue Program provides crisis residential supports to adults. Each contracted behavioral health clinic is required to have a telephone protocol for responding to clients calling with a crisis.

Recognized evidence-based practices, best emerging practices and culturally competent services that promote resilience through nationally recognized integrated service models: Trillium will support the following services that meet these criteria: Assertive Community Treatment Teams, Acceptance and Commitment Therapy, Collaborative Problem Solving, Cognitive Behavioral Therapy, Treatment Foster Care, D.B.T., Circle of Security, PCPCH, wraparound services, Motivational Interviewing, First Episode Psychosis (the RAISE project), Outcome Informed Treatment.

Oral Health

No later than July 1, 2014, ORS 414.625 requires each CCO to have a formal contractual relationship with any DCO that serves Members of the CCO in the area where they reside.

A.3.6.e. Describe the Applicant's plan for developing a contractual arrangement with any DCO that serves Members iu the area where they reside by July 1, 2014. Identify major elements of this plan, iucludiug target dates and benchmarks.

There are four DCOs in the applicant's service area and not all may be ready for a launch on August 1, 2012 but a full and adequate panel of dental providers will be available no later than July 1, 2014. The applicant plans to work with the DCOs toward contracts that are sustainable and that actuarially fit in the fixed global budget. Trillium also plans to monitor all DCOs, even if not yet contracted, for performance improvement, complaints, utilization and access to ensure that future contract arrangements result in high levels of quality, access and cost.

A.3.6.f. Describe the Applicant's plan for coordinating care for Member oral health needs, prevention and wellness as well as facilitatiug appropriate referrals to dental.

Trillium has already incorporated a representative from the Lane County dental community in its planning and organizational process. DCO's currently providing care to Lane County OHP members will be encouraged to join Trillium and to participate in its community-wide information sharing infrastructure in order to better collaborate and coordinate dental care with a member's other health needs.

Through electronic data and communication tools, dental providers will be part of the patient centered care team. Oral health prevention will be incorporated, along with other wellness messaging and interventions provided to members to encourage health. Providers will use consistent oral health messaging across provider types. Example: Pediatrician and dental provider both using appropriate materials and anticipatory guidance messages for young children and their caregivers, thereby re-enforcing the messages. Better coordination and communication tools will streamline and facilitate appropriate and timely dental referrals.

Hospital and Specialty Services

Adequate, timely and appropriate access to hospital and specialty services will be required. Hospital and specialty service agreements should be established that include the role of patient-centered primary care homes.

A.3.6.g. Describe how the Applicant's agreements with its hospital and specialty care providers will address:

- **Coordination with a Member's patient-centered primary care home or primary care provider**
- **Processes for PCPCH or primary care provider to refer for hospital admission or specialty services and coordination of care.**
- **Performance expectations for communication and medical records sharing for hospital and specialty treatments, at the time of hospital admission or discharge, for after-hospital follow up appointments**
- **A plan for achieving successful transitions of care for Members, with the PCPCH or primary care provider and the member in central treatment planning roles.**

Area hospitals are currently entering into agreements with primary care groups that outline communication expectations and processes for admission referrals and post hospital coordination of care. These agreements also include assurances to access to post hospital follow-up care within clinically indicated time frames.

Trillium will build on the current arrangements its providers have with hospitals and specialty services with regard to referrals and admissions. Initially, hospitals and specialty services will be encouraged to incorporate Trillium's information infrastructure into their workflows to ensure that coordination occurs with the member's PCPCH. Use of that infrastructure will also ensure that whenever transitions occur they are documented in the member's Trillium health record and care plans are updated. Language relating to performance expectations and timely information sharing will be incorporated into the language of any agreements between the parties and Trillium. Trillium will monitor compliance with performance expectations.

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

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

A.3.7.a. Describe how the Applicant

- **Will effectively provide health services to Members receiving DHS Medicaid-funded LTC services whether served in their own home, community-based care or nursing facility and coordinate with the DHS Medicaid-funded LTC delivery system in the Applicants service area, including the role of type B AAA or the APD office;**
- **Will use best practices applicable to individuals in DHS Medicaid-funded LTC settings including best practices related to care coordination and transitions of care;**
- **Will use, or participate in, any of the following models for better coordinating care between the health and DHS Medicaid-funded LTC systems, or describe any alternative models for coordination of care:**
  - **Co-Location: co-location of staff such as type B AAA and APD case managers in healthcare settings or co-locating behavioral health specialists in health or other care settings where Members live or spend time,**
  - **Team approaches: care coordination positions jointly funded by the DHS Medicaid-funded LTC and health systems, or team approaches such as a multi-disciplinary care team including DHS Medicaid-funded LTC representation,**
  - **Services in Congregate Settings: DHS Medicaid-funded LTC and health services provided in congregate settings, which can be limited to one type of service, such as "in home" personal care services provided in an apartment complex, or can be a comprehensive model, such as the Program of All-Inclusive Care for the Elderly (PACE).**
  - **Clinician/Home-Based Programs: increased use of Nurse Practitioners, Physician Assistants, or Registered Nurses who perform assessments, plan treatments, and provide interventions to the person in their home, community-based or nursing facility setting.**

Trillium will identify and ensure that all members in care settings will receive the most appropriate options for their identified level of care need. Coordination of communication with S&DS will be through Trillium communication infrastructure supplemented by inter-disciplinary meetings.

Trillium's Clinical Advisory Panel is responsible for the identification and implementation of best practices throughout the organization. As a participant in Trillium, S&DS will assist the CAP in identifying and implementing best practices related to transitions and LTC. Trillium will leverage and build on care transition models already in place, especially with respect to members transitioning to and from LTC.

Trillium and S&DS will pursue expansion of co-location models designed to provide support, referral and education for members/community. An example of a current success is the co-location of a LaneCare funded Psychiatric Nurse Practitioner in the local APD office for three years. Joint staffing and interdisciplinary meetings with key partners, including S&DS will be established. Trillium's communications infrastructure will allow multiple forms of communication to meet the needs of the organizational partnerships responsible for care in LTC settings. S&DS currently co-locates Medicaid intake case managers at area hospitals.

Trillium utilizes mid-level practitioners and Registered Nurses who perform assessments, plan treatments, and provide interventions to members in their home, community-based or nursing facility.

Trillium will meet regularly as a multi-disciplinary team (LTC3) with S&DS, DD, LMHA, and Trillium staff to coordinate complex case decision making and build coordination between all these organizations.

Trillium will employ a complex case management approach utilizing ENCCs to facilitate physical and behavioral health care coordination. A multi-disciplinary case management committee model will review and make recommendations for a comprehensive care plan for those members with the highest, most complex needs. Service providers of the member will be included in the review.

A.3.8. Utilization management

A.3.8.a. Describe how the Applicant will perform the following UM activities tailored to address the needs of diverse populations including members receiving DHS Medicaid-funded LTC services, members with special health care needs, members with intellectual disability and developmental disabilities, adults who have serious mental illness and children who have serious emotional disturbance.

- **How will the authorization process differ for acute and ambulatory levels of care**
- **Describe the methodology and criteria for identifying over- and under-utilization of services**

For the populations referenced in this section the current authorization procedures utilized by Lipa and LaneCare will continue to be utilized. Those procedures are designed to ensure that members receive all the appropriate care allowed under OHP rules and guidelines. With respect to medical services, once a member has been admitted to a hospital for an acute illness, no specific authorizations are required for any services deemed by their attending physicians to be necessary.

UM/QM/HE will identify services of concern for over- and under- utilization by reviewing the literature and recent utilization data against evidence based best practice standards. For services of highest concern, utilization reports will be run to identify patients and providers with opportunities for improvement. Results will be linked to patient care plans, patients, and/or providers as appropriate.

The behavioral health care system will collect the following data to identify over- and under-utilization of services:

- An outcome measurement tool Psychiatric admissions and lengths of stay
- Discharge from outpatient behavioral health services to PCPCH
- Discharge from outpatient Behavioral Health services as a result of termination
- Place of outpatient services
- Levels of care for members enrolled in outpatient services
- Emergency Department admissions

Section 4 - Health Equity and Eliminating Health Disparities

Health equity and identifying and addressing health disparities are an essential component of HST. Health equity is the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing efforts to eliminate health disparities.

A.4.1. CCOs and their providers are encouraged to 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. Describe how the Applicant and its providers will achieve this objective.

Health Equity is an important component of the UM/QM process. Trillium will involve providers and members at each step of the way to develop best practices of culturally appropriate care, reduce health disparities, and improve health.

To reduce health disparities and improve health of patients who self identify as racial and ethnic minorities, Trillium will promote best practices of culturally appropriate care. Data collected through the Community Health Assessment and during year one by race/ethnicity and region/neighborhood on important inter-related topics for equitable quality improvement in Lane County including, tobacco use, obesity, hyper-tension, asthma, infant mortality, low birth weight, mental health, substance abuse and addiction. This first year report will help guide future investments to increase health equity and to reduce disparities. The overall approach will be culturally specific and linguistically appropriate.

- Physical and behavioral health providers participate on Trillium's Board of Directors and other health equity-related Board subcommittees. The Board assigns direct oversight of UM/QM/HE functions to the Trillium UM/QM/HE Committee that oversees and directs the Program. The Committee, staffed with community members and providers representing each provider group and different specialties, meets regularly.

- Behavioral health and physical health providers representing provider groups in the community participate on Trillium's Clinical Advisory Panel (CAP). CAP providers review Trillium's Community Health Assessment and participates in developing its Community Health Equity Improvement Plan. The improvement plan prioritizes disparities for corrective action, specifies interventions, and measurable objectives for improvement. Three equity issues are targeted for improvement in the first year of CCO operation, one physical health, one mental health and one service focused. Metrics (overlapping with required First Year CCO Indicators as much as possible) are defined and baselines measured. Equity activities are reviewed annually for effectiveness/revision and new topics are considered for intervention based on new community assessments.

- Contracted and non-contracted providers in the community receive information about UM/QM/HE activities through the Trillium website, social media, quarterly provider newsletters, and other modes suggested by the CAP.

A.4.2. Describe how the Applicant will track and report on quality measures by these demographic factors that includes race, ethnicity, primary language, mental health and substance abuse disorder data.

Trillium quality metrics will be analyzed by demographic factors including race, ethnicity, primary language, mental health and substance abuse disorders, as well as any other measurable factor determined to be of interest in assessing health equity by the CAC or CAP. Computations will be performed by Trillium's health care analysis system. Reporting of findings will follow Trillium's Quality Management policies and procedures.

Section 5 - Payment Methodologies that Support the Triple Aim

A.5.1. Demonstrate how Applicant's payment methodologies promote or will promote the Triple Aim and in particular, how the Applicant will:

- **Provide comprehensive coordination or create shared responsibility across provider types and levels of care and creates incentives for using such delivery systems such as PCPCHs;**

Trillium uses and will continue to use a variety of payment methods to reimburse participating providers. Methods include but are not limited to: fee-for- service (FFS), full capitation, partial capitation, case- and episode-based payments and pay-for-performance. The various methods will be incorporated into a target budget model where payments will be paid out of provider pools that will have a predetermined budget. Through the coordination of care it is anticipated that savings will be made creating surpluses in the pools. A portion of the CCO share of net surpluses will be distributed to participants based on their achievement of predetermined goals related to the Triple Aim. Prior to each fiscal year, the Governing Board will adopt a specific distribution formula for the net savings for that fiscal year that will reflect performance goals.

To the extent PCPCHs demonstrate lower cost quality care; the target budget model described above will encourage providers to use efficient and effective delivery systems. As the CCO develops it will identify opportunities to reward improved outcomes from provider collaboration.

- **Provide financial support, differentially based on the tier level achieved, to PCPCHs for meeting the PCPCH standards;**

The infrastructure and practice changes necessary to move to higher tiers of PCPCH certification will require additional financial resources from the providers. Trillium is considering creating a transformation funding pool that could be used to finance some of providers' additional expenses for PCPCHs.

