ATTACHMENT 1 – Application Cover Sheet

Applicant Information - RFA # 3402

Applicant Name: **Cascade Health Alliance**

Form of Legal Entity (business corporation, etc.) **LLC**

State of domicile: **OREGON**

Primary Contact Person: **William Guest, III** Title: **CEO**

Address: **2909 Daggett Avenue Suite 225**

City, State, Zip: **Klamath Falls, OR 97601**

Telephone: **541-851-2012** Fax: **541-885-9858**

E-mail Address: **billg@cascadecomp.com**

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

Name: **William Guest, III** Title: **CEO**

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

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

and conditions in Appendix G, except to the extent Applicant has timely requested a change or clarification or filed a protest in accordance with the RFA.

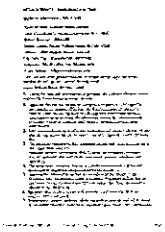
8. If awarded a Contract, Applicant will meet the highest standards prevalent among Medicaid health plans in Oregon.
9. Applicant and its Affiliates complied with the Code of Conduct in Section 7.15 of the RFA in connection with the RFA.
10. Applicant accepts the terms and conditions for OHA's web portal, as posted on the web portal.
11. Applicant will negotiate in good faith regarding the statement of work for the Contract.

Apr 27, 2012

X William C. Guest III
William C. Guest III (Apr 27, 2012)

William Guest, III
CEO

Date:_____ (Authorized to Bind Applicant)



Application Cover Sheet Attachment 1

EchoSign Document History April 27, 2012

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By:	Kathy Pence (kathyp@cascadecomp.com)
Status:	SIGNED
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Signed document emailed to William C. Guest III (billg@cascadecomp.com) and Kathy Pence (kathyp@cascadecomp.com)
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ATTACHMENT 6 – ATTESTATIONS, ASSURANCES AND REPRESENTATIONS

Applicant Name: **CASCADE HEALTH ALLIANCE** **RFA 3402**

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	X			
• Outcomes and evaluation	X			
• Performance measurement	X			
• Health management and care coordination activities	X			
• System coordination and shared accountability between DHS Medicaid-funded LTC system and CCO	X			
• Mental health and addictions coordination and system management	X			
• Communications management to providers and Members	X			
• Provider relations and network management, including credentialing	X			
• Health information technology and medical records	X			
• Privacy officer	X			
• Compliance officer	X			

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
Attestation A-2. Applicant will participate in the learning collaboratives required by ORS 442.210.	X			
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.	X			

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.	X			
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.	X			
Attestation B-3. Applicant will assure that all provider and supplier contracts or agreements contain the required contract provisions that are described in the Contract.	X			
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.	X			
Attestation B-5. Applicant will have all provider contracts or agreements available upon request.	X			
Attestation B-6. As Applicant implements, acquires, or upgrades				

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
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.	X			
Attestation B-7. Applicant's contracts for administrative and management services will contain the OHA required contract provisions.	X			
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.	X			
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.	X			
Attestation B-10. Applicant, through its contracted or deemed Participating Provider network, along with other specialists outside the network, community resources or social services within the CCO's service area, will provide ongoing primary care and specialty care as needed and guarantee the continuity of care and the integration of services through: • Prompt, convenient, and appropriate access to Covered Services by enrollees 24 hours a day, 7 days a week; • The coordination of the individual care needs of enrollees in accordance with policies and procedures as established by the Applicant; • Enrollee involvement in decisions regarding treatment, proper education on treatment options, and the coordination of follow-up care; • Effectively addressing and overcoming barriers to enrollee compliance with prescribed treatments and regimens; and • Addressing diverse patient populations in a culturally competent manner.	 X X X X X			
Attestation B-11. Applicant will establish policies, procedures, and standards that: • Assure and facilitate the availability, convenient, and timely access to all				

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
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.	X X X X X			
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.	X			
Attestation B-13. Applicant will provide all services covered by Medicaid and comply with OHA coverage determinations.	X			
Attestation B-14. Applicant, Applicant staff and its affiliated companies, subsidiaries or subcontractors (first tier, downstream, and related entities), and subcontractor staff will be bound by 2 CFR 376 and attest that they are not excluded by the Department of Health and Human Services Office of the Inspector General or by the General Services Administration. Please note that this attestation includes any member of the board of directors, key management or executive staff or major stockholder of the Applicant and its affiliated companies, subsidiaries or subcontractors (first tier, downstream, and related entities).	X			
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.	X			

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]	X			
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]	X			
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]	X			
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	X			

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]				
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]	X			
Assurance B-6. Applicant will have written procedures approved in writing by OHA for accepting, processing, and responding to all complaints and Appeals from Members or their Representatives that are consistent with Exhibit I of the Appendix G "Core Contract". The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.228, 438.400 – 438.424; and OAR 410-141-3260 to 410-141-3266]	X			
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]	X			
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]	X			
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]	X			
Assurance B-10. Applicants will provide Intensive Care Coordination (otherwise known as Exceptional Needs Care Coordination or ENCC) to Members who are Aged, Blind or Disabled. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.208 and OAR 410-141-3405]	X			
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]	X			
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]	X			

Assurance B-13. Applicant will maintain an efficient and accurate system for capturing encounter data, timely reporting the encounter data to OHA, and validating that encounter data based on written policies, standards, and procedures that are in accordance with accepted professional standards, CCO and OHP Administrative Rules and OHA Provider Guides. The Applicant will have monitoring systems in operation and review the operations of these systems on a regular basis. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.242; and the Contract]	X			
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]	X			

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.	X			CHA will contract with Cascade Comprehensive Care, Inc. (parent) to provide administrative services.
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.			X	Contract will be final for readiness review. See B-1
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.	X			See Representation B-1
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.	X			See Representation B-1
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.	X			See Representation B-1
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.	X			See Representation B-1
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.	X			See Representation B-1
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.	X			See Representation B-1
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.	X			See Representation B-1
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.	X			See Representation B-1

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.	X			See Representation B-1
Representation B-11. Applicant will have an administrative or management contract with a delegated entity to delegate all or a portion of other services that are not listed.	X			See Representation B-1

(Applicant Authorized Officer)
Signature

X William C Guest III

William Guest, III
CEO

Date April 28, 2012

Cascade Health Alliance RFA 3402

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.

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1. Technical Application, Mandatory Submission Materials

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

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

☒ **c.** This Technical Application Checklist

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

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

☒ **f.** Organizational Chart.

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

h. Questionnaires

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

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

☒ (3) Accountability Questionnaire (Appendix C)

☒ • Services Area Table.

☒ • Publicly Funded Health Care and Service Programs Table

☒ (4) Medicare/Medicaid Alignment Demonstration Questionnaire (Appendix D).

2. Technical Application, Optional Submission Materials

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

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

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

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

APPENDIX E

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

APPENDIX F

- ☐ **a.** Base Cost Template

ATRIO
HEALTH PLANS
Get Greater Value From Medicare

April 18, 2012

Cascade Health Alliance, LLC
c/o Bill Guest
2909 Daggett Ave., Ste. 200
Klamath Falls, OR 97601

RE: Letter of Support for the creation of the Cascade Health Alliance, LLC CCO

Dear Cascade Health Alliance, LLC:

ATRIO Health Plans, Inc. is writing this letter to express our support for your Letter of Intent with the Oregon Health Authority to become a Coordinated Care Organization (CCO). As you are aware, ATRIO has an extensive relationship with your parent organization, Cascade Comprehensive Care, which serves as our local Medicare administrator in Klamath County. Through this relationship we are well aware of your hard-earned reputation for providing excellent care in a cost efficient manner, your dedication to member satisfaction, and your ability to manage a global budget.

We believe that Cascade Health Alliance has the experience and expertise to operate as a CCO. Cascade Comprehensive Care is already used to a patient centered and team-focused model of care. Operating as a CCO will allow better coordination of services and also the ability to focus on prevention, chronic illness management, and patient-centered care.

We share your goal of providing high-quality healthcare in a cost efficient manner and believe that your efforts will have a profound impact on the quality and cost of the delivery system in Klamath County. ATRIO fully supports the efforts of Cascade Health Alliance as it seeks to become a Coordinated Care Organization.

Sincerely,

Ruth Rogers Bauman, CEO

2270 NW AVIATION DRIVE . SUITE 3 . ROSEBURG, OR 97470 . 541.672.8620 . FAX 541.672.8670

Klamath County Chamber of Commerce

205 Riverside Street Suite A • Klamath Falls, Oregon 97601
(541) 884-5193 Phone • (541) 884-5195 Fax
www.klamath.org - inquiry@klamath.org

April 19, 2012

Bill Guest
Cascade Comprehensive Care
2909 Daggett Ave., Suite 200
Klamath Falls Oregon

RE: Cascade Comprehensive Care/Cascade Health Alliance

Dear Mr. Guest

The Klamath County Chamber of Commerce supports Cascade Comprehensive Care's application to become the Coordinated Care Organization (CCO), named Cascade Health Alliance, for specific areas in Klamath County.

Cascade Comprehensive Care (CCC) is a Klamath Falls-based business that has provided excellent and efficient Oregon Health Plan services to thousands of Klamath County's citizens for more than 16 years. This high level of service has been delivered through a unique collaboration between Sky Lakes Medical Center and local physicians, and places Cascade Health Alliance in a very favorable position to serve the local population into the future.

The Chamber's mission is to improve Klamath County "by advancing its economic vitality and quality of life." Cascade Health Alliance will compliment this mission by:

- meeting the needs of local healthcare consumers through positive partnerships with all parties;
- managing financial resources efficiently and lowering overall costs while improving service levels;
- giving local healthcare providers a stake in successfully providing healthcare to the community;
- supporting organized physician recruitment and retention efforts to maintain a high level of healthcare services in Klamath County;
- and by creating more jobs in our community.

Local control has recently been lost for two of Klamath County's most important businesses, and the struggling economy has impacted us all. The Chamber of Commerce believes maintaining local control of our healthcare delivery system is essential to our economic vitality and quality of life.

Thank you for your consideration.