- **Align financial incentives for evidence-based and best emerging practices.**

Trillium will regularly monitor provider performance related to coordination, equity, efficiency, effectiveness, quality of care and service, adherence to evidence based guidelines including over- and under-utilization, and outcomes of care. Trillium is considering creating a transformation financial pool that will incent creative practices that help providers reach the performance goals of the Triple Aim.

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. Describe the Applicant's current capacity and plans to improve HIT in the areas of data analytics, quality improvement, patient engagement through HIT (using tools such as email, personal health records, etc.) and other HIT.

- **Data analytics**
  - Trillium maintains a proprietary health care analysis system that allows for the reporting and analysis of data for Quality Management, Utilization Review, Health Equity Evaluation, Care Coordination, Fraud and Abuse Review, Performance Dashboards, and Program Monitoring and Evaluation and other information needs. Information from across the spectrum of care is grouped into clinically meaningful cases/episodes allowing for the comparative analysis of outcomes, utilization and costs, for groups and individual members and providers. The system incorporates best practice standards to identify gaps in quality care. Prospective and retrospective risk indicators help identify high risk members, cost effective providers and local evidence-based best practices. During the first year Trillium, system data quality and completeness will be improved and routine reports related to needs, risks, equity, quality, efficiency, cost, and best practices will be developed and analyzed for action.
  - Trillium is working with a private vendor to design and implement a communication information system for timely integration and sharing of health-related information about members to Trillium participants and relevant entities within the community. The member information sharing system houses data from health assessments, EMRs, Trillium's clinical analysis system, providers, community health workers, and other organizations. The tool assembles data to help develop member care plans and shares information with appropriate others determined by customizable access rules.

- Trillium is developing a compliance system. The system provides timely updating of compliance requirements, policies and procedures, and monitoring of privacy and security issues, authorizations and appeals, complaints, and grievances. Priorities for the first Trillium contract period include installation and testing of the compliance system, development of a compliance dashboard report for prompt identification of performance problems, and refinement of processes related to data sharing.

- Trillium participates in HEDIS, CAHPS, and HOS. Data are analyzed to identify best practices and opportunities for improvement.

- Dashboard reports are generated monthly for two levels of Trillium users, department managers and senior leaders. The reports are being revised for Trillium use and to be more performance focused, prospective, and actionable.

- Performance reports include Trillium's annual target measures related to the Triple Aim and all required indicators. Performance reports are generated and analyzed regularly.

- **Quality improvement**

  Community discussions are currently underway regarding strategies to improve the quality of the HIT in Lane County. These discussions include consideration of an HIE system.

  Discussions about improving the quality and timeliness of HIT in Lane County are underway.

  - Trillium, in partnership with the CAP, will work to improve data quality and completeness and maximize the use and coordination of existing provider HIT systems.
  - Trillium is developing a communications system to link member information from different health and social service providers within the community and then appropriately share it according to defined access rules in keeping with privacy and security standards.
  - Trillium is working to expand the use of EMRs in the County, to offer providers without EMRs alternative ways to obtain and receive relevant patient information, to make the most of EMRs by encouraging EMR-use standards, and to facilitate the sharing of information from different EMR systems by examining alternative HIE systems.

- **Patient engagement through HIT (using tools such as email, personal health records, etc.) and other HIT.**

Patient Engagement: Patients are engaged primarily via telephone. Newsletters for members are published quarterly. There is a static website with pages for members and providers that could be made more dynamic. We will be building an interactive website to allow interaction between the member and Trillium, including links to health and wellness information, community resource information, patient self assessment tools, and exploring the potential of hosting personal health records.

A.6.1.b. What are the Applicant's strategies to track and increase adoption rates of federal ONC certified EHRs?

Lane County already has a relatively high adoption rate of EHR systems. Approximately 90% of providers in Lane County currently have EHRs or are in the implementation process. Trillium plans to work with the community toward the selection, installation of an HIE. Effort will be made to evaluate the quality of translated EHR data for use. Consideration will be for HIE systems that include the capacity to link providers without EMR systems to the network of information.

A.6.1.c. Describe how the Applicant will facilitate meaningful use and HIE and also ensure that every provider in its network is either:

- **Registered with a statewide or local Direct-enabled Health Information Services Provider (registration will ensure the proper identification of participants and secure routing of health care messages and appropriate access to the information); or**
- **A Member of an existing Health Information Organization (HIO) with the ability for providers any EHR system (or with no EHR system) to be able to share electronic information with any other provider within the CCO network.**

Trillium will expect provider participation in collaborative HIT planning and development. A focus will be aimed at optimizing the compatibility of their systems. Trillium will educate providers on free to low-cost EMR options. Trillium will incorporate incentives through its compensation model to support meaningful use within the community and ensure that providers are either 1) registered with a state wide or local Direct-enabled Health Information Services Provider or 2) a member of an existing HIO.

APPENDIX B – Provider Participation and Operations Questionnaire

Section 1 - Service Area and Capacity

See: Appendix B, Attachment 1- Service Area Table spreadsheet

Section 2 - Standards Related To Provider Participation

Standard #1 - Provision of Coordinated Care Services

Trillium is experienced in managing both Medicaid and dually eligible Medicare/Medicaid Members because of the relationships between Trillium and Lipa. Trillium has established comprehensive and integrated care management networks and delivery systems serving both populations for all areas of care. Trillium has contract relationships with long term care and community based facilities for its Special Needs and Institutional Special Needs plans to better serve dual eligible members. Furthermore, Trillium has been working in conjunction with Lane County providers to prepare for implementing the CCO in our community. The provider panel will build on the existing panels of Lipa and LaneCare to meet the needs of Trillium members. Trillium will use Community Health Workers, from the first group that completed training in April 2012.
*The full Participating Provider Table B-1 will be submitted by the readiness review date.

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

Trillium's application for the CCO is supported by providers and facilities in our community that offer a wide range of specialties that allow Members, including those with special health care needs, access to care. Some of these services include: Geriatric Services, Pediatric Services, Pain Management, Mental Health and Chemical Dependency. Trillium utilizes the services and support of PeaceHealth's Senior Health and Wellness Center for members that need Geriatric services, particularly in providing assistance to these members' specific health needs. Trillium will work with the pain management specialists serving Lane County who will assist members by offering evaluations, treatment recommendations, as well as coordination of care and alternative approaches. Trillium has coordinated plans for care with multiple chemical dependency facilities which offer services such as: Inpatient Treatment, Residential Treatment, Outpatient Treatment, Family Programs, Children's Programs, and Detoxification Services. PCP groups in Lane County have over 40 Pediatric PCPs who specialize in a variety of pediatric services. The provider panel will build on the existing panel of Lipa and LaneCare to meet the needs of Trillium members.

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

See: Appendix B, Attachment 2- Publicly Funded Health Care and Service Programs Table

(a) Public sector partners have been part of the development of the CCO since the beginning, helping to shape the structure, governance, and mission of the organization. For more than a year, development efforts have included representatives of Lane County (both as the Local Public Health Authority/Mental Health Authority and as the Mental Health Organization) and Senior & Disabled Services to ensure that the CCO would be community-based, and responsive to the larger needs of the community. The planning discussions have focused on how to best leverage the many different resources available to create a coordinated system that could move all of Lane County toward the Triple Aim. In many cases, partners acknowledged that improvements in one part of the system might accrue benefits to other parts of the system, and that a commitment to sharing resources would be the only way to meet our goals. These partners have a history of joint efforts that demonstrate

this shared vision and commitment to shared savings. As one example, in preparation for launching a CCO, Lane County, through LaneCare, contracted with Lipa in January to begin managing a joint behavioral health benefit integrating mental health and chemical dependency.

Additionally, the development process for the CCO engaged a broad range of providers, with public and private providers working side by side to design the very best system. Providers in the public mental health system have been working with the help of consultants to prepare for this change, and enhance their readiness for a more integrated system. Public and private providers were convened through the local United Way last year to move forward the local effort for recruiting and training Community Health Workers, as a key strategy for launching this CCO. And, most recently a Steering Committee was formed to work on the design of the CCO, including Lane County, Senior & Disabled Services, and other publicly funded providers in the Steering Committee and the System Design and Financial/IT work groups.

Development of the CCO has been a public/private partnership at every stage, from designing the governance structure, to establishing priorities for transformation, to writing the application document itself. This is a commitment to engagement of the whole community, in a process that will truly transform health and health care in Lane County

(b) As the local mental health authority and one of Trillium's community partners, Lane County has been fundamental in establishing the CCO application and implementation plan. Trillium is currently completing its contract with Lane County, which includes the elements required in statute, and goes beyond that to create a true partnership approach to achieving the Triple Aim in Lane County. A fully executed agreement will be available for the Readiness Review. The agreement specifies a strong role for the County on Trillium's Board as well as the Community Advisory Council. Additionally, the agreement specifies that Lane County will manage the mental health and chemical dependency side of Trillium, building on the County's expertise as an MHO, as well as promoting coordination with the County as the Mental Health Authority and Community Mental Health Program. Lane County and Trillium will coordinate on specific mental health system issues, including crisis services, transitions in and out of residential or state hospital services, care coordination of residential services, management of specific community-based services, and specialized services to reduce recidivism in the criminal justice system.

In Lane County, there is a history of coordination regarding point of contact services, and the Trillium/Lane County agreement builds on that history. Lane County will continue to provide public health services, such as immunizations, sexually transmitted disease, and maternal child health services, and will receive payment for those as appropriate through Trillium. Additionally, Lane County will coordinate with Trillium on important system issues that impact the health of the whole population such as prenatal care, tobacco prevention, alcohol and drug prevention, and chronic disease prevention.

Lane County will also provide to Trillium members mental health services, chemical dependency services (particularly methadone treatment), primary care, and prenatal services through the County's Federally Qualified Health Centers. This part of the agreement promotes significant access to integrated care in a Patient Centered Primary Care Medical Home for Trillium members, and also provides a way to support a strong safety net option for others in the community.

(c) Not Applicable; Trillium will have contracts that provide the services required in ORS 414.153 (4).

Standard #4 – Services for the American Indian/Alaska Native Population (AI/AN)
(a) LaneCare has actively reached out to the AI/AN communities in Lane County. There are a very small number of OHP members in this population group that are accessing mental health treatment through OHP providers. One of the LaneCare ENCCs is a member of the AI/AN communities and has helped with referrals and organizing a coordinated care approach. Trillium will consult with Tribal clinics outside of Lane County, e.g. Cow Creek Health and Wellness Center, Coquille Community Health Center and Chemawa Indian Health Center, to learn how to most effectively provide culturally relevant services.

Standard #5 – Indian Health Services (IHS) and Tribal 638 facilities
(a) There are no Indian Health Service or Tribal 638 facilities in Lane County.

- Based on consultations with the clinics identified in Standard #4, Trillium will establish referral processes that could be applied with other IHS and Tribal clinics.

- Based on consultations with the clinics identified in Standard #4, Trillium will determine what additions or modifications need to be made to the prior authorization process.

Standard #6 – Integrated Service Array (ISA) for children and adolescents
(a) LaneCare Coordinators manage the Integrated Service Array (ISA) system, and work with DHS and child safety providers including: case managers, foster families, family support services, and a full continuum of clinical services.

The following contractors will continue to provide ISA services:

- Day Treatment: Child Center, Jasper Mountain

- Residential Services: Looking Glass, Jasper Mountain, Trillium Family Services (no relation to the applicant), SOASTC

- ICTS: Looking Glass, Child Center, Options Counseling, Center for Family Development, Oregon Social Learning Center, Jasper Mountain, South Lane Mental Health

- Treatment Foster Care: Oregon Social Learning Center, Jasper Mountain

(b) Trillium will continue to facilitate regular meetings to discuss members in ISA services with community partners that include: mental health providers, child welfare, developmental disabilities, Department of Youth Services, family members, and other community members as appropriate. Trillium will continue the ISA Community and Family Advisory Council meetings in partnership with Oregon Family Support Network on a regular basis.

(c) The ISA providers incorporate team-based care approaches that engage the family in

community-based wraparound services, guided by family-driven, strength-based assessments. Payment rates are enhanced for this level of care due to unreimbursed expenses. Services are provided in the community, in homes and in schools by Qualified Mental Health Professional and Qualified Mental Health Associate level professionals. Commitments to culturally appropriate services include bi- and multi-cultural providers and peer specialists from Latino, Asian, African American, Native American, and other populations.

Standard #7A– Mental Illness Services

(a) Trillium will contract with a broad panel of mental health providers including a full continuum of care for all ages, (acute, residential and outpatient) including family and peer support organizations. Members receive full care coordination services and LaneCare supports community based care and offers an incentive for services provided in the home and community.

(b) Screening for mental illness is a routine part of preventive care services and is incorporated in recommended guidelines as part of preventive care visits. Those same guidelines support the use of evidence based screening tools such as PHQ-2, BDI, and others. All providers participating in Trillium are required to deliver services consistent with those guidelines, and periodic performance reviews will be conducted to document compliance with those requirements. As part of the physical/mental health collaboration at the core of Trillium, all parties will be working to better educate both sides of the system about how to improve recognition of the signs, symptoms, and behaviors.

Standard #7B – Chemical Dependency Services

(a) Trillium will contract with a broad panel of community-based outpatient chemical dependency service providers. This includes age-specific services for adolescents and for adults, providers that serve Spanish speaking individuals, and providers in the rural communities of Cottage Grove, East Springfield, and Florence. Most chemical dependency providers also provide mental health services, and the system. Providers self-authorize a course of treatment. Trillium will support in-home Behavior Support Specialists and Recovery Peer Support Specialists to assist those in nonclinical settings. The county also has two detoxification clinics including one with state funded beds. When the residential chemical dependency funds are integrated into Trillium, care coordinators will assist in member access to a full continuum of care following ASAM guidelines.

(b) Screening for chemical dependency is a routine part of preventive care services and is incorporated in recommended guidelines as part of preventive care visits. Those same guidelines also support the use of evidence based screening tools such as AUDIT-C, CAGE, DAST, and others. All providers participating in Trillium are required to deliver services consistent with those guidelines and periodic performance reviews will be conducted to document compliance with those requirements.

Standard #8 – Pharmacy Services and Medication Management

(a) Trillium will adopt Lipa's current OHP programs which have been managing the prescription drug benefit for members for well over a decade. The current pharmacy services program is designed around the Oregon Health Plan's Condition/Treatment Pairs funding and covered services. The pharmacy services program includes a drug formulary, pharmacy call center, and prior authorization/appeal process. There is a drug formulary that offers a basic and affordable

prescription drug benefit. There are customer service supports for providers, pharmacies and members to improve access to the prescription benefit or provide options. The prior authorization/appeal process ensures that the prescription drug benefit is used to treat funded condition/treatment pairs on the Prioritized List.

(b)

- Trillium will use a restrictive drug formulary to manage the medication benefit for members. The drug formulary contains utilization management edits and covers all major therapeutic classes. Members can request coverage for non-formulary medications and UM restrictions through the in-house prior authorization process.

- Trillium will use a custom drug formulary that Lipa created through the Pharmacy and Therapeutics (P&T) Committee. The Drug Formulary is a continually updated list of medications covered for OHP members. The purpose of the Drug Formulary is to encourage the use of safe, effective, and affordable medications.

- Trillium will use a minimum of utilization management controls such as step therapy, prior authorization, age restrictions and quantity limits. Trillium will use these controls in the drug formulary to promote patient safety, appropriate use, and dose optimization for key therapeutic classes.

- The P&T Committee reviews all the therapeutic classes periodically. The voting members of the P&T Committee are working physicians from Lane County. Trillium's clinical pharmacists prepare all of the materials for P&T Committee review and decisions.

(c) Trillium will contract with a Pharmacy Benefit Manager (PBM) to engage a pharmacy network with sufficient access for all our members. Beyond this national pharmacy network, Trillium will contract with specialty pharmacies and other pharmacies to provide enhanced pharmacy services to meet our member needs. Trillium employs a searchable drug formulary on the website with a link to our Prior Authorization form. Policies and procedures for submitting a request for coverage are also provided on the member accessible website as well as in the member handbook.

(d) All of Trillium's pharmacy claims processing use an online adjudication system provided by the Pharmacy Benefit Manager. The majority of current pharmacy claims are processed electronically in real-time. Pharmacies can phone an internal pharmacy benefit specialist during normal business hours to assist them immediately with processing medication claims and for advice on the coordination of benefits. Trillium contracts with the Pharmacy Benefit Manager for after-hours provision of a Pharmacy Help Desk.

(e) For Medicaid, Trillium will process Prior Authorization (PA) requests via in-house pharmacy benefit staff. The hours of operation are 8 am through 5 pm, Monday through Friday. Trillium has the ability to receive requests via fax 24 hours a day, 7 days a week. Trillium also has an emergency plan for coverage of medications after hours, on weekends, and during holidays through policies and procedures established with the Pharmacy Benefit Manager.

For Medicare, Trillium uses the PBM to process initial PA requests. The PBM provides PA processing 24/7 to meet the requirements of a standard request in 72 hours and an urgent request in 24 hours. Trillium reviews any appeals based on denials of PA requests.

(f)

- The current financial terms with the OHP Pharmacy Benefit Manager (PBM) includes a discount from Average Wholesale Price (AWP) as follows:
  - Brand: Lower of Usual and Customary or AWP minus 17.5% + $1.50 dispensing fee.
  - Generic: Lower of Usual and Customary or AWP minus 17.5% + $1.50 dispensing fee or PBM Maximum Allowable Cost (MAC) + $1.50 dispensing fee.
  - No other rebate or incentive agreements or other funds.
  - No other pricing arrangements between OHP and the PBM.
  - All compound claims for the contracted compounding pharmacy are priced at AWP – 15% +$2.00 dispensing fee.

- The dispensing fees for all types of prescriptions are $1.50 per claim, unless otherwise stated.

- There is no administrative fee for electronically submitted claims. Claims submitted manually for direct member reimbursement cost $1.50 per claim.

(g) Trillium is willing to work with our Pharmacy Benefit Manager to engage and utilize 340B providers and pharmacy as part of the CCO process. Since Section 7101 of the Affordable Care Act (ACA) expanded the definition of covered entities that are now eligible to participate in the 340B Program, Trillium would be willing to take advantage of these cost savings where applicable. Trillium is able to process pharmacy claims at point-of-sale for 340B, and contract pricing, as well as setup custom formularies to maximize the discounts and develop special networks. Under the provision, children's hospitals, free-standing cancer centers, critical access hospitals, sole community hospitals and rural referral centers are now eligible to participate in the Program.

(h) Trillium has experience with an in-house Medication Therapy Management (MTM) program in place for the Medicare business. The MTM program provides Comprehensive Medication Reviews to targeted members. In addition, Trillium provides provider notices through the web portal communication tool as well as fax notification and phone calls. The MTM program provides the ability to trend and report outcomes.

(i) Trillium utilizes a nationally recognized e-prescribing network, to connect physicians, hospitals, pharmacy benefit managers, and pharmacies. Provider offices, clinics, and hospitals use e-prescribing software or Electronic Medical Record (EMR) that is certified to connect to this network. Lane County pharmacies have seen an increase in prescriptions sent to the pharmacy via an e-prescribing network within the last year.

Standard #9 – Hospital Services

(a) Trillium has contracts in place for inpatient and outpatient hospital services. When members

need services that are not available locally, Trillium will utilize arrangements with quaternary care facilities in the Portland Metro area. When out of state services are needed, Trillium will arrange for those services using the processes it developed as an OHP FQHP. Since all of the local hospitals are expected to contract with Trillium to provide services, they will be subject to terms that ensure timely and appropriate member access to services. Trillium will conduct necessary surveys and audits to ensure compliance with those terms.

(b) Members will be provided information upon enrollment on how to appropriately access care, including urgent care. Members will be encouraged to contact Trillium with questions or concerns about access. Trillium will track members' health service contacts by care type and work with members who have access barriers or seem to be inappropriately using services. Medically high risk members will be assigned a care coordinator, given contact information for their care coordinator who will proactively work with members on access issues. Some of the high risk members may be assigned a community health worker to help address access barriers.

Trillium has reporting capabilities to identify ambulance, Emergency Room, urgent care utilization. Trillium will review ER, urgent care and ambulance claims for appropriate use. Where inappropriate ER use is identified, Trillium will contact the member to educate them about appropriate health care resources. Where utilization is an indicator of above average health risk or unaddressed health related needs, the services of community health workers or other community based services will be used to better address member's needs and reduce the need for ER and urgent care services. Ambulance use will be similarly addressed.

Members who extensively utilize ER and urgent care services will be monitored by ENCCs and may become candidates for presentation to the Complex Case Management Committee (CCMC). The CCMC would develop a care plan for the member to best meet their health care needs by directing them back to their PCP for comprehensive, member-centered care.

(c)

- Trillium reviews claims for indication of Adverse Events. Claims with Serious Reportable Adverse Events (SRAE) reported are denied based on Medicare MSP guidelines and sent for review and investigation by an MSP specialist. Once liability is determined, any services not related to the SRAE will be processed for payment.

- Trillium reviews claims for Point Of Access (POA) indicators to correctly identify conditions acquired after admission to the hospital. Payment will continue to be made according to the Medicare MS-DRG guidelines.

(d) Trillium follows Medicare guidelines in reviewing and adjudicating hospital claims regarding hospital re-admissions. Any claim determined to be a re-admission for the same condition will be returned to the provider to be combined with the original claim to be paid under the same DRG payment. For any claims that appear to be a re-admission for the same condition, medical records will be reviewed.

(e) The primary innovation to be deployed by Trillium is its collaborative communication

system. This system will allow for timely intervention with the most appropriate provider/community resources needed to prevent worsened health status, hospital admissions, and ER use. This system of enhanced communications and collaboration will also reduce the risk of hospital re-admissions due to transition failures.

Specifically related to hospital transitions, Trillium will work with area hospitals and PCPCHs to standardize and implement best practices from innovative strategies such as Project BOOST, Project Red and the Care Transitions Intervention. Core components include re-admission risk screening, pre-discharge medication reconciliation, patient education using the Teach Back method, a personal health record tool, post-discharge follow-up calls and primary care visits within 7 days where indicated by protocol.

Trillium will explore the potential for a community-wide after-hours nurse triage and health information phone system.

With regard to behavioral health related transitions Trillium will maintain the existing behavioral health system crisis supports and hospital diversion programs that include: 1) 24/7 Youth Crisis Network that provides crisis phone support, hospital emergency based mental health services, mobile crisis outreach across the entire County, and three days of crisis respite when needed for youth; 2) White Bird 24/7 Crisis Phone Support for the hospital emergency department to divert individuals from a psychiatric hospitalization when a next day appointment is sufficient; 3) CAHOOTS which is a crisis mobile response for adults with difficult community behaviors due to a behavioral health condition; 4) Royal Avenue Program which provides crisis residential supports for adults; 5) Safe Center that provides crisis residential support for youth, and the Lane County/PeaceHealth Transitions Team that supports a safe and timely transition from hospital care with intensive community supports; and 6) the First Episode Psychosis services.

Section 3 - Assurances of Compliance with Medicaid Regulations and Requirements
Trillium has policies and procedures in place to meet the Medicaid Assurances 1-14 listed in Attachment 6. Monitoring and auditing are conducted to ensure compliance with the Medicaid regulations and requirements.

Previous experience of managing the Medicaid program with Lipa and LaneCare has allowed Trillium to develop a strong structure for Compliance, Care Coordination through the ENCC's, Quality Improvement, data reporting and validation, enrollment and disenrollment. Trillium has educational materials and programs in place for member and provider support.

APPENDIX C – Accountability Questionnaire

This questionnaire consists of two sections:

Section 1: Accountability Standards
Section 2: Quality Improvement Program

For background and further information, see Chapter 7 of the CCO Implementation Proposal, "Accountability."