Best regards,

Stan Gilbert
President

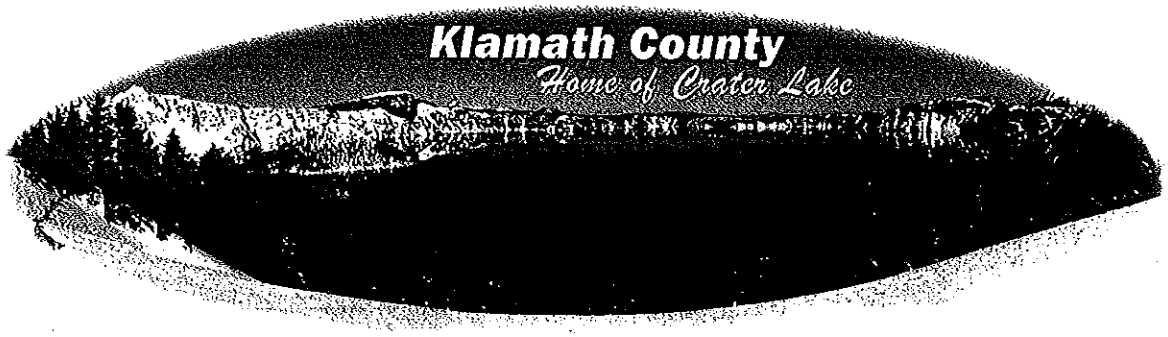
"The Klamath County Chamber of Commerce is committed to Klamath County by advancing its economic vitality and quality of life through the education, promotion and networking of our members"

-----Original Message-----
From: David Panossian [mailto:panda@e-isco.com]
Sent: Monday, April 09, 2012 6:22 PM
To: Bill Guest
Subject: Letter of support from KFIPA

Bill

KFIPA and its 55 specialist physicians support CCC in forming the CCO in Klamath County. KFIPA has been working with CCC for the past 17 years and has developed a very strong working relationship with CCC and it's staff.
CCC has been a quality leader in managed care and has been rated as one of the top managed care plans for OHP in Oregon. In addition there has been already an established relationship with Skylakes Medical Center as a partner in health care. KFIPA believes that CCC has the financial strength to capitalize the formation of the CCO in Klamath County. KFIPA looks forward to partnering with the different health care organizations in the community to continue to provide the high level of care that has been the standard at CCC. If you have any further questions, please feel free to contact me.

David Panossian MD
President of KFIPA



Klamath County Commissioners

Al Switzer, *Commissioner*
Position One

Dennis Linthicum, *Commissioner*
Position Two

Cheryl Hukill, *Commissioner*
Position Three

April 26, 2012

Cascade Comprehensive Care, Inc.
Bill Guest
2909 Daggett Avenue suite 200
Klamath Falls, Oregon 97601

Dear Mr. Guest;

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

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

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

Enclosed with this letter is this link to the public meetings where this issue was discussed and then voted on during a work session on April 25, 2012. (http://www.viddler.com/v/253fa2a4)

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

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

Sincerely,

Dennis Linthicum,
Chair

Cheryl Hukill,
Vice-Chair

Al Switzer,
Commissioner

305 Main Street, Klamath Falls, Oregon 97601
Phone: (541) 883-5100 | Fax: (541) 883-5163 | Email: bocc@co.klamath.or.us

Klamath Health Partnership, Inc.

Our mission is to serve our community by offering excellent care and eliminating barriers to health.

Nuestra misión es servir a nuestra comunidad brindándole un excelente cuidado clínico y eliminando las barreras al acceso a los servicios de salud.

April 26, 2012

RE: Formation of a CCO

To Whom It May Concern:

Klamath Health Partnership, Inc. (KHP), a 501(C) 3 community health center in Klamath Falls, Oregon, has had a long –term relationship with Cascade Comprehensive Care (CCC) who is applying to become a Coordinated Care Organization (CCO). Approximately, 38% of our patient base is Medicaid patients, and of that 30% are enrolled in Cascade Comprehensive Care. KHP has an excellent working relationship with CCC in providing services to community.

We fully support the request of CCC to become a CCO, operating in Klamath County as "Cascade Health Alliance". KHP will continue to provide medical, dental, and mental health services to the uninsured and underinsured residents in Klamath County, and looks forward to continuing our relationship and shared commitment to our community with Cascade Comprehensive Care as they move forward in the transformation of health care delivery in our county.

KHP is strongly supportive of the CCO being intimately involved in the well being of our community, and having a vested interest in the overall health of the residents of Klamath County. It is our belief that Cascade Comprehensive Care would best fit that function.

Sincerely,

Debra K. Miesch, MBA
Chief Executive Officer

(541) 851-8110
Klamath Open Door
2074 South Sixth Street
Klamath Falls, Oregon 97601
Fax (541) 851-8114

(541) 880-2090
Klamath Open Door Dental
2074 South Sixth Street
Klamath Falls, Oregon 97601
Fax (541) 880-2092

(541) 783-2292
Chiloquin Open Door
PO Box 695
Chiloquin, Oregon 97624
Fax (541) 783-3160

www.klamathopendoor.org

KLAMATH PEDIATRIC CLINIC, P.C.
PHYSICIANS & SURGEONS
2310 Mountain View Blvd. • Klamath Falls, OR 97601-1134
(541) 883-3591 • Fax (541) 883-2886

Charles M. LaBuwi, M.D. John A. Wilson, M.D. Tracy W. Graham, M.D.
Carrie A. Ganong, M.D. Eleanor Lustig-Butts, C.P.N.P.

April 6, 2012

Dear Oregon Health Authority Members,

RE: Community Care Organization

I am writing this letter in support of the application submitted by Cascade Comprehensive Care.

As the largest pediatric clinic in Klamath Falls, historically, we have provided ongoing care to approximately 25% of all OHP clients in the county. Going back almost two decades, our relationship with Cascade Comprehensive Care has been harmonious and symbiotic. For many years we also served on the provider panel for Care Oregon. The relationship proved to be financially unrewarding. Along with the lack of local case management, and the contrast between the ease of interacting with Cascade Comprehensive Care versus the struggle of dealing with the Care Oregon bureaucracy forced us to sever that relationship several years ago.

Furthermore, the difficulty of obtaining needed mental health care for our patients in a timely manner, especially psychiatric care, has over the years, fostered a mistrust of the mental health system. Commingling monies targeted for Klamath County with those of other counties has lead to a lack of transparency and what seems to be a diversion of needed resources.

We urge you to support the application of Cascade Comprehensive Care, our local community entity.

Respectfully submitted,

John A. Wilson, MD

John A. Wilson, M.D.

From: DBooie@aol.com [mailto:DBooie@aol.com]
Sent: Wednesday, February 22, 2012 7:02 AM
To: billg@cascadecomp.com
Subject: CCO development

Bill,
As president of Linkville IPA, I want to inform you that at our last Board meeting the various legal options for proceding with the development of a CCO were discussed. Without exception the members were in favor of CCC pursuing the formation of a for-profit entity using the existing company as the foundation on which to build. Based on CCC's past history this form has proven successful in aligning incentives and building capital while maintaining financial flexibility,community responsive, and provider friendliness.
You have demonstrated the professional expertise and already have most of the necessary infrastructure in place to ensure continued success.
You have our full support in this endeavor.

Sincerely,
Charles LaBuwi,M.D.
President, Linkville IPA

SKY LAKES
MEDICAL CENTER
LIFE : HEALING : PEACE™

2865 Daggett Avenue
Klamath Falls, OR 97601
Ph 541 882 6311

skylakes.org

Paul R. Stewart
President & CEO

April 25, 2012

Bill Guest, President and Chief Executive Officer
Cascade Comprehensive Care
2909 Daggett Avenue, Suite 200
Klamath Falls, Oregon 97601

Dear Bill

Sky Lakes Medical Center is providing this letter in support of CCC's application to become a CCO for most of Klamath County.

We believe this locally owned and governed entity is in the best position to accomplish the aims of transformation contemplated by Oregon healthcare legislation. As a partnership of the main local healthcare providers, with a successful track record of over 16 years successfully managing physical health, A&D, and some behavioral health services for 10,000 Medicaid enrollees, CCC can move forward with the integration of other mental and dental health services.

With the support of the region's not-for-profit hospital and the local physicians, CCC has been able to develop a cutting-edge risk model that seeks to align financial incentives towards quality, access and efficiency. We believe mental and dental health services can be successfully coordinated alongside the physical health to achieve some of the financial incentives contemplated by state legislation.

In addition, Sky Lakes Medical Center has been successful in recruiting additional primary care providers that will allow CCC to expand Medicaid enrollment up to the full capacity needed for our county.

We believe the introduction of outside entities to this process would be potentially disruptive to existing collaboration and cooperation, and fully support CCC's application to become a CCO.

Sincerely,

Paul R. Stewart
President and CEO

REC'D APR 17 2012

CITY OF KLAMATH FALLS, OREGON

500 KLAMATH AVENUE – P.O. BOX 237
KLAMATH FALLS, OREGON 97601

Sister City
ROTORUA, NEW ZEALAND

April 16, 2012

Mr. Bill Guest
Director, Cascades Comprehensive Care
2909 Daggett Avenue, #200
Klamath Falls OR 97601

Re: Letter of Support

Dear Mr. Guest,

I am writing in support of Cascade Comprehensive Care as the designated Coordinated Care Organization for the area in and around Klamath Falls.

I am strongly in favor of this request because the two Independent Physicians Associations and Sky Lakes Medical Center have been successfully administering healthcare functions to our local citizens since 1994. Further, I believe all three entities have a vested interest in the well-being of our community, and the incentives provided in the CCO fit well with the philosophical perspective of the CCC.

Best wishes in your pursuit of this worthy endeavor.

Sincerely,

Todd Kellstrom
Mayor

TK/ds

c: Klamath Falls City Council
Klamath County Board of County Commissioners

BESTCARE
TREATMENT SERVICES

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

April 5, 2012

Oregon Health Authority
500 Summer Street NE
Salem, Oregon 97301

RE: Letter of Support for Cascade Health Alliance CCO Application

Dear Oregon Health Authority,

BestCare Treatment Services, Inc. supports the application of Cascade Health Alliance to be the Coordinated Care Organization for Klamath County. Cascade Comprehensive Care, Inc. has spearheaded the organization of Cascade Health Alliance to be the CCO in Klamath County. CCC has built on its strong track record of services in Klamath County and its strong ties to the hospital and physicians of Klamath County to develop a CCO that fits the needs to Klamath County.