Section 1 – Accountability Standards

C.1.1. Background information

Accountability for each aspect of the Triple Aim—better health, better care and lower costs—is a central tenet of Health System Transformation. As required by HB 3650, CCOs will be held accountable for their performance on outcomes, quality, health equity and efficiency measures identified by OHA through a robust public process in collaboration with culturally diverse stakeholders. CCO accountability metrics will function both as an assurance that CCOs are providing quality care for all of their Members and as an incentive to encourage CCOs to transform care delivery in alignment with the goals of HB 3650.

OHA will distinguish CCO accountability measures (including both core and transformational measures) from transparency measures intended to promote community and consumer engagement and to enable evaluation of HST. The performance expectations outlined below (meeting minimum standards or improving on past performance) will apply to accountability metrics only. Metrics for transparency are intended to be calculated by OHA, rather than CCOs, and will be publicly reported but will not affect CCOs' Contract status or eligibility for incentives.

Accountability measures for CCOs will be phased in over time to allow CCOs to develop the necessary organizational infrastructure and enable OHA to incorporate CCO data into performance standards. In year 1 (2013), CCOs accountability will be for reporting only. In year 2 (2014) and beyond, CCOs will be accountable for meeting minimum standards on core accountability measures and improving on their past performance for transformational accountability measures. Quality incentives for exceptional performance may be offered but not in the first year. While annual reporting will serve as the basis for holding CCOs accountable to contractual expectations, OHA will assess performance more frequently (e.g. quarterly or semi-annually) on an informal basis to facilitate timely feedback, mid-course corrections, and rapid improvement.

Proposed core and transformational accountability measures are shown in Attachment 8, Table C-1 (Year-one CCO Accountability Metrics)), along with the domain(s) and, where applicable, alignment with national quality measure sets. Potential transparency measures are shown as well. The next stage of metrics development will be for OHA to establish a technical group of culturally diverse internal and external experts to build measure specifications, including data sources, and to finalize a reporting schedule. This stage of the work will be completed by May 2012. Further work, such as establishing benchmarks for core measures

and annually reviewing CCO accountability metrics for appropriateness and effectiveness, will also involve the technical workgroup. It is possible that CMS may request the inclusion of additional measures from its Adult Medicaid and CHIPRA core measure sets as CCO accountability measures.

> ***Note*: Depending on the particular metric, reports and data may flow from CCOs to OHA or the reverse. For example, it may be advantageous for OHA to collect Member experience data on behalf of CCOs just as the agency does now for MCOs. Likewise, metrics developed from claims data can come from the OHA All-Payer All-Claims (APAC) database rather than be individually collected from CCOs.**
>
> ***Shared accountability for DHS Medicaid-funded LTC*: DHS Medicaid-funded LTC services are legislatively excluded from CCO budgets aud will continue to be paid for directly by the Department of Human Services (DHS). But in order to reduce cost shifting and ensure shared responsibility for delivering high quality, person-centered care, CCOs and the DHS Medicaid-funded LTC system will need to coordinate care and share accountability. A set of CCO-DHS Medicaid-funded LTC joint accountability measures will be identified by June 2012 reflecting leverage areas where the activities of one system have significant impacts on the costs and outcomes realized in the other system. A selection of these measures will be tied to future incentive payments for CCOs (and for DHS Medicaid-funded LTC providers, depending on available funding).**

C.1.1.a. Describe any quality measurement and reporting systems that the Applicant has in place or will implement in the first year of operation.

- Currently, Trillium is working collaboratively on two quality improvement projects. The first is the ABCD III initiative, in collaboration with DMAP, other MCOs in the state and OPIP. The second is a project focused on chemical dependency services and is a collaboration between Lipa, LaneCare, and HPRNW.

- Trillium monitors the participating provider panel to ensure the network includes sufficient numbers of Primary Care Provider (PCPs), specialists and behavioral health specialists to meet the needs of members and to ensure timely access to care. Provider network monitoring is conducted and analyzed quarterly. Additionally, Trillium conducts secret shopper calls to a sample of network providers annually.

- Lipa conducts provider office site visits to confirm that specified contracted providers adhere to the conditions of their contract, in terms of access; the condition, adequacy and safety of the physical facility; and HIPAA privacy considerations. Site visit reports are compiled and analyzed quarterly.

- Lipa conducts medical record review oversight to confirm that contracted providers adhere to the conditions of their contract, in terms of maintenance of medical records for members; documentation as a reflection of treatment and planning; and medical record keeping practices. Medical record review reports are compiled and analyzed quarterly.

- The behavioral health system reports quality outcome measures from a standardized client feedback measurement tool.

- Trillium maintains a proprietary health care analysis system that allows for the reporting and analysis of data for Quality Management, Utilization Review, Health Equity Evaluation, Care Coordination, Fraud and Abuse Review, Performance Dashboards, and Program Monitoring and Evaluation and other information needs. Information from across the spectrum of care is grouped into clinically meaningful cases/episodes allowing for the comparative analysis of outcomes, utilization and costs, for groups and individual members and providers. The system incorporates best practice standards to identify gaps in quality care. Prospective and retrospective risk indicators help identify high risk members, cost effective providers and local evidence-based best practices. During the first year of the CCO, system data quality and completeness will be improved and routine reports related to needs, risks, equity, quality, efficiency, cost, and best practices will be developed and analyzed for action.

- Trillium is working with a private vendor to design and implement a system for the timely integration and sharing of health-related information about members to CCO participants and relevant entities within the community. The member information sharing system houses data from health assessments, EMRs, Trillium's clinical analysis system, providers, community health workers, and other organizations. The tool assembles data to help develop member care plans and shares information with appropriate others determined by customizable access rules.

- Trillium is developing a compliance system. The system provides timely updating of compliance requirements, policies and procedures, and monitoring of privacy and security issues, access, authorizations and appeals, complaints, and grievances. Priorities for the first CCO contract period include installation and testing of the compliance system, development of a compliance dashboard report for prompt identification of performance problems, and refinement of processes related to data sharing.

- Trillium participates in HEDIS, CAHPS, and HOS. Data are analyzed to identify best practices and opportunities for improvement.

- Trillium is working to expand the use of EMRs in the County, to offer providers without EMRs alternative ways to obtain and receive relevant patient information, to make the most of EMRs by encouraging EMR-use standards, and to facilitate the sharing of information from different EMR systems by examining alternative HIE systems.

- Dashboard and performance reports are generated regularly. Reports include quality management indicators, key performance indicators supporting the Triple Aim, and all required metrics.

- Trillium is developing a member satisfaction survey that will be able to be analyzed by socio-demographic factors associated with health equity.

C.1.1.b. Will the Applicant participate in any external quality measurement and reporting programs (e.g. HEDIS reporting related to NCQA accreditation, federal reporting for Medicare Advantage lines of business)?

Trillium will participate in the following external quality measurement and reporting programs:

- Trillium will contract with a certified HEDIS vendor. Trillium will contract with a certified survey vendor to administer both the CAHPS and the HOS to Medicare beneficiaries.
- Trillium will contract to measure member satisfaction.
- Trillium currently is URAC accredited in Health Utilization Management. Trillium will report its quality improvement outcomes to CMS for the Medicare Advantage products and to OHA/DMAP for the OHP product.

C.1.1.c. Explain the Applicant's internal quality standards or performance expectations to which providers and contractors are held.

Providers who serve high-risk populations or who specialize in the treatment of costly conditions are also protected from discrimination.

Trillium maintains specific criteria and quality standards regarding performance expectations to which providers and contractors are screened and upheld. These quality standards include, but are not limited to:

- Trillium's credentialing procedure ensures that all participating health care providers meet Trillium's credentialing standards. Trillium, or its delegated entity, performs initial evaluation of new applicants for contract participation; ongoing evaluation of potentially adverse information that becomes available regarding contract participants; and systematic re-evaluation of contract participants every two years. The evaluations include verification of information as specified in the Provider Credentialing Policy and the Regulatory/Accreditation Requirement Verification Tables as well as a review of any information available regarding each applicant and participant.

- Trillium has oversight responsibility to confirm that specified contracted providers adhere to the conditions of their contract with Trillium, in terms of access for Trillium members, the condition, adequacy and safety of the physical facility, HIPAA privacy considerations, maintenance of medical records, documentation as a reflection of treatment, and planning and medical record keeping practices. To comply with this responsibility, Trillium performs medical record reviews and site reviews of the facilities of specified contracted providers and provides a periodic report to the Quality Management/Utilization Management Committee (QM/UMC) Committee. Both medical record reviews and site reviews may be conducted for other provider types as well, if warranted by circumstances such as complaints or if mandated by contractual or regulatory requirements.

- Trillium has written standards for timeliness of access to care and member services that meet or exceed such standards as may be established by CMS and OHA/DMAP. Trillium monitors its provider network's compliance with these standards, and takes corrective action as necessary. Trillium ensures that the hours of operation of its providers are convenient to members. The evaluation of adequate and appropriate access to care will be assessed using

existing contract language, policies, and procedures, along with the implementation of a Secret Shopper Research Questionnaire. A comparison of all licensed providers by county, issued by the Oregon Board of Medical Examiners, will be cross- referenced to all Trillium contracted providers to determine whether their licensure is current and without hindrance of any kind.

- Trillium's contracted providers may not deny, limit, or condition the coverage or furnishing of benefits to Trillium-eligible individuals on the basis of any factor related or not related to health status including, but not limited to: medical condition, mental condition, or physical illness; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; mental or physical disability; race, color, ethnicity or national origin; ancestry; age; gender; religion; source of payment; sexual orientation or marital status; or any other characteristic or classification deemed protected under state or federal law.

    - Trillium's providers are expected to meet industry coding and data quality standards.

C.1.1.d. Describe the mechanisms that the Applicant has for sharing performance information with providers and contractors for Quality Improvement.

Trillium communicates performance information with providers and contractors through a variety of means. Information is most often shared during committee meetings. Committee members are expected to take information back to their offices and colleagues. In addition, a provider newsletter is published in which performance information, clinical guideline updates, and general administrative and benefit information is shared with providers. This same information is also made available on the Trillium website.

Trillium will work with the CAP to find additional ways to communicate to the provider community and contractors.

C.1.1.e. Describe the mechanisms that the Applicant has for sharing performance information in a culturally and linguistically appropriate manner with Members.

Trillium shares performance and other information with its members through periodic newsletters that are culturally and linguistically appropriate. Newsletters are written at a 6th grade or lower reading level and offered in English, Spanish or any requested language or format.

C.1.1.f. Describe any plans to use quality measures and/or reporting in connection with provider and contractor incentives or any alternative payment mechanisms.

Trillium will provide incentives based on quality measures to support quality care and the Triple Aim. Trillium providers share in surpluses and losses and are incented to provide efficient and effective care. Trillium will incorporate incentives through its compensation model to support quality outcomes.

C.1.1.g. Describe the Applicant's capacity to collect and report to OHA the accountability quality measures listed in the Table, if it is determined that those should be reported by CCOs. (Some may be collected by OHA.) Note: since measure specifications are

not provided, capacity can be described in general terms based on the data type shown. Include information about the Applicant's capacity to report on measures that are not based on claims data.

Trillium has the capacity, either directly or through the use of a vendor, to collect and report all of the OHA accountability quality measures. The data type listed for each measure is collected and maintained by Trillium. Trillium will work with providers to improve the coding of claims and therefore the reliability of data available for reporting quality measures.

Trillium has the capacity to report indicators requiring CAHPS, HEDIS, and HOS data.

Section 2 – Quality Improvement Program

C.2.1. Quality Assurance and Performance Improvement (QAPI)

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

Oregon will continue its robust monitoring of CCO system performance and will continue to assure that established standards for quality assessment and improvement are met. Many oversight mechanisms used today will continue in the future. The transition from managed physical and mental health care organizations (and DCOs, over time) to CCOs will mean a greater focus on person-centered care, prevention and continuous Quality Improvement.

C.2.1.a. Describe the Applicant's Quality Improvement (QI) program.

Trillium's Quality Management Program (QMP) is comprehensive in nature, encompassing all departments to create and maintain a culture of quality and promote the sharing of information throughout the organization. The QMP uses a systematic, integrated approach to planning, designing, measuring, assessing, and improving the quality of care and service provided to our members. In order to be successful, the QMP must work in collaboration with and respond to the needs of partners including members, providers, community agencies, regulators, and staff, not only to meet the current needs of the members, but also to begin to address the future needs of the members.

The establishment of priorities and standards that encompass quality management activities within the health plan resides with the QM Department. In addition, the QM Department serves as a resource for the various departments throughout the company. It is the QM Department's responsibility to plan, implement, monitor and document many of the activities within the health plan, assist others with these activities, and coordinate the reporting of all QM activities to the QM/UM Committee. QM staff ensures that all quality related activities meet contractual and regulatory requirements and conducts the initial review and update of the QMPD QM Work Plan and is responsible for the collection of QM activity documentation for reporting out to regulatory, contracting, and accrediting bodies. While the QM Department is responsible for coordinating quality activities with other performance monitoring and management activities, leadership responsibilities for various projects are assigned as appropriate and can rest with the functional area

or an internal work team. That includes the designation of a clinical staff person for all activities that are clinical in nature.

The Board of Directors (Board) as the governing body retains final authority and responsibility for the quality and safety of care and service provided to members. The Board has elected to assign direct oversight of all QM functions to the Quality Management/Utilization Management Committee (QM/UMC) thereby empowering the QM/UMC to make operational decisions on behalf of the Board.

The QM/UMC is staffed with physicians from the community, representing each of the physical health primary care provider groups, specialty providers, and behavioral health. The QM/UMC provides oversight and direction to the QM program. This includes review and approval of the QM Program Description and Work Plan, all QM activities, and regular reports including the annual evaluation of the Quality Management program. The QM/UMC exercises this ability to support the QM program through monthly meetings. The Board reviews and approves the QM Program Description and annual evaluation.

C.2.1.b. Describe the Quality Committee structure and accountability including how it reflects the diverse Member and practitioner community within the proposed service area.

The Board of Directors (Board) is the governing body and retains final authority and responsibility for the quality and safety of care and service provided to members. The Board assigns direct oversight of all QM functions to the QM/UMC thereby empowering the QM/UMC to make operational decisions on behalf of the Board.

The QM/UMC provides oversight and direction to the Quality Management Program. This includes review and approval of the QM Program Description and Work Plan, all QM activities, and regular reports including the annual evaluation of the Quality Management Program. The QM/UMC exercises this ability to support the Quality Management Program through regular meetings. A summary of each meeting including all actions taken is provided to the Board. The Board reviews and approves the QM Program Description and annual evaluation.

The QM/UMC is comprised of community physicians within the contracted network representing each of the main provider groups as well as specialty offices.

The County Quality Assessment/Performance Improvement (QA/PI) Committee is responsible for review, revision and monitoring of the quality assessment/performance improvement plan, as well as input on access, utilization and continuity of the service delivery system. The QA/PI Committee includes staff of LaneCare, as well as representatives of providers, consumers, families and allied government agencies. The QA/PI Committee meets periodically and reports to the LaneCare Executive Committee and Operations Council.

C.2.1.c. Describe how the Quality plan is reviewed and developed over time.

The quality plan, known as the QM Program Description, is the core document of the QM program. It establishes the framework and key processes that enable the plan to carry out its commitment to ongoing quality care and provides a clear definition of the QM Program objectives, scope, and

structure. It is reviewed annually and modified to reflect changes in policy, contractual obligations, regulations and community needs.

The QM Work Plan is reviewed and developed by the QM Department in conjunction with the review of the QM Program Description. The Work Plan describes all scheduled QM activities and reporting. It serves as a guide for the QM Program and includes (as applicable) planned activities and interventions, responsible person(s), frequency, data source(s), baseline measures, goals, and analysis/notes. The Work Plan is reviewed and updated throughout the year as necessary.

Both the QM Program Description and the QM Work Plan are developed by staff with review and input by the QM/UMC. The QM/UMC approves the final documents prior to implementation. The Board also reviews and approves the QM Program Description.

C.2.1.d. Describe how all Applicant's practitioners, culturally diverse community-based organizations and Members can be involved and informed in the planning, design and implementation of the QI program.

Trillium will ensure practitioners, culturally diverse community-based organizations, and Members can be involved and informed in the planning, design, and implementation of the QI program.

- Providers are involved in shaping and implementing the QI Program in a number of ways.
    - Trillium's Board of Directors has ultimate responsibility for the QI Program. It has representation from the broad provider community and the community at large.
    - Trillium QM/UMC membership includes representatives from physical, behavioral, and oral health providers as well as individual providers selected for their expertise in specific fields related to Trillium's quality initiatives.
    - Providers are instrumental in the actualization of improved care quality and will be involved in various educational approaches as necessary.
    - Trillium will monitor providers' quality performances. Providers will receive feedback about their quality performance relative to their peers. Best practices will be identified. Measuring performance and establishing expectations will give providers a stake in the QI process and motivate provider involvement in all phases of QI initiatives.
- In addition to representation of the Board of Directors, Members are involved in the QI program in several ways.
    - The CAC's community needs assessment will serve as a base for UM/QM/HE initiatives. The CAC includes broad representation from culturally diverse community organizations, members and non-members.
    - Members will be informed about QI initiatives through various means, including regular member newsletters, so they can better expect and recognize quality care.
    - Information about providers' QI performances will be made available to Members.

C.2.1.e. Describe how the QI program specifically addresses health care and health outcome inequities, care coordination and transitions between care settings.

Health care equity, health outcomes, care coordination and appropriate transitions between care settings are an important component of quality care. Trillium will address each of these by identifying gaps made evident through the community needs assessment. Additionally, monitoring of quality metrics will inform the QI program and lead to quality initiatives supporting the Triple Aim.

Quality metrics will include:

- Monitoring over / under-utilization to identify patterns of health care inequities.
- Monitoring of care coordination to identify quality opportunities identified by staff related to access, disease management, and transitions of care.
- Monitoring and analysis of complaints and grievances to identify patterns related to health care equity, health outcomes, care coordination and appropriate transitions between care settings.
- Quality metrics will be analyzed by race, ethnicity primary language, mental health and substance abuse.

C.2.1.f. Describe how regular monitoring of provider's compliance and Corrective Action will be completed.

In addition to monitoring of provider compliance with all contractual requirements, rules and regulations, Trillium will ensure provider compliance with the Quality Management program's initiatives. Providers will be vested in all activities initiated by Trillium through close monitoring of provider performance related to activities. Trillium will monitor and work with providers who do not meet established performance expectations or who do not comply with QM-directed quality initiatives.

C.2.1.g. Describe how the Applicant addresses QI in relation to:

- **Customer satisfaction: clinical, facility, cultural appropriateness**
- **Fraud and Abuse/Member protections**
- **Treatment planning protocol review/revision/dissemination and use with evidence based guidelines**

Trillium's QM program will address the following areas through routine monitoring by the internal QM/UM committee:

- Customer satisfaction: clinical, facility, cultural appropriateness:
  - Member satisfaction surveys.
  - Medical record review conducted for both physical and behavioral health providers to assure quality services that are clinically sound and culturally appropriate are being delivered.
  - On-site visits to facilities for both physical and behavioral health providers to assure safety, cleanliness and HIPAA privacy requirements have all been met.
  - Monitoring of complaints and grievances.

- Fraud and Abuse/Member protections:
  - Fraud and Abuse Policies and Procedures.

  - Compliance Committee monitoring.
  - Monitoring of complaints and grievances.

- Treatment planning protocol review/revision/dissemination and use with evidence based guidelines:
  - Policies and Procedures for developing and adopting evidence based guidelines approved by the QM/UMC. All adopted guidelines are disseminated to providers via the provider newsletter, website and/or blast fax.

- Medical chart reviews are conducted to support customer satisfaction, protection from fraud and abuse, and treatment planning. Chart reviews confirm compliance in terms of: maintenance of medical records for members, documentation of treatment and planning, medical record keeping practices, quality of care, and the use of evidence based practices, and appropriate level of service and timeliness.

C.2.2. Clinical Advisory Panel

An Applicant is encouraged but not required to establish a Clinical Advisory Panel (CAP) as a means of assuring best clinical practices.

C.2.2.a. If a CAP is established, is a representative of the CAP included on the Governing Board?

Yes. A representative from the Clinical Advisory Panel (CAP) will be included to sit on the Governing Board.

C.2.2.b. If a CAP is not established, describe how Applicant's governance and organizational structure will achieve best clinical practices.

We will be implementing a CAP, this is not applicable.

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

C.2.3.a. Please describe policies, processes, practices and procedures you have in place that serve to improve Member outcomes, including evidence-based best practices, emerging best practices, and innovative strategies in all areas of Health System Transformation, including patient engagement and activation.

Trillium has policies, procedures and practices that serve to improve Member outcomes. These include:

- Policies and procedures for creating and disseminating evidence based clinical practice guidelines
- Professional trainings addressing evidence based practices and emerging best practices for example mental health/physical health integration training
- Ongoing data analysis to identify opportunities for improvement:
  - Initiation and engagement
  - Place and type of service

  - Levels of care
  - Appropriateness of care
  - Compliance with evidence based practices
  - Quality measures
  - Health outcomes
  - Costs
- Annual satisfaction surveys
- Engagement with CAC and CAP

C.2.3.b. Also describe key quality measures in place that are consistent with existing state and national quality measures, and will be used to determine progress towards improved outcomes.

Trillium uses quality measures that are consistent with existing state and national quality measures and these will be used to determine progress toward improved outcomes. They include:

- All measures indicated in table C-1.
- Additional Medicaid HEDIS measures not listed in table C-1, using a certified HEDIS vendor.
- Additional CAHPS measures not listed in table C-1, using a certified survey vendor.
- Childhood Immunization rates, currently a joint effort between Lipa, ALERT and DMAP.
- Trillium maintains a proprietary health care analysis system that allows for the reporting and analysis of data for Quality Management, Utilization Review, Health Equity Evaluation, Care Coordination, Fraud and Abuse Review, Performance Dashboards, and Program Monitoring and Evaluation and other information needs. During the first year, Trillium system data quality and completeness will be improved and routine reports related to needs, risks, equity, quality, efficiency, cost, and best practices will be developed and analyzed for action.
- The behavioral health system uses validated outcome measurement tools. There will be continuous improvement in the quality of tools selected.
- Over-and/or under-utilization of behavioral health services monitoring including: psychiatric hospital admissions; lengths of hospital stay; and discharge from outpatient behavioral health services.
- Oregon Behavioral Health System Development and Program Outcome Measures.

Quality measures are analyzed and reviewed by the internal QM committee and presented to the QM/UMC for recommendations and action.

C.2.3.c. Please describe your experience and plan to emphasize and implement wellness and health improvement activities and practices within your organization for Members and staff, including partners and contracts in place to strengthen this aspect of health care.

Trillium will promote employee wellness programs in collaboration with its primary partners. PeaceHealth's health and wellness committee is actively pursuing strategies to improve employee

health and to spread these strategies to other employers in the community, including CCO partner organizations. Lane County Public Health will be a partner in these efforts.

C.2.3.d. Outline your experience, staffing, policies, procedures, and capacity to collect the necessary electronic and other data that will be required for meeting regular performance benchmarks to evaluate the value of Health Services delivered by your CCO. CCO accountability metrics serve to ensure quality care is provided and to serve as an incentive to improve care and the delivery of services.

Trillium has experience, staffing, policies, procedures and the capacity necessary to collect all data required to meet performance standards. Outcome results will be evaluated to identify system improvements or enhancements.

Lipa and LaneCare currently hold contracts with DMAP and AMH and have successfully met all regular performance benchmarks, evaluations, and requirements. Additionally, Lipa and Trillium Medicare Advantage plans have achieved URAC accreditation in Health Utilization Management.

Meeting URAC standards requires the establishment of robust policies and procedures to support health plan operations. Policies and procedures have been established to ensure data is collected and stored in a manner that is valid, reliable and complete.