BestCare Treatment Services, Inc. provides residential and outpatient chemical dependency services in Klamath County. BestCare Treatment Services has been an Oregon 501(c)3 non-profit since November 1997, delivering residential and outpatient drug and alcohol treatment services, primarily in Central Oregon. BestCare has grown from a single, very modest A&D residential treatment facility in Redmond to an entity that has six offices and three residential facilities in four cities across Deschutes, Klamath, and Jefferson counties. BestCare now delivers not only A&D services, but is also the county contracted mental health and developmental disabilities services provider for Jefferson County, outpatient mental health services in Deschutes County, facilitates the only statewide all Spanish-language A&D residential facility in Oregon, and is the contracted provider of residential and outpatient A&D services for Klamath County.

Sincerely,

Rick Treleaven, LCSW
Executive Director

Neal D. Boren
610 N. 11th
Klamath Falls, OR 97601
541.274.9544
nealb@cascadecomp.com

EXPERIENCE

2/2010 – Present
Network Administrator/CIO
Cascade Comprehensive Care Inc., 2909 Daggett Ave. Suite 200

Responsible for the daily maintenance, care and operation of the CCC computer environment not limited to servers, workstations, phone system, internet connectivity and all hardware associated with this environment. I am responsible for ongoing network analysis, budgeting and purchasing of software and hardware to support the business needs of staff and CCC.

2/2010 – Present
Licensed Computer Consultant in Klamath Falls, OR

2/2001 – 2/2010
Network Engineer
ISCO LLC, 3815 South Sixth Street, Suite 105, Klamath Falls, Oregon

Managed a large group of business clients providing solutions ranging from simple network troubleshooting to complete network design and implementation.

I handled the development and execution of disaster recovery plans ranging from offsite, tape, SAN and other solutions. I administered small to medium-sized business networks running primarily Microsoft products. I do have a lot of experience with Unix/Linux variants, various internet mail servers and Macintosh systems.

Specialized in implementing Active Directory Domains running Windows 2000, 2003 and 2008 server. Within these environments I have extensive knowledge administrating Microsoft Exchange, IIS, SQL (other variants besides Microsoft), ISA Server, MS and third party Fax Servers, backup solutions, NAS, SAN technologies and others.

Knowledge of these products includes installation, configuration, management and troubleshooting. This position involved extensive documentation, performance monitoring and tuning for ongoing preventative maintenance of internal and client systems.

I was highly involved in ISCO's internal network design, including that of our Internet services. I have extensive Internet connectivity experience involving LAN, WAN, VPN's, Terminal Services, firewall/proxy products, routers, MikroTik and wireless technologies. My position was extremely detail oriented, required thorough daily documentation and client communication with an emphasis on organization and client relations.

Many of the clients that I administered were maintained within management contracts. My role was to work closely as their administrator on budgeting, forecasting their needs for software/hardware growth,

implementing new technologies to meet industry regulations as needed and to constantly update and monitor with a preemptive approach to maintaining their network infrastructures.

As lead engineer and a mentor to the other technical staff I was a point of escalation for complex technical issues that could not be resolved by others.

10/99 - 1/2001
Information Systems Coordinator
Molded Fiber Glass Northwest, Stevenson, Washington
Call Monica Masco, Controller during my employment (509)427-7609

Managed all computing and information systems the company relied upon for daily business activities. Purchased, maintained and upgraded software and hardware on all computer systems. The computing environment was a mix of Windows 9X, NT Server/Workstation, Windows 2000, Unix Servers and Print Servers. As systems administrator, trained employees on using their computers, managed domain users and upgraded the network infrastructure. Developed MFG/NW's web site, updated all computer systems in preparation for Y2K, created a backup policy and led a successful rollout of their MS+/Progress data base system. Position required the knowledge of many different operating systems, networking environments, EDI communication systems and the patience to resolve simple to complex issues.

2/99 - 9/99
Network Technician and Computer Support Specialist
Providence Hood River Memorial Hospital, Hood River, Oregon

Maintained a Windows, NetWare, Unix/AIX/HP-UX environment. Implemented upgrade of network components to Cisco 10/100 smart switches on a fiber backbone. This included configuration and installation of the switches and cabling all wiring closets. Assisted with the upgrade of their NetWare 3.x file server, print servers and NT servers. Supervised backup systems, maintaining MS Proxy Server on NT4 and monitoring employee Internet traffic. Provided training in various computer applications, responded to employee computer issues and purchased and setup new computers.

3/98 - 1/99
Network Technician and Computer Support Specialist
Skamania Networks, Stevenson, Washington

Assisted in creation of Skamania Networks, Columbia Gorge ISP. Helped build an entire Unix/NT4 network. Aided with all router and server configuration, performing all wiring and setup of wireless communication systems for Internet access on both sides of the Columbia River. Provided technical support to customers of all networks, troubleshooting basic to complex computer issues. Delivered excellent customer service with patience, utilizing quality communication skills, with extensive time invested after hours.

2/97 - 3/98
Technical Support Specialist
Keane Inc., Kirkland, Washington

Employed as a Technical Support Specialist for Microsoft on the Windows 95 and Internet Explorer 4.0 project. Provided networking and end-user technical support for Win95, all versions of Internet Explorer up to 4.0 and Internet Explorer for the Macintosh. The network support for Win95 involved many platforms including Windows NT, Novell NetWare, and Macintosh computers. Provided excellent customer service and troubleshooting expertise in supported products.

4/95 - 1/96
Help Desk Technician
North Seattle Community College, Seattle, Washington

Performed various on-site networking functions including working at their in-house help desk. Provided technical support over the phone for faculty members involving many different issues and platforms. Helped set up computer labs, running cable and configuring new computers for student use. Attended North Seattle Community College, obtaining a Technical Support Specialist Certificate.

Interests

Family, music composition, photography, web design, hiking, mountain-biking, fishing and camping.

Education

I have current Microsoft Certified Professional (MCP) certifications in server 2003 and am working to complete my MCSE certification.

I posses basic C, C+ programming experience, knowledge in Python, Visual Basic and other scripting languages and troubleshooting. Included in my experience are web design, hosting, web server configuration and troubleshooting.

North Seattle Community College – 1994-1996
Seattle, WA

Evergreen State College – 1986-1988
Olympia, WA

Graduated Oliver M. Hazen High School - 1986
Renton, WA

WILLIAM C. GUEST III

PROFESSIONAL SUMMARY

Twenty-nine years of administrative management and financial experience in the healthcare field with progressively increasing scope of responsibilities and influence. Demonstrated strengths in general and decision support management including administration, budgeting, financial planning, cost accounting, productivity systems and case mix management. Management experience over reimbursement, management engineering and managed care functions. Varied experience at a large acute care non-profit hospital setting, at the corporate office of a multi-hospital regional non-profit health care network and at a for-profit provider owned managed care organization. Solid background in financial operations and integrated financial systems. Excellent problem solving skills based on an approach that emphasizes process-based analysis, collaboration, facilitation and innovation. Knowledgeable in wide variety of personal computer systems and software, and their use as analytical or problem solving tools. Effective communicator of ideas and solutions to employees, management, and Boards.

PROFESSIONAL EXPERIENCE:

Cascade Comprehensive Care Inc., Klamath Falls, Oregon - June 1996 to Present
President and Chief Executive Officer

Hired at this physician owned managed care organization responsible for 10,000 Oregon Health Plan (Medicaid) covered lives. Successfully negotiated sale of stock to new primary care physicians. Guided transition of company from physician care organization to a fully capitated health plan, with revenues growing from $4.7 million to $13 million in first three years and to $34 million in 2011. Implemented risk contracts with primary care physicians, specialist's Independent Practice Association and local hospital. Designed and implemented risk pools for primary, secondary (specialty), institutional, pharmacy, lab, and alcohol/drug treatment. Negotiated sale of company to future minority shareholders of specialists and local non-profit hospital in accordance with long-term company strategic goals. Responsibilities include direct and indirect management of the following functions: provider contracting, claims adjudication, member services, quality assurance, utilization management, information systems, case management, risk/actuarial management (including stop-loss insurance and IBNR calculations), human resources and financial management. Helped create ATRIO Health Plans Inc. (12,000 enrollees), and obtained a Medicare Advantage Contract with federal government. Acted as Executive Director of Preferred Health Plan Inc, (a licensed commercial health insurance company) via a management services contract.through employer.

Holy Cross Health Services of Utah, Salt Lake City, Utah - 10/90 to 5/96
Vice-President, Finance and Chief Financial Officer 8/94 to 5/96
Director of Financial Planning - Regional Office 7/92 to 8/94
Director of Budgeting and Corporate Reporting 10/90 to 7/92

Hired at the corporate office as a Director of Budgeting and Corporate Reporting just as this system was creating an integrated healthcare delivery system from its three decentralized hospitals and twelve primary care clinics. Promoted to Director of Financial Planning and assumed additional responsibilities of cost accounting, and case mix management as CFO positions were eliminated at hospital subsidiaries and consolidated at a regional level. Communicated monthly financial status of regional subsidiaries to board and management through both written reports and board committee presentations. In FY 94, Holy Cross Health Services of Utah had gross revenues in excess of $220 million, assets of $156 million, and annual capital budgets of $10 -20 million. Promoted to Vice-President, Finance and Chief Financial Officer to coordinate financial merger and dissolution activities when regional facilities were sold to HealthTrust Inc. in August 1994.

Saint John's Hospital and Health Center, Santa Monica, California - July 1983 to October 1990
Director of Financial Planning 9/88 to 9/90
Director of Budget and Reimbursement 12/86 to 8/88
Senior Financial Analyst 10/84 to 11/86
Financial Analyst 7/83 to 10/84

EDUCATION:
Master of Public Administration/Health Services Administration, 1983, Brigham Young University, Graduated with Distinction. GPA = 3.83/4.00.
Bachelor of Science, Magna Cum Laude, 1982, Brigham Young University,
Major: Finance, Minor: Business. GPA = 3.82/4.00.

OTHER EXPERIENCE:
- **Board of Directors, ATRIO Health Plans Inc.**(Medicare Advantage Plan), Chairman, July 2005 to July 2006; Director, July 2005 to Present; Chairman, January 2012 to present
- **Board of Directors, Klamath Basin Senior Citizen's Council,** July 2006 – Present
- **Board of Directors, PHP Health Plan** August 2000 to January 2010
- **Executive Director, PHP Health Plan,** November 2006 to November 2007
- **Board of Directors, St. John's Federal Credit Union,** December 1987 to September 1990.
- **Volunteer Service** - LDS Church, Veracruz and Oaxaca, Mexico, (Speak, read, and write fluent Spanish), July 1977 through June 1979.