C.2.3.e. What other strategies will you implement to improve patient care outcomes, decrease duplication of services, and make costs more efficient?

Trillium will take the following actions to improve patient care outcomes, decrease duplication of services and make costs more efficient:

- Train, certify and deploy Community Health Workers (CHWs) to primary care medical homes to assist Members in navigating both the behavioral and physical health care systems; CHWs will work with Members to address health and wellness activities thereby reducing costs through preventative measures
- Train professionals on evidence based practices and emerging best practices
- Promote the adoption and dissemination of population management best practices, e.g., the use of patient registries and care pathways

C.2.3.f. Describe your policies and procedures to ensure a continuity of care system for the coordination of care and the arrangement, tracking and documentation of all referrals and prior authorization.

Lipa and LaneCare currently maintain accountability for the arrangement, tracking, and documentation of referrals and prior authorizations. Existing policies and procedures regarding referrals, prior authorizations, and continuity and coordination of care will be maintained and revised, as needed. Trillium will develop additional policies and procedures to support changing needs.

Policies exist to address:

- Care Coordination and Continuity of Care - members will be assessed for unmet health and care coordination needs to ensure continuity of care and integration of services.

- Referrals and Prior Authorization processes exist to ensure accurate and timely utilization management decision-making.

APPENDIX D – Medicare/Medicaid Alignment Questionnaire

This Appendix consists of the following sections:

Section 1: Background Information
Section 2: Ability to Serve Dually Eligible Individuals

Section 1 - Background Information – Inclusion of Dually Eligible Individuals in CCOs

The OHA is preparing a formal proposal to CMS for a Demonstration to integrate care for individuals dually eligible for Medicare and Medicaid (Medicare/Medicaid Alignment Demonstration). CMS has offered all states the previously unavailable opportunity to pursue Three-Way Contracts between health plans, the state, and CMS for blended Medicare and Medicaid payments to plans, set at a level to target savings that can be shared. Interested CCOs may apply for the Demonstration; CCOs will not be required to participate.

Oregon's proposal to CMS was released for a 30-day public comment period on March 5, 2012, and can be viewed online at: https://cco.health.oregon.gov/Pages/Medicare-Medicaid-Proposal.aspx. Following that public comment period, the proposal will be submitted to CMS, with a current target date of early May, 2012, after which CMS will have its own 30-day public comment period. If Oregon's proposal receives federal approval following the CMS public comment period, CMS and Oregon will negotiate remaining requirements and finalize payment rates for CCOs participating in the Demonstration. These details will be part of a memorandum of understanding (MOU) between CMS and OHA targeted to be signed in fall, 2012. The target date for interested CCOs to begin providing Medicare services through the Demonstration to dually eligible individuals is January 1, 2014.

OHA has been working closely with CMS throughout the development of the CCO proposal to ensure that the general CCO structure will be acceptable for the Demonstration and Three-Way Contracts. In order to participate in the Three-Way Contracts and offer Medicare benefits, interested CCOs will be asked to provide information as part of the Demonstration application process and will need to meet requirements set forth by CMS and OHA, specific to the Demonstration. Applicants are not required to have prior experience as a Medicare Advantage (MA) plan (or as a Special Needs Plan in particular) in order to participate in the CMS Demonstration. Relevant CMS guidance is posted on the CMS website for the Demonstration: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html.

Section 2 - Ability to Serve Dually Eligible Individuals

CCOs will be expected to provide integrated and coordinated health care and care management for all of their Members, including Members who are dually eligible for Medicare and Medicaid services. CCOs will be required to provide covered Medicaid

services for dually eligible Members whether or not the Member is enrolled in a Medicare Advantage plan that is owned, affiliated or contracted by the CCO. To effectively integrate and coordinate health care and care management for dually eligible Members, CCOs will also be required to be able to provide Medicare benefits to dually eligible Members. This requirement will apply to all CCOs, whether or not the Demonstration proceeds and without regard to whether a particular CCO has a Three-Way Contract under the Demonstration.

Each CCO must meet this requirement for all dually eligible Members in any part of the CCO's service area(s) by January 1, 2014. By that date, dually eligible Members must be able to access their Medicare benefits through the CCO. This may be accomplished either through the CCO directly via CCO participation in the Medicare/Medicaid Alignment Demonstration, or through a Medicare Advantage plan that is owned, affiliated, or contracted by the CCO. An exceptions process will be available if a CCO cannot fully meet this requirement on the established timeline.

D.2.1. Describe the Applicant's approach to be able to provide Medicare benefits to dually eligible Members by January 1, 2014. Include:

D.2.2.a. The Applicant's initial capacity to provide both the Medicaid and Medicare benefit to dually eligible Members in each of its proposed service area(s);

Trillium currently serves the Dual population in Lane County and is prepared to continue to do so in 2014.

D.2.2.b. The timeline and milestones the Applicant will achieve to meet this requirement fully by January 1, 2014,

Trillium currently has a Dual SNP plan in Lane County and will be prepared to meet all of the CMS requirements for serving dual eligible members.

D.2.2.c. Whether Applicant plans to meet this requirement through:

- **Participation in the Medicare/Medicaid Alignment Demonstration;**
- **An owned, affiliated, or contracted Medicare Advantage plan; or**
- **A combination of these options.**

Trillium plans to meet this requirement through the participation in the Medicare/Medicaid Alignment Demonstration.

Coordinated Care Organizations (CCO)

RFA 3402

Appendix H: Transformation Scope Elements

RESPONSE to APPENDIX H is OPTIONAL

Appendix H contains certain Health System Transformation elements that can serve as a starting point for incorporating the Applicant's proposals into Contract language. This is Applicant's opportunity to facilitate the contracting process by supplying language that translates its unique approach to coordination and integration of care into a form that can be a starting point for Contract negotiations. Applicant may modify Appendix H, submit its own proposed approach to Contract provisions, or allow OHA to draft the statement of work.

Applicant is invited and encouraged to use its response to Appendix H or its alternative proposed Contract language, to inform OHA about how it proposes to accomplish the Work, including the flexibilities and local initiatives that are being proposed. See **Section 3.2** of the RFA for additional instructions.

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Response to APPENDIX H is OPTIONAL.

General Overview of Health Transformation

In 2011 the Oregon Legislature and Governor John Kitzhaber created coordinated care organizations (CCO's) in House Bill 3650 (2011), aimed at achieving the Triple Aim of improving health, improving health care and lowering costs by transforming the delivery of health care. The legislation builds on the work of the Oregon Health Policy Board since 2009. Essential elements of that transformation are:

- Integration and coordination of benefits and services;
- Local accountability for health and resource allocation;
- Standards for safe and effective care, including culturally and linguistically competent care; and
- A global Medicaid budget tied to a sustainable rate of growth.

Consistent with the CCO Implementation Proposal of the Oregon Health Policy Board dated January 24, 2012, Contractor is a community-based organization governed by a partnership among providers of care, socially and culturally diverse community members and those taking financial risk. Contractor has a single global Medicaid budget that grows at a fixed rate, and is responsible for the integration and coordination of physical, mental, behavioral and dental health care for people eligible for Medicaid. Contractor is the single point of accountability for the health quality and equitable outcomes for the Medicaid population it serves. Contractor has the financial flexibility within available resources to achieve the greatest possible outcomes for their membership.

Contractor acts as an agent of Health System Transformation as called for by HB 3650 (2011) and SB 1580 (2012) and applicable administrative rules. Contractor's Work is guided by the policy objectives of Health System Transformation and will help to achieve the triple aims of health reform: a healthy population, extraordinary patient care and reasonable costs. Contractor's objectives include:

- Ensuring access to an appropriate delivery system network centered on Patient-Centered Primary Care Homes(PCPCH);
- Ensuring Member rights and responsibilities;
- Working to eliminate health disparities among their Member populations and communities;
- Using alternative provider payment methodologies to reimburse on the basis of outcomes and quality;
- Developing a health information technology (HIT) infrastructure and participating in health information exchange (HIE);
- Ensuring transparency, reporting quality data, and;
- Assuring financial solvency.

In general, Contractor implements Health System Transformation consistent with its Application as negotiated with and approved by OHA during the RFA certification and contracting process. Contractor achieves baseline objective of Health System Transformation and has an accountable plan for achieving all of the objectives over the period of its certification.

A. CCO Criteria

Part 1 – Governance and Organizational Relationships

1. Governing Board and Governance Structure

Contractor establishes, maintains and operates with a governance structure that complies with the requirements of ORS 414.625(1)(o).

2. Community Advisory Council (CAC)

Contractor establishes a Community Advisory Council (CAC) that includes appropriate community representation in each service area. The duties of the CAC include, but are not limited to:

(1) Identifying and advocating for preventive care practices to be utilized by the Contractor;

(2) Overseeing a community health assessment and adopting a community health improvement plan to serve as a strategic population health and health care system service plan for the community served by the Contractor; and

(3) Annually publishing a report on the progress of the community health improvement plan.

3. Clinical Advisory Panel

Contractor establishes an approach within its governance structure to assure best clinical practices. This approach is subject to OHA approval, and may include a clinical advisory panel. If Contractor convenes a clinical advisory panel, this group has representation on the governing board. The clinical advisory panel has representation from behavioral health and physical health systems and Member representation.

4. Community Health Assessment and Community Health Improvement Plan

Contractor's CAC partners with the local public health authority, local mental health authority, community based organizations and hospital system to develop a shared community health assessment and adopt a community health improvement plan to serve as a strategic population health and health care system service plan for the community served by Contractor. Community health assessment includes a focus on health disparities experienced by various dimensions of the community, including but not limited to racial and ethnic disparities in the community. The health assessment is transparent and public in both process and result.

a. The community health assessment adopted by the CAC describes the scope of the activities, services and responsibilities that the Contractor considers upon implementation of the plan. The activities, services and responsibilities defined in the plan may include, but are not limited to:

(1) Analysis and development of public and private resources, capacities and metrics based on ongoing community health assessment activities and population health priorities;

(2) Health policy;

(3) System design;

(4) Outcome and Quality Improvements;

(5) Integration of service delivery; and

(6) Workforce development

Through its community health assessment, Contractor identifies health disparities associated with race, ethnicity, language, health literacy, age, disability, gender, sexual orientation, geography, occupation or other factors in its service areas. Contractor and Contractor's CAC work with OHA Office of Equity and Inclusion to develop meaningful baseline data on health disparities.

b. Community Health Improvement Plan

The Contractor, through its CAC, develops and implements a community health improvement plan. The community health improvement plan describes the scope of the activities, services and responsibilities that the Contractor considers upon implementation of the plan. The Contractor provides a copy of the plan and any updates to the OHA. The activities, services and responsibilities defined in the plan may include, but are not limited to:

(1) Analysis and development of public and private resources, capacities and metrics based on ongoing community health assessment activities and population health priorities;

(2) Health policy;

(3) System design;

(4) Outcome and Quality Improvement;

(5) Integration of service delivery; and

(6) Workforce development.

Part 2 – Health Equity and Eliminating Health Disparities

Contractor demonstrates how it carries out the health improvement strategies tailored to reduce health disparities and improve the health and well-being of all Members.

Contractor collects and maintains race, ethnicity, and primary language data, including mental health and substance abuse disorder data, for all Members on an ongoing basis in accordance with standards jointly established by OHA and DHS. Contractor tracks and reports on any quality performance improvements and outcome measures by these demographic factors and develops, implements, and evaluates strategies to improve health equity among Members.

Contractor partners with local public health and culturally, linguistically and professionally diverse community partners to address the causes of health disparities.

Part 3 – Payment Methodologies that Support the Triple Aim

Contractor demonstrates how it will use alternative payment methods alone or in combination with delivery system changes to achieve better care, controlled costs, and better health for their Members.

The schedule by which Contractor implements alternative payment methodologies is defined. Payments to Patient-Centered Primary Care Homes for individuals with chronic conditions, however, are implemented immediately.

Contractor's payment methodologies comply with additional requirements established in law in conjunction with those requirements under Health System Transformation that encourage efficiency and the elimination of care defects and waste, including:

1. Contractor pays hospitals other than Type A and B Rural hospitals using Medicare-like payment methodologies that pay for bundles of care rather than paying a percentage of charges.