ACADEMIC SCHOLARSHIPS AND HONORS:

Advanced Member, Healthcare Financial Management Association
Valedictorian - Samuel Ayer High School, 1976, GPA 3.98/4.0
Student Body President, Samuel Ayer High School, 1975-76

M. Katherine Pence, RN, BSN, MBA
5393 Knightwood Drive
Klamath Falls, OR 97603
541-850-2016 work
kathyp@cascadecomp.com

Thirty-five years of Nursing and Nursing administration experience in rural healthcare settings in the Pacific Northwest. Demonstrated experience in budgeting, management, resource management, quality improvement and accreditation. Effective communicator in collaborative community settings, staff and committee meetings. Strong background in project management, experience in computer software implementation. Varied clinical experience in non profit hospital settings and outpatient dialysis. Recent managed care experience in Medicare and Medicaid programs.

Work History:

Director of Operations
Cascade Comprehensive Care, May 2011- present
Klamath Falls, OR

Director Quality Improvement
Cascade Comprehensive Care, 3/2007 – May 2011
Klamath Falls, OR

Clinical Manager Sky Lakes Dialysis Center 1/2001 – 3/2007
Klamath Falls, OR

Staff RN West Dialysis Center (Sky Lakes) 1/2000 – 1/2001
Klamath Falls, OR

Director Med/Surg/Orthopedics, 11/1991- 1/2000
Merle West Medical Center
Klamath Falls, OR

Director Medical/Surgical Services and ICU, 5/1987 – 11/1991
Ketchikan General Hospital
Ketchikan, Alaska

Nursing Supervisor, 9/1985- 5/1987
Ketchikan General Hospital
Ketchikan, Alaska

Nursing Manager Med/Surg/Orthopedics, 1979-1982, 1983 - 1985
Tillamook General Hospital
Tillamook, OR

RN Office Staff, 1982-1983
Clyde E. Hunt, MD
Orthopedics
Tillamook, OR

RN Staff, 1977-1979
Ashton, Memorial Hospital
Ashton, Idaho

Education:

Bachelor Science Nursing 1977
Idaho State University
Pocatello, Idaho

Masters Business Administration 1991
University of Alaska, SE
Juneau, AK

Certifications:
Nursing Administration, CNA 1986 - 1991
Nephrology Nursing, CNN 2006 -2009

Professional Associations
Board Member Klamath Crisis Center 7/2010 – 5 /2011
Soroptimist International Klamath Falls 1999 – present

Curriculum Vitae

Lawrence Lee Cohen, M.D. FAAFP

Home address:

P.O. Box 331
Chiloquin, OR 97624

Work addresses:

Cascades East Family Medicine Residency
2801 Daggett Ave.
Klamath Fall, OR 97601

Cascade Comprehensive Care
2909 Daggett Ave, Suite 200
Klamath Falls, OR 97601

Phone:
Home 541-783-3412
Office 541-274-6733
Office 541-883-2947

Cell: 541-892-4891
e-mail: docman@centurytel.net

Education:

-UCLA, Los Angeles, Ca. B.A., Zoology 1975

-Autonomous University of Guadalajara, Mexico M.D. 1979

-U C Irvine School of Medicine, Irvine, Ca. Fifth-Pathway Certification 1980

-Loma Linda University School of Medicine, Glendale Adventist Medical Center Family Practice Residency Program 1980-1983

Licensure/Certifications:

-ACLS certification 1980, 1984, 1996, 2006

-State of California M.D. (unlimited) 1981-1995

-State of Oregon M.D. (unlimited) 1993-Present

-DEA license 1981-Present

-Certification/Recertification
American Board of Family Practice 1984, 1990, 1996, 2002, 2009

-Fellow, American Academy of Family Practice 2010-Present

Professional experience:

-Private group practice (Family Medicine) Glendale, Calif. 1984-1993

-Clinical Instructor, Loma Linda University School of Medicine
Glendale Adventist Medical Center Family Practice residency 1985-1990

-Public practice (Federally Qualified Health Center) Chiloquin, OR 1993-1997

-Private solo practice Chiloquin, OR 1997-2006

-Clinical instructor, OHSU School of Nursing 1997-2002

-Adjunct Assistant Professor. OHSU School of Medicine 2002-2006

-Assistant Professor, OHSU School of Medicine, Department of Family Medicine
Cascades East Family Medicine Residency Program 2006-Present

-Medical Director, Cascade Comprehensive Care, Inc Feb 22, 2012-Present

Special skills/experience: -Fluent in Spanish

Leadership positions:

-Chief Resident, Glendale Adventist Family Medicine Residency Program 1983

-Family Practice Department Vice-chairman and Chairman
Verdugo Hills Hospital, Glendale, California 1988-1991

-Medical Staff Vice-President and President
Merle West Medical Center/Sky Lakes Medical Center 2005-2008

Professional societies:

-Klamath County Medical Society 1994-Present

-Oregon Medical Association 1994-Present

-American Academy of Family Practice 1984-Present

Personal:

-married, no children

-interests include kayaking, hiking, bicycling, traveling/camping, choral singing

Curriculum Vitae

Lawrence Lee Cohen, M.D. FAAFP

Home address:

P.O. Box 331
Chiloquin, OR 97624

Work addresses:

Cascades East Family Medicine Residency
2801 Daggett Ave.
Klamath Fall, OR 97601

Cascade Comprehensive Care
2909 Daggett Ave, Suite 200
Klamath Falls, OR 97601

Phone:
Home 541-783-3412
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Cell: 541-892-4891
e-mail: docman@centurytel.net

Education:

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-State of Oregon M.D. (unlimited) 1993-Present

-DEA license 1981-Present

-Certification/Recertification
American Board of Family Practice 1984, 1990, 1996, 2002, 2009

-Fellow, American Academy of Family Practice 2010-Present

Professional experience:

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-Clinical Instructor, Loma Linda University School of Medicine
Glendale Adventist Medical Center Family Practice residency 1985-1990

-Public practice (Federally Qualified Health Center) Chiloquin, OR 1993-1997

-Private solo practice Chiloquin, OR 1997-2006

-Clinical instructor, OHSU School of Nursing 1997-2002

-Adjunct Assistant Professor. OHSU School of Medicine 2002-2006

-Assistant Professor, OHSU School of Medicine, Department of Family Medicine
Cascades East Family Medicine Residency Program 2006-Present

-Medical Director, Cascade Comprehensive Care, Inc Feb 22, 2012-Present

Special skills/experience: -Fluent in Spanish

Leadership positions:

-Chief Resident, Glendale Adventist Family Medicine Residency Program 1983

-Family Practice Department Vice-chairman and Chairman
Verdugo Hills Hospital, Glendale, California 1988-1991

-Medical Staff Vice-President and President
Merle West Medical Center/Sky Lakes Medical Center 2005-2008

Professional societies:

-Klamath County Medical Society 1994-Present

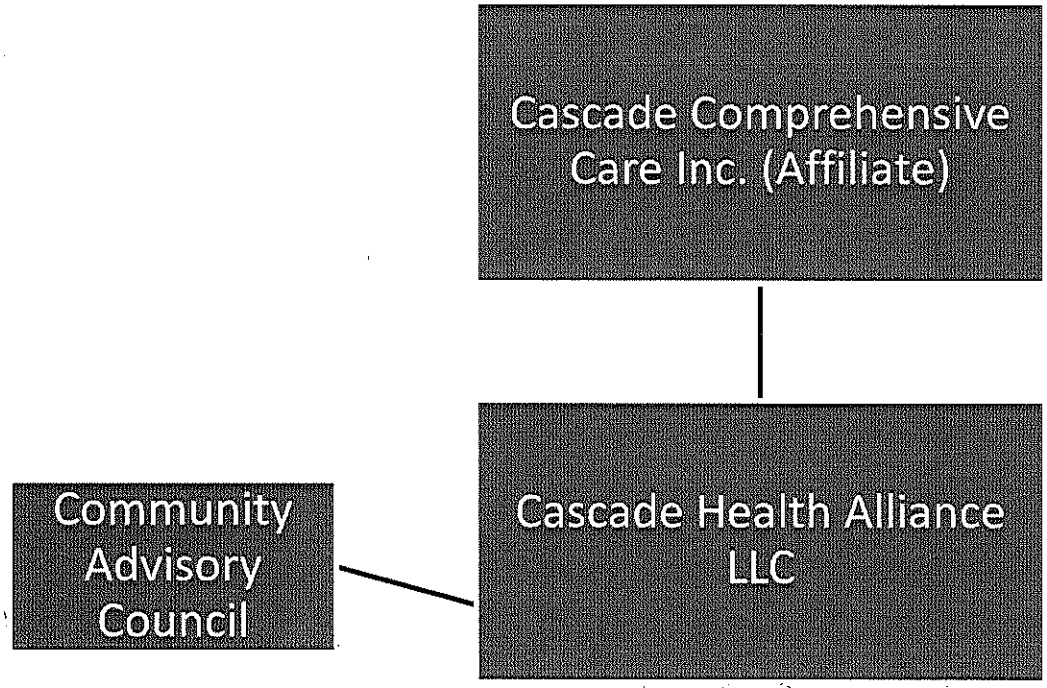
-Oregon Medical Association 1994-Present

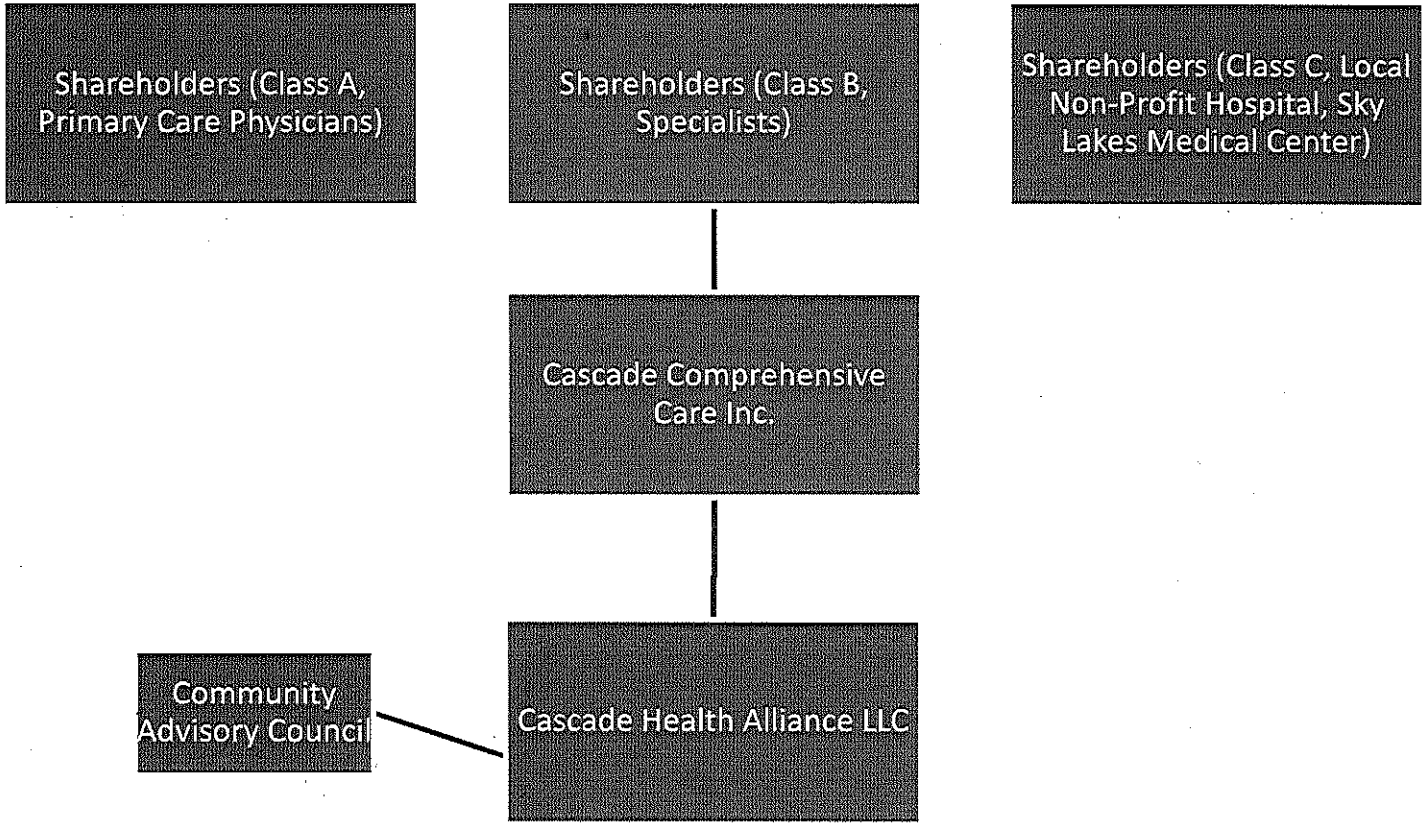
-American Academy of Family Practice 1984-Present

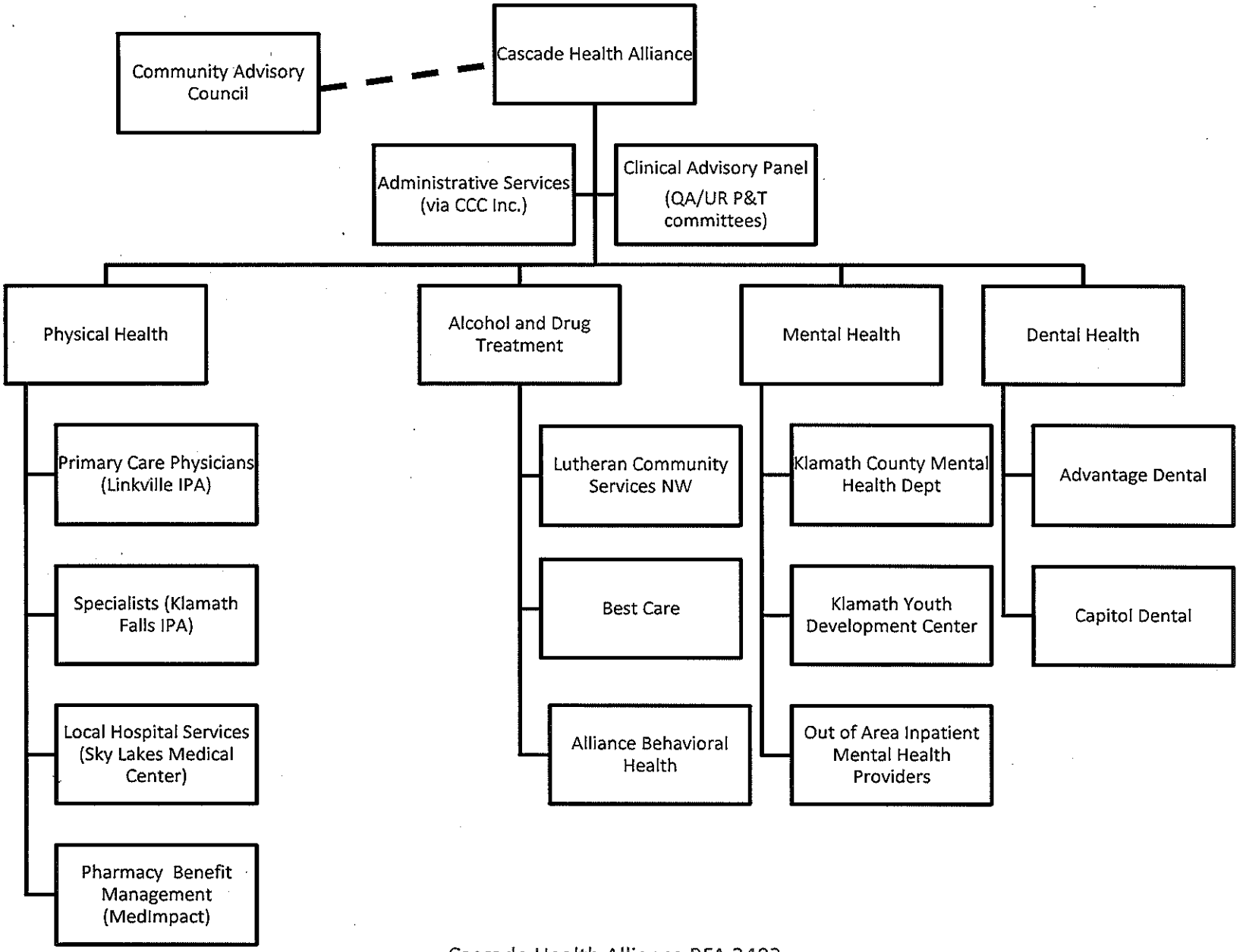
Personal:

-married, no children

-interests include kayaking, hiking, bicycling, traveling/camping, choral singing


Cascade Comprehensive Care Inc. (Affiliate)
Cascade Health Alliance LLC
Community Advisory Council


Shareholders (Class A, Primary Care Physicians)
Shareholders (Class B, Specialists)
Shareholders (Class C, Local Non-Profit Hospital, Sky Lakes Medical Center)
Cascade Comprehensive Care Inc.
Community Advisory Council
Cascade Health Alliance LLC


Community Advisory Council
Cascade Health Alliance
Administrative Services (via CCC Inc.)
Clinical Advisory Panel (QA/UR P&T committees)
Physical Health
Alcohol and Drug Treatment
Mental Health
Dental Health
Primary Care Physicians (Linkville IPA)
Specialists (Klamath Falls IPA)
Local Hospital Services (Sky Lakes Medical Center)
Pharmacy Benefit Management (MedImpact)
Lutheran Community Services NW
Best Care
Alliance Behavioral Health
Klamath County Mental Health Dept
Klamath Youth Development Center
Out of Area Inpatient Mental Health Providers
Advantage Dental
Capitol Dental

Service Area Table For Cascade Health Alliance		
Service Area Descripton	Zip Codes	Maximum Number of Members - Capacity Level
Klamath County (partial)	97601, 97602, 97603, 97604, 97621, 97622, 97623, 97624, 97625, 97626, 97627, 97632, 97633, 97634, 97639	10,600

Cascade Health Alliance APPENDIX A – CCO Criteria Questionnaire

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.
Cascade Health Alliance, LLC
2909 Daggett Ave, Suite 225 Klamath Falls, OR 97601.

b. Describe Applicant's Affiliates as relevant to the Contract. **Cascade Health Alliance (CHA) affiliated with Cascade Comprehensive Care (CCC) as its parent company.**

c. What is the Applicant's intended effective date for serving Medicaid populations? **CHA intends to have a contract effective August 1, 2012.**

d. Is the Applicant invoking alternative dispute resolution with respect to any provider (*see* OAR410-141-3268). If so, describe.
We have not invoked alternative dispute resolution at this time. We have been contacted by Theresa Jensen who works for "Oregon Consensus" who had been asked by the Oregon Health Authority to " provide a wide range of neutral process support to whatever configuration of CCO(s) emerge in Klamath County." We have had two conversations with Ms. Jensen on the phone and accepted her request to meet with her (which we did on April 24, 2012 in Klamath Falls, Oregon. 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.

NA

f. What is the proposed service area by zip code?
Klamath County 97601, 97602, 97603, 97604, 97621, 97622, 97623, 97624, 97625, 97626, 97627, 97632, 97633, 97634, 97639

g. What is the address for the Applicant's primary office and administration located within the proposed service area?
2909 Daggett Avenue, Suite 225
Klamath Falls, OR 97601

h. What counties or portions of counties are included in this service area?
Klamath County zip codes 97601, 97602, 97603, 97604, 97621, 97622, 97623, 97624, 97625, 97626, 97627, 97632, 97633, 97634, 97639
Describe the arrangements the Applicant has made to coordinate with County governments and establish written agreements as required by ORS 414.153
MOUs with Klamath DHS for LTC, KCMH and Klamath County Health Department have been requested to address provision of required services. CHA expects to have MOUS in place prior to contract signing.

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")? **Yes.** If so, what type of managed care organization?
Fully Capitated Health Care Plan.

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, the legal entity has changed. The current MCO (CCC) has incorporated a subsidiary, Cascade Health Alliance, LLC (CHA); CHA is the legal entity applying to be the CCO.