2. Contractor does not pay any provider for services rendered in a facility if the condition is a health care acquired condition for which Medicare would not pay the facility.

3. In addition to the base CCO Payment rate paid to Contractor, OHA pays a hospital reimbursement adjustment to the CCO Payment rate to Contractor in accordance with the CCO Payments calculation reflected in the rate schedule in the Core Contract. Contractor distributes such hospital reimbursement adjustment amounts to eligible hospitals located in Oregon that receive Medicare reimbursement based upon diagnostic related groups, in accordance with requirements established by OHA.

4. Contractor or its Subcontractors are responsible for appropriate management of all federal and state tax obligations applicable to compensation or payments paid to Subcontractors under this Contract.

Part 4 – Health Information Systems

1. Electronic Health Information

Contractor demonstrates how it will achieve minimum standards in foundational areas of HIT use (electronic health records, health information exchange) and develop its own goals for transformational areas of HIT use (analytics, quality reporting, patient engagement, and other health IT).

a. Electronic Health Records Systems (EHRs)

Contractor facilitates Providers' adoption and meaningful use of EHRs. Electronic Health Records are a foundational component of care coordination because they enable Providers to capture clinical information in a format that can be used to improve care, control costs, and more easily share information with patients and other providers. In order to facilitate advanced EHR adoption and meaningful use, Contractor:

(1) Identifies EHR adoption rates; rates may be divided by provider type and/or geographic region.

(2) Develops and implements strategies to increase adoption rates of certified EHRs.

(3) Considers establishing minimum requirements for EHR adoption over time. Requirements may vary by region or provider type;

b. Health Information Exchange (HIE)

(1) Contractor facilitates electronic health information exchange in a way that allows all Providers to exchange a patient's health information with any other of its Participating Providers, including ensuring that every Provider is:

(a) Registered with a statewide or local Direct-enabled Health Information Service Provider (HISP); or

(b) A member of an existing Health Information Organization (HIO) with the ability for providers on any EHR system (or with no EHR system) to be able to share electronic information with any other provider within Contractor's network.

(2) Contractor also considers establishing minimum requirements for HIE, including rates of e-prescribing and electronic lab orders, over time.

(3) Contractor leverages HIT tools to transform from a volume-based to a value-based delivery system. In order to do so, Contractor initially identifies its current capacity and develop and implement a plan for improvement (including goals/milestones, etc.) in the following areas:

(a) Analytics that are regularly and timely used in reporting to its provider network (e.g., to assess provider performance, effectiveness and cost-efficiency of treatment, etc.).

(b) Quality Reporting (to facilitate Quality Improvement within Contractor as well as to report the data on quality of care that allows the OHA to monitor Contractor's performance).

(c) Patient engagement through HIT (using existing tools such as e-mail).

(d) Other HIT (e.g., telehealth, mobile devices).

B. Delivery of Benefits

Part 1 – Benefits

1. Flexible Services and Supports

In addition to traditional service and supports for physical, mental health, chemical dependency and dental services, Covered Services include the provision of Flexible Services and supports that are consistent with achieving wellness and the objectives of an individualized care plan. A Flexible Service or support is ordered by and under the supervision of a Network Provider in accordance with Contractor policy for authorizing Flexible Services or supports.

2. Children's Wraparound Demonstration Project Responsibilities

As mandated by ORS 418.975 to 418.985, Contractor creates a system of care by implementing a Children's Wraparound Demonstration Project, providing oversight and, in collaboration with OHA, evaluation.

Contractor develops local and state level partnerships to collaborate with OHA on the implementation of ORS 418.975 to 418.985 in the development of the Statewide Children's Wraparound Initiative.

Trillium will support wraparound approaches for children and families to help them succeed in community placements. These approaches will include expanded care coordination with family teams; wraparound, community-based support and services; flexible funds; iudividualized strength-based care plans; and system coordination. Trillium's ENCCs will be actively involved in identifying children, participating in system coordination, authorizing care, aud supporting transitions.

1. **Trillium will expand upon the existing system of care for children by implementiug a Children's Wraparound Project. This project will incorporate the existing strengths of the Lane County ISA system:**

- Five contractors that provide community-based wraparound services in the family homes and in the child's school
- Flexible funds
- System of Care approach with partnerships with child welfare, department of youth services, mental health providers, families, developmental disabilities, and other organizations as relevant.
- Community and family advisory committees.
- Partnership with Oregon Family Support Network and YouthMove Oregon.
- Weekly community meetings to review process and youth in residential care to expedite transition back to community.

2. Trillium will continue to support the Early Childhood Mental Health Project:

Goal: Improve the identification of children who need mental health services by increasing screening opportunities in a range of settings.

The ASQ-SE is the screening tool to indicate if there is a need for a mental health assessment and mental health services. This project has expanded on existing screening and referral systems by incorporating: Parent Helpline, Early Childhood CARES (EC Cares), Early Head Start Programs, CDRC (Child Development & Rehabilitation Center), Center for Family Development, Willamette Family Treatment Center, Pearl Buck, Relief Nursery, and First Place Family Center.

The project has increased the number of physicians who complete developmental screenings and refer to Early Childhood CARES, the Parent Helpline and mental health provider agencies. Currently Success by Six and Early Childhood CARES are working with Peace Health, Oregon Medical Group, and LIPA (Lane Individual Practices Association) to expand their screening efforts and coordinate referrals to Parent Help Line and Early Childhood CARES. Utilization of these referral sources will facilitate getting families to qualified mental health providers.

Goal: Work across disciplines to identify and serve children collaboratively through a multidisciplinary, wraparound team (MDT) approach.

The project team meets twice a month for 4 hours and identifies the needs and issues of the child and family from the perspectives of different disciplines and plans for services and supports that are integrated and meet the identified needs effectively and efficiently. The team will use the ECSII as a tool to bring the information from various disciplines together. Members of the team: (1) Developmental-behavioral pediatrician; (2) Psychiatric nurse practitioner; (3) Developmental specialist, through Early Childhood CARES, Mental Health; (4) DHS/Child Welfare; (5) current mental health therapist, (6) cultural support person(s) and (7) service providers involved with specific children and families.

3. Trillium will support the Youth in Transition project, which provides community supports to members age 15-21 that have a serious mental health challenge and need wraparound supports to more successfully negotiate the transition to adulthood.

Objectives include: 1) Increase success for youth transitioning to adulthood in achieving better mental health; 2) Increase amount and effectiveness of supports and services for youth and young adults in transition; 3) Increase collaboration between systems and overall responsiveness; 4) Increase the cultural competence of programs and systems so that youth and families are full

partners in their recovery process including involvement in program design and implementation and; 5) Increase opportunities for youth and young adults to become contributing adults. Target outcomes for youth are: Less time spent in hospitals, less symptomatic, demonstrate improved life functioning, less time unemployed, lower dropout rates, lower rates of arrest and recidivism, more time spent in independent living situations, earn more income from competitive employment, experience more positive social relationships, and express greater satisfaction with life. System/Program outcomes include youth have a greater knowledge and experience in navigating the adult system with good patterns of connection/communication developed with adult mental health system.

Part 2 – Patient Rights and Responsibilities, Engagement and Choice

1. Member and Member Representative Engagement

Contractor actively engages Members as partners in the design and, where applicable, implementation of their individual treatment and care plans through ongoing consultation regarding individual and cultural preferences and goals for health maintenance and improvement. Member choices are reflected in the development of treatment plans and Member dignity is respected. Members are positioned to fulfill their responsibilities as partners in the primary care team at the same time that they are protected against underutilization of services and inappropriate denials of services.
Contractor demonstrates the means by which Contractor:

a. Uses Community input and the Community health assessment process to help determine the best, most culturally appropriate methods for patient activation, with the goal of ensuring that Member act as equal partners in their own care.

b. Encourages Members to be active partners in their health care and, to the greatest extent feasible, develop approaches to patient engagement and responsibility that account for the social determinants of health and health disparities relevant to Members.

c. Engages Members in culturally and linguistically appropriate ways.

d. Educates Members on how to navigate the coordinated care approach.

e. Encourages Members to use wellness and prevention resources, including mental health culturally-specific resources provided by community based organizations and service providers, and to make healthy lifestyle choices.

f. Meaningfully engages the CAC to monitor patient engagement and activation.

g. Provides plain language narrative and alternative (video or audio) formats for individuals with limited literacy that inform patients about what they should expect from Contractor with regard to their rights and responsibilities.

h. Works with the Member's care team, including providers and community resources appropriate to the Member's individual and cultural health as a whole person.

2. Member Engagement and Activation

Contractor implements policies and procedures assuring that each Member:

a. Is encouraged to be an active partner in directing the Member's health care and services and not a passive recipient of care.

b. Is educated about the coordinated care approach being used in the community and how to navigate the coordinated health care system.

c. Has access to advocates, including qualified Peer Wellness Specialists where appropriate, Personal Health Navigators, and qualified Community Health Workers who are part of the Member's care team to provide assistance that is culturally and linguistically appropriate to the Member's need to access appropriate services and participate in processes affecting the Member's care and services.

d. Is encouraged within all aspects of the integrated and coordinated health care delivery system to use wellness and prevention resources and to make healthy lifestyle choices.

e. Is encouraged to work with the Member's care team, including providers and community resources appropriate to the Member's health as a whole person

Part 3 – Providers and Delivery System

1. Integration and Coordination

Contractor develops, implements and participates in activities supporting a continuum of care that integrates mental health, addiction, dental health and physical health interventions in ways that are seamless and whole to the Member and serves Members in the most integrated setting appropriate to their health. Integration activities span a continuum ranging from communication to coordination to co-management to co-location to the fully integrated Patient Centered Primary Care Home.

2. Delivery System Features

Contractor ensures that Members have access to high quality appropriate integrated and coordinated care. Contractor accomplishes this through a Provider Network capable of meeting Health System Transformation objectives. Contractor focuses on the following elements of a transformed delivery system critical to improving the Member's experience of care as a partner in care rather than as a passive recipient of care:

a. Patient-Centered Primary Care Homes

Contractor demonstrates the method and means by which Contractor uses PCPCH capacity to achieve the goals of health system transformation including:

- How Contractor partners with and implement a network of PCPCHs as defined by Oregon's standards to the maximum extent feasible, including but not limited to the following
  - Assurances that the Contractor enrolls a significant percentage of Members in PCPCHs certified as Tier 1 or higher according to Oregon's standards; and
  - A concrete plan for increasing the number of enrollees served by certified PCPCHs over the first five years of operation, including targets and benchmarks; and

- A concrete plan for Tier 1 PCPCHs to move toward Tier 2 and 3 of the Oregon standard over the first five years of operation, including targets and benchmarks.

- How Contractor requires Contractor's other contracting health and services providers to communicate and coordinate care with the PCPCH in a timely manner using electronic health information technology, where available, in order to assure a comprehensive delivery system network with the PCPCH at the center, and with other health care providers and local services and supports under accountable arrangements for comprehensive care management.
- How Contractor's PCPCH delivery system elements ensures that Members of all communities in its service area receive integrated, culturally and linguistically appropriate person-centered care and services, and that Members are fully informed partners in transitioning to this model of care.
- How Contractor encourages the use of federally qualified health centers, rural health clinics, school-based health clinics and other safety net providers that qualify as PCPCHs to ensure the continued critical role of those providers in meeting the health of underserved populations.

b. Care Coordination

Contractor demonstrates the methods and means by which Contractor addresses the following elements of care coordination in their applications for certification:

- How Contractor supports the flow of information, identify a lead Provider or care team to confer with all providers responsible for a Member's care, and, in the absence of full health information technology capabilities, how Contractor implements a standardized approach to patient follow-up.
- How Contractor works with Providers to develop the partnerships necessary to allow for access to and coordination with social and support services, including culturally specific community based organizations, community based mental health services, DHS Medicaid-funded LTC services and mental health crisis management services.
- How Contractor develops culturally and linguistically appropriate tools for provider use to assist in the education of Members about care coordination and the responsibilities of each in the process of communication.
- How Contractor meets OHA goals and expectations for coordination of care for individuals receiving DHS Medicaid-funded LTC services given the exclusion of Medicaid funded long term services from Contractor's global budget.
- How Contractor meets OHA goals and expectations for coordination of care for individuals receiving both Medicaid-funded and non-Medicaid-funded residential addictions and mental health services given the initial exclusion of these services from Contractor's global budget.
- How the contractor coordinates with the state institutions and other mental health hospital settings to facilitate incoming Member's transition into the most appropriate, independent, and integrated community-based settings.