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. **No**

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? **YES** Does this Application propose any change in the current Service Areas? **We are asking that all requested service area zip codes be opened to CHA until a capped limit of 10,600 is reached. Our enrollment capacity may be adjusted in the future as access to primary care providers changes.**

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")? **No**

n. Does the Applicant have experience as a Medicare Advantage contractor ? **We have experience indirectly through our subsidiary ATRIO a Medicare Advantage Plan who provides coverage for our dual eligible members.** Does the Applicant have a current contract with Medicare as a Medicare Advantage contractor? **NO**
What is the service area for the Medicare Advantage plan?
Klamath County zip codes 97601, 97602, 97603, 97604, 97621, 97622, 97623, 97624, 97625, 97626, 97627, 97632, 97633, 97634, 97639.

o. Does the Applicant hold a current certificate of insurance from the State of Oregon Department of Consumer and Business Services, Insurance Division? **NO**

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.
CCC/CHA intends to continue and expand its current risk-sharing model. Although not directly rewarding healthcare quality, it has provided demonstrably improved health outcomes. This model works in this geographically isolated high desert basin because its residents are more likely to remain with CCC/CHA than a similar population in areas where there is access to other health plans. Our members are our neighbors and will remain so. Therefore, their long-term well-being benefits not only providers, but the community as a whole.

(2) Coordinating the delivery of physical health care, mental health and chemical dependency services, oral health care and covered DHS Medicaid-funded LTC services.
CHA has 16 + years operational experience with the CCC Medical Management and Case Management (CM) team coordinating the delivery of physical health care, mental health care, chemical dependency services, outpatient pediatric dental services and covered DHS Medicaid LTC services. Our CM team has effectively coordinated the care of our 9650+ members addressing prior authorization of requested services, coordinating care with members, PCPs and other ancillary services. CHA RN Case Managers communicate and collaborate with Mental Health case managers/providers, APD arranging appropriate placement and services for our members as needed. RN case managers also coordinate with members, PCPs and local Substance Abuse Disorder providers for substance abuse disorders referrals utilizing screening, brief intervention, referral and treatment. CCC has supported the implementation and utilization of the SBIRT model of screening and intervention by our primary care providers. We have collaborated with the local mental health department and chemical dependency treatment providers to facilitate referrals for Mental Health and Chemical dependency through use of referral form that is inclusive of release of information. CCC also coordinated a year-long effort in 2011 to place an Substance Abuse Disorders counselor in both of our two largest clinics on a part-time basis.
In the past month we have added another RN case manager to assist in our chronic disease management program. We have in place active and effective ENCCs (Exceptional Needs Care Coordinators) who assist our 1950+ ENC members with Transitions of care to and from all levels of care including individualized care plans shared with PCP, sending and receiving facilities and member/family when appropriate. We have well - established working relationships with our local DHS APD, Long Term Care providers, assisted living

facilities, and our many Adult Foster Homes/Programs in the community.
CCC also employs an RN Maternity Case Manager (MCM) who coordinates care for all pregnant members. Emphasis is on high risk mothers to promote healthy moms and healthy babies, reduce prematurity and complications. The MCM collaborates with PCP, OB provider, member, DHS and other appropriate services to assure early prenatal care, prevention, education, screening and treatment referral for tobacco use and or substance abuse. We have an incentive program of a $50.00 gift card to a local department store for every mom who meets criteria. (Sign up for WIC, sees her dentist, makes prenatal visit before 13 weeks plus documentation of additional three visits, contacts with MCM three times through-out pregnancy, optimally one of these face to face, take prenatal vitamins).

We will be exploring the opportunity for utilization of doulas within our community in the next year or two as we further refine our program.

Moving forward CHA and its Case Managers will be assisting members in gaining access to non-covered services and that are provided under separate contract with OHA. As stated above we have working relationships with Mental Health, DHS APD and Chemical Dependency providers that will facilitate these interventions through the use of shared treatment/care plans.
For most of the past twenty years, our medical director has functioned as medical director for all of the residential and most of the outpatient substance abuse disorders providers programs in our community. His close relationships with the counselors has proved a valuable resource, facilitating the communication among various providers as well as with CCC.

(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.
CHA reviews available data regularly to get a sense of our population demographics. We have participated in the past with a collaborative effort with Klamath County Health Department in the Early Childhood Cavity Prevention program. Klamath County was a demonstration project and we saw significant improvement in our children's oral health. We have participated in PIPs that addressed Asthma, Tobacco Cessation and Substance Abuse Disorders. Through collaboration with our affiliated Medicare Advantage Plan, ATRIO we have worked with our SNP population to improve
quality indictors/outcomes for members with diabetes. CHA sees the transformation under the CCO model as an opportunity to engage our community members and health care providers in making meaningful changes and continue to address health needs of our county.
According to U.S. Census data, Klamath County had a population of approximately 66,380 in 2010, with a growth rate of 4.1 percent since 2000. The 2010 census indicates that the Hispanic or Latino population had the largest percentage of change.

AGE	%		ETHNICITY	%
Under 18	22.3		White	85.9
18-64	60.6		Black	0.7
65 and older	17.1		American Indian	4.1

SEX			Asian	0.9
Female	50.2		Hispanic	10.4
			2 or more	4.1

Persons Below the Federal Poverty Level	%
Klamath County	20.2
Oregon	14.3

2009 US Census Bureau

Leading Causes of Death in Klamath County:

- Cancer
- Heart Disease
- Diabetes
- * Chronic Lower Respiratory Disease
- * Stroke

Klamath County has a high prevalence of tobacco use, high blood pressure, obesity and high cholesterol, teen pregnancy, low rates of high school graduation.
Tobacco use and obesity are the leading causes of preventable death.
Source: Klamath County Health Dept report 2012/2013.

Number of individuals in Klamath County with developmental disabilities –
Children- 146 Adults 486
Number of individuals who live in licensed/certified home (group home, foster care...)
Children 19 Adults 104
Number of Adults in Support Service Brokerage 175
Carrie Buck Program Manager, Klamath County

CCC has worked with OHSU/CEFM residency clinic to bring substance abuse disorders providers into the office on a part time basis so that referrals can be initiated at the time the Primary Care Provider is seeing them. This has made a slight increase in substance abuse disorders treatment penetration but more over the rewards have been in the education of the residents and improving the communication and collaboration between substance abuse disorders providers and PCP.

CCC/CHA has programs in place to assist our members with diabetes. Members obtain their meter and testing supplies directly from CHA. An RN case manager reviews with the member their current understanding of diabetes, provides education related to blood glucose testing, diet, foot care and other important aspects of care. CM is able to determine whether a referral to a dietitian would be in the member's best interest and facilitates this referral. Case Manager or CM assistant down load member glucose meter data at each visit and relay the results to the PCP as well as the member, this is a teachable moment with the member. This approach supports the triple aim improving health, outcomes and decreasing costs. (CHA is able to purchase meters/supplies at a discounted price for our members' use at no cost to the member.) As we have more certified PCPCH's members will have more structure and support in meeting their health care needs and goals.

CCC/CHA provides Tobacco Cessation classes at no charge to our members. CHA covers tobacco cessation medications as ordered by member PCP. CCC/CHA has experienced a 20-40% quit rate among members

who participate in our program by self report. Members are allowed to attend as often as needed to achieve abstinence. The program is also open to the public for a nominal fee to cover education materials. Classes

are held year around at the Liskey Henzel Pavillion located near public transportation. Plus members have transportation available to them through their benefit package for these health education meetings. Members are self-referred or referred by Case Managers, PCPs and other providers. Looking ahead we need to collaborate with the CAC to identify ways to engage more members in tobacco cessation, by age, ethnicity and sex.

We also meet with local Mental Health, APD Caseworkers and Hospital Discharge staff to review member needs and develop a comprehensive Case/Treatment Plan that is shared with the member/family/caregiver and the Primary Care Providers. In the future with our work through the CCO we would like to explore new programs and outreach to more members. With results from a Community Needs Assessment we are hopeful that areas that may be lacking will be identified and measures can be put into place.

q. Identify and furnish résumés for the following key leadership personnel (by whatever titles designated): **Provided as separate documents for Appendix A**

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

r. Provide an organizational chart showing the relationships of the various departments. **Provided as separate documents for Appendix A**

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 **YES, Provider Contracts, Table B-1 (Participating Provider Table, MOUs, updated policies and procedures related to Medicare Assurances.**

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.
Cascade Health Alliance leaders and staff are reaching out to community leaders and members to receive input related to the community health needs assessment and the formation of the Community Advisory Committee. The Director of Operations is working with a diverse group of community leaders (including Sky Lakes Medical Center and Klamath County Health Department) to identify and secure a community wide needs assessment software program. Currently we are evaluating the product through Healthy Communities Institute. It is planned that this tool will be available to not only those providers requiring federal and state reporting requirements, but also community health providers, members and community at large. The local OHSU School of Nursing is gathering primary data from Klamath county residents to supplement this data base. We are engaging community members, specifically the local School of Nursing (OHSU) with request for continuing education offerings for RN Case Manager curriculum. We are also assisting our local primary care providers in achieving PCPCH certification. CHA staff and Board

members have reached out to other community groups requesting input related to the RFA from all but not limited to: Klamath County Mental Health, Klamath County Health Department, Sky Lakes Medical Center, Cascades East Family Medicine Residency, Klamath Community College, local IPAs, Med Impact, (PBM), ATRIO our partner for Medicare Advantage Plan, Klamath Open Door Family Practice (FQHC). CHA is soliciting feedback and participation with community leaders including the county commissioners to assist in the development of the Community Advisory Council. The CAC will have a majority representation of members who utilize CHA's services and represent members from the majority as well as the minority groups who utilize the CCO's services from Klamath County . This committee is currently under development and will reflect the geographic area served by CHA by age, race, ethnicity, economic status education and other meaningful factors. A public presentation is planned for May to share with the general public information about CCOs and CHA in particular.

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 Structure, consistent with ORS 414.625.

The Board of Directors of Cascade Health Alliance LLC shall consist of representatives of the following constituencies:

1. A majority interest consisting of the Persons that share in the financial risk of the organization who must constitute a majority of the governance structure, as follows: 3 shareholders (representing primary care physicians)/directors of the member, 3 shareholders/directors (representing specialists or non-primary care physicians of the member, and 3 appointed by the shareholder of the member representing Sky Lakes Medical Center, which is the local non-for profit hospital;

Representatives of the major components of the health care delivery system;

2. At least two health care providers in active practice, including:
   (a) A physician licensed under ORS chapter 677 or a nurse practitioner certified under ORS 678.375, whose area of practice is primary care; and
   (b) A mental health or chemical dependency treatment provider;
3. At least two members from the community at large, to ensure that the organization's decision-making is consistent with the values of the members and the community; and
4. At least one member of the community advisory council.

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.

In the absence of the identification of local county government designated members for the CAC member selection committee, we have identified a potential composition for the CAC.

1	Klamath County Representative
2	Klamath County Mental Health
3	Klamath County Health Dept
4	Klamath Youth Development Center
5	OHSU /CEFM (Residency Program)

6	Sky Lakes Medical Center
7	Klamath Falls Independent Physician Assoc. (Specialists)
8	Linkville IPA (Primary Care Physicians)
9	Dental
10	Substance Abuse Disorders
11	Consumer Representative
12	Consumer Representative
13	Consumer Representative
14	Consumer Representative
15	Consumer Representative
16	Consumer Representative
17	Consumer Representative
18	Consumer Representative
19	Consumer Representative
20	Consumer Representative
21	Consumer Representative

The community advisory council will include representatives of the community and of Klamath County government. Consumer representatives will constitute a majority of the membership. The CAC will meet no less frequently than once every three months. Its membership will be selected by a committee composed of equal numbers of county representatives and the members of the governing body of Cascade Health Alliance LLC.

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 Board of Directors of CHA will appoint as yet to be determined number (tentatively three but subject to negotiation with the local Klamath County government upon their response to previous requests to engage in the process) of their members to serve on the community advisory council selection committee (the "Selection Committee"). The Board of Directors of CHA will request that the Klamath County Board of Commissioners appoint an equal number of persons who are residents of Klamath County to serve on the Selection Committee."

The Selection Committee shall meet as needed to select members of the community advisory council. In making its selections, the Selection Committee shall comply with the equal representation requirements between the governing entity and the Klamath County government

A member of the community advisory council may resign at any time or be removed by majority vote of the Selection Committee at any time without cause. The Selection Committee may specify terms of office for members of the community advisory council, or adopt such policies and procedures as it considers desirable to facilitate appointment to the council of a group of individuals who meet the representation requirements set forth in subparagraph 2(a) above and are qualified to accomplish the duties of the council.

The Board of Directors of Cascade Health Alliance LLC shall consist of representatives of at least one member of the community advisory council.

The duties of the community advisory council include, but will not be limited to:

(a) Identifying and advocating for preventive care practices to be utilized by CHA;

(b) 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 CHA; and

(c) Annually publishing a report on the progress of the community health improvement plan.

5. The community health improvement plan adopted by the council should describe the scope of the activities, services and responsibilities that CHA will consider upon implementation of the plan. The activities, services and responsibilities defined in the plan may include, but are not limited to:

(a) Analysis and development of public and private resources, capacities and metrics based on ongoing community health assessment activities and population health priorities;

(b) Health policy;

(c) System design;

(d) Outcome and quality improvement;

(e) Integration of service delivery; and

(f) Workforce development.

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.

Behavioral and physical health providers in addition to consumers or family members with experience with Severe and Persistent Mental Illness (SPMI) or LTC services will participate in CHA's Community Advisory Council (CAC). Through review of the community needs assessment CAC members will have input towards developing the community health plan that will incorporate the needs of the members with severe and persistent mental illness or receiving LTC services. The Board will also be involved in the creation (as well as being members of) of clinical advisory board committees such as Utilization Management, Quality Improvement, and Pharmacy and Therapeutics. These committees will include representation from physical, mental and eventually dental health who will be able to assist the Governing Board in meeting the needs of members with severe and persistent mental illness and members receiving DHS Medicaid-funded LTC services.

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.

CHA, through Cascade Comprehensive Care has an established CAP. CCC/CHA has long-standing committees, (Quality Assurance, Utilization Review, and Pharmacy and Therapeutics). Their membership includes; Primary Care Physicians, local Physician Specialists, representatives from Sky Lakes Medical Center, CCC Medical Director and RN Case Managers. These committees review and

revise current and new policies and procedures along with clinical guidelines. The committee members seek out best practices and validate through established national guidelines (Milliman , ACOG, AAPP, etc.) It is our intention to incorporate additional provider members from Mental Health, Addictions and and Dental Health in our newly formed CCO. Final approval of policies, procedures and clinical guidelines is made by the Governing Board.
Having all services at the table will enhance the collaboration and communication to meet the triple aim goals of improving Health, improving Health Care and reducing cost.

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.
CHA is currently working with the local APD office to develop the formal MOU based on the template and guidance provided. MOU will completed before contract signing date. Draft content spelled out under A.3.5.j.

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.

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.
CHA is actively seeking an MOU with Klamath County Mental Health Authority. In our proposed CCO service area there is a Community Mental Health Provider (CMHP) delivering adult services, a CMHP that delivers child and family care, and providers that deliver chemical dependency services. There currently exists a robust, broad array of mental health and chemical dependency services, and our plan is to collaborate with the current providers in the region to continue and expand upon these services. Our longer term vision is to shift the existing behavioral health delivery system toward a

patient oriented health home model. We have already started these discussions, and if we are selected as a CCO that planning process will become more rigorous and focused. Historically CHA has worked closely with each. CHA Case Managers collaborate with Mental Health and Chemical Dependency Staff and or the member to assist the member in gaining access to non-covered services The CHA ENCC staff has begun working closely over the last 4 months to coordinate care for Members with both Mental and Physical Health issues. Our discussion with the County Mental Health Authority, CMHPs, and other local behavioral health providers focus on developing a comprehensive and coordinated behavioral health delivery system, and to ensure that our members have access to services which are not going to be provided under the global budget. In this process the staff has learned to address the Member's concerns and satisfaction along with meeting the physical and mental health needs of the member. There has also been discussion on issues identified regarding the Community Health Risk Assessment. The combined Staff has indicated that they would be in a position to make suggestions on services and changes in current programs that will make the system more efficient and expand in areas that may currently be inadequate to meet the needs in the community. CHA will collaborate with our County's Mental Health Authority to ensure that our members have access to the safety net services that are not included in the global budget. We will develop agreements for Crisis response, respite services, residential services, civil commitment and other local safety net services which will be included in our array of care for CHA members.

A.1.4.b. How will Applicant ensure that members receiving services from extended or long-term psychiatric care programs (e.g., secure residential 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?

Oregon Administrative Rules 309-032-1540 through 309-032-1550 identify requirements for service transfer and continuity of care for extended and long-term care behavioral health programs. CHA will comply with these rules, and ensure that CHA case managers interact with extended, long-term, residential, and hospital programs as well as CHA members and families to ensure collaboration and coordination of services. As a Fully Capitated Health Plan, Cascade Comprehensive Care already has medical case managers who coordinate health care services for its members. This often involves facilitating transitions from any type of facility, local or distant, and assuring that appropriate outpatient follow-up arrangements are firmly and timely in place. These arrangements frequently include discussion with the mental health provider. Most such discharge arrangements give us from hours to a couple days, so a five-working-day window would be relatively leisurely. As a CCO, CHA will expand its case management staff and develop policies and procedures that will require consumer and family involvement in transition planning. CHA case management staff will also assure that necessary services and actions occur to address the identified health and safety needs of members transitioning between services, and that members receive follow-up services as medically appropriate. Discharges will take place within five working days of receiving notification of discharge readiness.

CHA will utilize the procedures for Long – term Psychiatric Care Programs for 0-17, 18-64 and 64 and over, to ensure members receive services as medically appropriate to ensure discharge within five working days of receiving notification of discharge readiness.

CHA will also use Utilization Review and Case Management Transitions of Care Plan to facilitate the seamless transition of the member to the next appropriate level of care. CHA will make every effort to include the member/family and or caregiver in the care plan to promote continuity of care. In addition the Primary Care Provider and other members of care team will be involved and review the care plan for appropriateness, timeliness and cost effectiveness.

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?

CHA will ensure that 24/7 on call services are available to provide screening to determine nature of the situation and the member's immediate need for Covered Services; capacity to conduct the elements of a Mental Health Assessment that are needed to determine the interventions necessary to begin stabilizing the crisis situation; development of written initial services plan at the conclusion of the Mental Health Assessment, provision of covered services and outreach needed to address the Urgent or Emergency Situation and linkage with the public sector crises services, such as pre-commitment. CHA expects these services will be provided through our anticipated MOU with Klamath County Mental Health and Klamath Youth Development Center, who have these services in place and have provided them historically in collaboration with Sky Lakes Medical Center Emergency Room, local police, courts and juvenile justice, corrections providers.

Implementation of local drug and mental health courts would be interventions that could improve member outcomes and decrease overall costs. ENCCs and Case Managers from either the Physical Health or Mental Health systems would then follow the member to assure that the Member continues to receive the agreed upon services and that the Care Plan is updated as the Member's condition changes.

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

The CHA will continue to support and encourage community partners in providing the Triple Aim to the members. Currently the CHA through CCC has developed working relationships with the local APD, AFS, and DD caseworkers, Klamath County Mental Health Caseworkers, Klamath Youth Development Center, substance abuse disorders providers treatment agencies, local Law Enforcement including Parole Officers and as the case demands the Courts. The CCC staff frequently works with the local Tribal office to coordinate care for members covered under both the Tribal Health System and the OHP. CCC ENCCs and Case Managers work closely with the local School Nursing staff to assure members at the school are receiving the care and supplies that is required to promote better health and safety. Contact is also maintained with the local State RNs for the care of the LTC members in the community.

These are the majority of contacts that the CHA ENCCs and Case Managers currently maintain but not an all-inclusive list of partners, which are utilized to provide exceptional Member care. The CHA ENCCs and Case Managers are continuously working to develop Care Plans with input from the Member, Provider and Community Services, which meet the member's goals for increasing their health and lower health care costs. CHA is also looking forward to developing new relationships and exploring innovative new programs to help enhance the member's overall health status.

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 prevention 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 public health agencies, mental health agencies, hospitals, etc., to be found 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.

Historically we have relied on community health assessments done by our local Klamath County Health Department and Sky Lakes Medical Center or our internal reporting. CHA's Director of Operations is working with a diverse group of community leaders including SLMC and KCHD to identify and secure a community wide needs assessment software model. Currently we are evaluating a product through Healthy Communities Institute. The program draws from current databases in the nation, state, region, county and zip code level. It is planned that this tool will be available to not only those providers requiring federal and state reporting requirements, but also the CAC, community health providers, members and community at large to avoid duplication of efforts. We intend to have a decision made in the next 4-6 weeks.
The data would be updated annually, and the site would be centrally managed in the local community. CHA will work with OHA, including the Office of Equity and Inclusion, to identify the components of the community health assessment that will need to be included for our purposes and reported out per OHA's data policy.