Contractor demonstrates the methods and means by which Contractor utilizes evidence-based or innovative strategies within Contractor's delivery system networks to ensure coordinated care, especially for Members with intensive care coordination health, including members with severe and persistent mental illness receiving home and community based services under the State's 1915(i) State Plan Amendment, as follows:

- *Assignment of responsibility and accountability:* Contractor demonstrates that each Member has a primary care Provider or primary care team that is responsible for coordination of care and transitions.

- *Individual care plans:* Contractor uses individualized care plans to the extent feasible to address the supportive and therapeutic and cultural and linguistic health of each Member, particularly those with intensive care coordination health. Plans reflect Member, Family or caregiver preferences and goals to ensure engagement and satisfaction.
- *Communication*: Contractor demonstrates that Providers have the tools and skills necessary to communicate in a linguistically and culturally appropriate fashion with Members and their Families, extended family, kinship networks or caregivers and to facilitate information exchange between other providers and facilities (e.g., addressing issues of health literacy, language interpretation, having electronic health record (EHR) capabilities, etc.).

Contractor develops of a coordinated and integrated delivery system Provider Network that demonstrates communication, collaboration and shared decision making across the various providers and care settings. Contractor demonstrates, over time:

- How Contractor ensures a network of Providers to serve Members' health care and service health, meet access-to-care standards, and allow for appropriate choice for Members. Services and supports are geographically as close to where Members reside as possible and, to the extent necessary, offered in nontraditional integrated settings that are accessible to families, socially, culturally, and linguistically diverse communities, and underserved populations.
- How Contractor builds on existing Provider Networks and transforms them into a cohesive network of providers, including how it arranges for services with providers external to Contractor's service area, to ensure access to a full range of services to accommodate Member health.
- How it works to develop formal relationships with providers, community health partners, including culturally and socially diverse community based organizations and service providers, and state and local government support services in its service area(s), and how Contractor participates in the development of coordination agreements between those groups.

c. Care Integration

- *Mental Health and Chemical Dependency Treatment:* Outpatient mental health and chemical dependency treatment are integrated in the person-centered care model and delivered through and coordinated with physical health care services by Contractor.

- *Oral Health:* By July 1, 2014, Contractor will have a formal contractual relationship with any DCO that serves Members of Contractor in the area where they reside.

There are four DCOs in the applicant's service area and not all may be ready for a launch on August 1, 2012 but a full and adequate panel of dental providers will be available no later than July 1, 2014. The applicant plans to work with the DCOs toward contracts that are sustainable and that actuarially fit in the fixed global budget. Trillium also plans to monitor all DCOs, even if not yet contracted, for performance improvement, complaints, utilization and access to ensure that future contract arrangements result in high levels of quality, access and cost.

- *Hospital and Specialty Services:* Contractor provides adequate, timely and appropriate access to hospital and specialty services. Hospital and specialty service agreements are established that include the role of patient-centered primary care homes and that specify: processes for requesting hospital admission or specialty services and performance expectations for communication and medical records sharing for specialty treatments, at the time of hospital admission or discharge, for after-hospital follow up appointments. Contractor demonstrates how hospitals and specialty services are accountable to

achieve successful transitions of care. Contractor transitions Members out of hospital settings into the most appropriate, independent, and integrated community-based settings.

d. Health Leadership Council High Value Medical Home (*only applies in areas involved with this specific project*)

Not Applicable for this CCO.

3. Delivery System Dependencies

a. Shared Accountability for DHS Medicaid-funded Long-term Care Services

DHS Medicaid-funded LTC services are legislatively excluded in HB 3650 from CCO global budgets and will be paid for directly by the Department of Human Services, creating the possibility of misaligned incentives and cost-shifting between Contractor and the DHS Medicaid-funded LTC system. Cost-shifting is a sign that the best care for a beneficiary's health is not being provided. In order to prevent cost-shifting and ensure shared responsibility for delivering high quality, culturally and linguistically appropriate person-centered care, Contractor and the DHS Medicaid-funded LTC system share accountability, including financial accountability.

A shared financial accountability system will be developed based on incentives and/or penalties linked to performance metrics applied to the Contractor and/or to the DHS Medicaid-funded LTC system in its Service Area. Other elements of shared accountability between Contractor and the DHS Medicaid-funded LTC system in its Service Area will include contractual elements such as specific requirements for coordination between the two systems; requirements to clearly define roles and responsibilities between the two systems, through a memorandum of understanding, a contract, or other mechanism; and reporting of metrics related to better coordination between the two systems.

Further, since individuals receiving DHS Medicaid-funded LTC services and supports represent a significant population served by Contractor, Contractor includes these individuals and the DHS Medicaid-funded LTC delivery system in its Service Area in the community health assessment processes and policy development structure

b. Intensive Care Coordination for Special Health Members

(1) Contractor prioritizes working with Members who have high health care health, multiple chronic conditions, mental illness or chemical dependency and communities experiencing health disparities (as identified in the community health assessment) and involves those Members in accessing and managing appropriate preventive, remedial and supportive care and services to reduce the use of avoidable emergency room visits and hospital admissions.

(2) Contractor provides intensive care coordination or Case Management Services to Members who are aged, blind, disabled or who have complex medical health consistent with ORS 414.712, including Members with mental illness and Members with severe and persistent mental illness receiving home and community based services under the State's 1915(i) SPA.

(3) Contractor implements procedures to share the results of its identification and Assessment of any Member identified as aged, blind, disabled (including mental illness or substance abuse disorders) or having complex medical health with Participating Providers serving the Member so that those activities need not be duplicated. Contractor creates the procedures and shares information under ORS 414.679 in compliance with the confidentiality requirements of the Contract.

(4) Contractor establishes policies and procedures, including a standing referral process for direct access of specialists, in place for identifying, assessing and producing a treatment plan for each Member identified as having a special healthcare need. Each treatment plan is:

(a) Developed by the Member's designated practitioner with the Member's participation;

(b) Includes consultation with any specialist caring for the Member;

(c) Approved by the Contractor in a timely manner, if this approval is required; and

(d) In accordance with any applicable State quality assurance and utilization review standards.

c. State and Local Government Agencies and Community Social and Support Services Organizations

Contractor promotes communication and coordination with state and local government agencies and culturally diverse community social and support services organizations, including early child education, special education, behavioral health and public health, as critical for the development and operation of an effective Delivery System Network (DSN). Contractor consults and collaborates with Contractor DSN Providers to maximize Provider awareness of available resources for different Members' health, and to assist DSN Providers to be able to make referrals to the appropriate providers or organizations. The assistance that Contractor provides to DSN Providers in making referrals to State and local governments and to community social and support services organizations takes into account the following referral and service delivery factors:

d. Cooperation with Dental Care Organizations

Contractor coordinates preauthorization and related services with DCOs to ensure the provision of dental care that is required to be performed in an outpatient hospital or ambulatory surgical setting due to the age, disability, or medical condition of the Member.

e. Cooperation with Residential, Nursing Facilities, Foster Care & Group Homes

Contractor arranges to provide medication that is part of Capitated Services to nursing or residential facility and group or foster home residents in a format that is reasonable for the facility's delivery, dosage and packaging requirements and Oregon law.

C. Accountability

Part 1 - Quality and Performance Outcomes and Accountability

1. Quality and Performance Outcomes

As required by Health System Transformation, Contractor is held accountable for its performance on outcomes, quality, and efficiency measures incorporated into the Contract. Accountability metrics function both as an assurance that Contractor is providing quality care for all of its Members and as an incentive to encourage Contractor to transform care delivery in alignment with the goals of Health System Transformation. Further, Members and the public know about the quality and efficiency of their health care so metrics of outcomes, quality and efficiency are publicly reported. Health care transparency provides consumers with the information necessary to make informed choices and allows the community to monitor the performance of Contractor.

Contractor implements data reporting systems necessary to timely submit claims data to the All Payer All Claims data system in accordance with ORS 414.625, and the requirements of ORS 442.464 to 442.466.

2. Quality Assurance and Improvement

Contractor implements quality assurance and improvement measures demonstrating the methods and means by which Contractor carries out planned or established mechanisms for:

a. Establishing a complaint, Grievance and Appeals resolution process, including how that process is communicated to Members and providers;

b. Establishing and supporting an internal Quality Improvement committee that develops and operates under an annual quality strategy and work plan with feedback loops; and

c. Implementing an internal utilization review oversight committee that monitors utilization against practice guidelines and treatment planning protocols and policies.

3. Measurement and reporting requirements

Contractor plans and implements the necessary organizational infrastructure to address performance standards established for the Contract.

a. In the first year, accountability is for reporting only.

b. In future years, Contractor is accountable for meeting specified performance benchmarks (see accountability standards below), specifically: to meet or exceed minimum performance expectations set for core measures and to improve on past year performance for transformational measures (see below for description of care and transformational categories).

c. Initially, "reporting year" is based on the effective date of each the contract; that is, year 1 a contract that starts operation in July 2012 runs through December 2013 and year 1 for a Contractor that is certified in October 2012 will run through December 2013. Contractor meets performance benchmarks by January 2014. [*Contracts that begin operation less than a year before that date will have a shorter reporting-only accountability period and Contracts that start on or after January 2014 will have no phase-in period at all.*]

d. Performance relative to targets affects Contractor's eligibility for financial and non-financial rewards. Contractor's performance with respect to minimum expectations is assessed as part of OHA monitoring and oversight. Initially, monitoring and oversight is aimed at root cause analysis and assisting Contactor in developing improvement strategies; continued subpar performance leads to progressive remediation established in the Contract, including increased frequency of monitoring, Corrective Action Plans, Enrollment restrictions, financial and non-financial sanctions, and ultimately, non-renewal of contracts.

e. OHA will convene a Metrics and Scoring Committee to assist in building measure specifications and establishing performance targets for year 2 forward. The Committee will also advise OHA annually on

adopting, retiring, or re-categorizing Contractors performance measures, based on evaluation of the metrics' appropriateness and effectiveness.

f. Annual reporting serves as the basis for holding Contractor accountable to contractual expectations; however, OHA assesses performance more frequently (e.g. quarterly or semi-annually) on an informal basis to facilitate timely feedback, mid-course corrections, and rapid improvement recommendations to Contractor. The parties document any changes agreed to during these informal procedures.

g. The performance measures reporting requirements measure the quality of health care and services during a time period in which Contractor was providing Coordinated Care Services. The performance measures reporting requirements expressly survive the expiration, termination or amendment of the Contract, even if Contract expiration, termination or amendment results in a termination, modification or reduction of the Contract or the Contractor's Enrollment or service area.

h. Contractor includes any additional measures requested by CMS from its Adult Medicaid and CHIPRA core measure sets as CCO accountability measures.

4. Specific areas of CCO accountability metrics

Contractor is accountable for both core and transformational measures of quality and outcomes:

a. Core measures are triple-aim oriented measures that gauge Contractor performance against key expectations for care coordination, consumer satisfaction, quality and outcomes. The measures are uniform across CCOs and encompass the range of services included in CCO global budgets (e.g. behavioral health, hospital care, women's health, etc.).

b. Transformational metrics assess Contractor progress toward the broad goals of Health System Transformation and therefore require systems transitions and experimentation in effective use. This subset may include newer kinds of indicators (for which Contractor may have less measurement experience) or indicators that entail collaboration with other care partners.

c. Accountability metrics that are applicable in Year 1 of this Contract are found in RFA Table C-1.