Applicant should describe the mechanisms by which the CAC will meaningfully and systematically engage diverse populations as well as individuals receiving DHS Medicaid-funded LTC and individuals with severe and persistent mental illness, in the community health assessment process.

The CAC will engage our covered populations including those with severe and persistent mental illness and those receiving DHS Medicaid-funded LTC services by using a wide range of available databases reflecting the diverse service area population. Composition of CAC will include covered members comprising at least 51 % of membership in addition to representatives from community wide physical health, mental health, chemical dependency, social services, dental, public health, schools, and other interested parties. The CAC be responsible for meeting regularly and for sharing community health assessment results and recommendations at minimum annually with the CCO and OHA.
An example of proposed representatives for CAC see A.1.1.b

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.
CCC/CHA follows policies and procedures designed to assist members in choosing providers, requesting second opinions, well women care, services not requiring referral and other member rights related to access to care as outlined in our contract with OHA. CHA continues to provide case managers to assist members with coordination of care, developing care plans jointly with members/care givers. CHA will continue to work with PCPs and PCPCHs to assure culturally and linguistically appropriate approach to member care and treatment plans through policies/procedures and provider education. New materials will be developed to reflect the new models of CCO and PCPCHs.

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.
PCPCHs will be actively engaging our members in their treatment plans with each visit. Cascades East Family Medicine Center, a PCPCH, through their EMR is currently providing members with copies of their treatment plan at the conclusion of their visit. The treatment plan includes medications, vital signs, instructions for care, member education and lab results when available. They have the capability to provide the majority of this information in Spanish, the local predominant non- English ethnic/cultural group. This particular clinic is also exploring

implementation of "My Chart" software. CHA is working with this clinic to determine whether this can be implemented community wide. "My Chart" is web based and allows members to sign in with password to view their own chart.
As part of the PCPCH certification, the PCPCH certified clinics will be gathering member experience data to measure member satisfaction with their PCP encounters.

CHA ENCC staff work closely with the Member and Primary Provider to develop a personalized and specific Care Plan during transitions of care. The member is encouraged to assist in defining a large portion of their goals and interventions. This process empowers the member and makes it more likely that they will meet the goals that they set for themselves and make lifestyle changes to better their health status.

Member surveys conducted through PCPCP's, CAHPs survey, member interactions and recommendations from the CAC will be reviewed, analyzed and acted upon through CHA's Quality Improvement Program. Information is fed back to providers as part of the quality improvement processes.

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 members about what they should expect from the CCO with regard to their rights and responsibilities; and
•Meaningfully engage the CAC to monitor and measure member engagement and activation. CHA is encouraging our providers to become PCPCHs as the model encompasses the above services. Cascade Health Alliance will work with our providers to develop culturally and linguistically appropriate materials to encourage members to utilize preventive services, and make healthy life style choices. As we move forward, we will encourage the development and use of peer support health care navigators in our clinic settings.
CHA will provide each enrollee with a new member handbook that meets their cultural and linguistic needs, taking into account the need for alternate formats for those members with disabilities, (aged, blind, hearing impaired). The member handbook will be written at a 6th grade level, addressing member rights and responsibilities, how to access a Patient Centered Primary Care Home, Emergent, Urgent and routine care and other information as per OARs and contract.
Meaningful engagement of the CAC to monitor and measure member engagement and activation will be facilitated by sharing CAHPs reports, utilization reports and community needs assessment information on a regular basis with the CAC. The CAC will be represented on the CHA governing board. CAC will be responsible to provide an annual report to OHA on the CCO/CHA performance.

Section 3 – Transforming Models of Care

Transformation relies on ensuring that Members have access to high quality care: "right care, right place, right time". This will be accomplished by the CCO through a provider network capable of meeting 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.

CHA is currently working with our provider network on an individual basis. We direct them to the PCPCH web site, follow up with their point person to answer questions, offer technical assistance, discuss available support through CHA to assist them in achieving Tier 1, 2, or 3 status. CHA is offering to assist with providing relevant member data, offer links and documentation related to cultural and linguistic needs of the members. CHA providers have in most cases staff who are qualified interpreters and are culturally competent for our Hispanic population. For those clinics without a Spanish interpreter or in need of another language they have access to CHA's contracted interpretation services at no cost to the clinic or the member.

A.3.1.b.Describe Applicant's plan for engaging Members in achieving this transformation. Integral to transformation is the member-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 member and family-centered approach to all aspects of care, and an emphasis on whole-person care in order to address a member's physical and behavioral health care needs.

CHA is working with our contracted providers to have all clinics achieve PCPCH status. We believe all of our members would be better served in this environment. The more clinics we have certified and engaged as primary care homes, the more exposure our members with have to the health care model and the services they provide. Currently we are working with the FQHC (Klamath Health Partnership) and Klamath Pediatric Clinic (Sanford Clinic) to achieve PCPCH status. Cascades East Family Medicine Center is a Tier 3 PCPCH. We will approach our remaining clinics over the course of the summer in assisting them in achieving Tier 1-2 or 3 status.

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 concrete 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.

CHA currently is contracting with:
Cascades East Family Medicine Center, Tier 3 Certified with member capacity for 2208 members. They will be adding 2 additional providers in August 2012 that will increase their capacity by approximately 1000 members.
We are in discussion with Klamath Open Door Family Practice for PCPCH application – Capacity 2800. KODFP intends to submit their application by April 30, 2012.

We are also in discussion with Klamath Pediatric Clinic/Sanford Clinic for PCPCH application – Capacity 3000

These 3 clinics serve 75% of our projected 10,600 members.
CHA's goal is to have KODFP and KPC/Sanford Clinic on board as Tier 2-Tier 3 clinics by August 1, 2012. Going forward we will engage all other local clinics in our service area to achieve PCPCH status within the next 2 years.

•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.
We have electronic prior authorization capabilities and engage utilization review process for requested services. CHA case mangers collaborate with providers for admissions, transitions of care, and complex high cost testing/imaging and other requested services. We will also have available secure email for providers and case managers to communicate for coordination of care. All of our providers have direct phone contact with our case managers and access to our medical director. CHA will encourage co location of behavioral, mental and dental health to improve communication and collaboration between providers.

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.

Through our MOU with APD and CHA the PCPCH will be involved as part of the care team for members needing LTC services. CHA/DHS case managers will be communicating care plans and case conferences as needed with the PCPCH providers/case managers. Our plan at this time is to utilize secure email and fax communications and multidisciplinary meetings.
Members are identified for care coordination through many avenues including by not limited to; APD screening, transitions of care, provider visits, emergency room utilization, chronic disease reports to name a few.

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 member centered primary care homes.
CHA will continue to engage the local FQHC as a primary provider for our members and assist with its achievement of PCPCH certification. CHA/CCC has contract agreements with the FQHC for payment and capacity and will continue to do so under the CCO. We have been and will continue to collaborate and coordinate care with the school nurses for our children with needs. CHA will collaborate and support additional safety net providers through a MOU with Klamath County Mental Health Authority. Currently there are no rural health, migrant or school based health clinics in our service area.

A.3.2. Other models of member-centered primary health care. NA

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.
We have multiple service sites in our urban area to meet the needs of our members. All are located near public transportation routes. We have one PCP clinic in Chiloquin that provides care to members in the surrounding area. The OHSU Residency program has a medical bus that provides outreach medical services to Sprague River, Bly, Beatty, Merrill. Working with our care provider partners, CHA will develop a health care resource map of our service area that identifies the geographic location of our service providers. We will identify the location of all primary, specialist, behavioral health, substance abuse treatment, and dental services that will be part of our continuum of care. Gaps in geographical service locations will be noted and new delivery service areas can be prioritized. As we expand our provider network we will focus on developing new primary health care sites in underserved areas, and consider developing resources in non-traditional locations that receive consumer visits. Our case managers and other community-based health workers will reflect the cultural and ethnic composition of our service area. For us, this means that we will develop a community health team and primary care services that are reflective of our agricultural roots, our Native American history and population, and the Hispanic culture in the region. Many of our CHA partners have developed successful outreach services to these populations, and we will incorporate these existing outreach efforts into our CCO model.

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?
Currently Klamath County is affected by the nationwide shortage of physicians, and especially primary care physicians which particularly affects rural areas. Of the 13,000 Oregon Health Plan eligible in our county, approximately 3,000 are "open-card" or fee for service clients without the benefits of managed care, and therefore very limited access to primary care.

This lack of primary care providers directly affects the ability of any CCO to provide coordinated services. With coordinated care, savings can be generated in utilization that may be applied to improved primary care reimbursement rates. This creates a more attractive environment for physician

recruitment. We presume that similar efficiencies will extend to the mental health system.

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.

CHA will provide a public presentation open to members and all interested local parties explaining the CCO model and CHA's role. The presentation will allow for questions and feedback from the participants.
New Member Handbooks will address in plain straightforward language the CCO model and Patient Centered Primary Care Home after a contract is signed with OHA and ready for distribution August 1, 2012. Informational flyers in the provider clinics, hospital, pharmacies, chemical dependency treatment centers, mental health centers and other areas of service will be provided to augment communication regarding CCO and PCPCH. CHA will also provide a link to the CHA website for more information on CCO/PCPCH/Care Coordination/Provider Panel etc.

A.3.4. Provider Network Development and Contracts

A.3.4.a. Describe how the Applicant will build on existing provider networks that deliver 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.

CCC/CHA has existing relationships with needed out of area specialists in Medford, Bend, Portland and Eugene, including but not limited to NICU, Cardiac Surgery, Pediatric Oncology, Pediatric Cardiology, Urology, Neurosurgery, tertiary hospital care. CHA has sent out MOU's to physical health, chemical dependency and mental health providers locally and out of area to maintain and expand our panel to meet the needs of our community.

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.
CHA will utilize prior authorization and concurrent utilization review along with case management to decrease the use of unnecessary inpatient services. The case managers also will work collaboratively to assure right service, right time and right level of care. CHA case managers and local Mental Health Case Managers and Chemical dependency staff have been collaborating to identify high risk, high utilizers and complex members and work to implement an appropriate care treatment plan focused on addressing acute problems and establishing long term goals and interventions to avoid unnecessary emergency room use, non-medically necessary inpatient care, decrease length of stay and prevent readmissions. . Integrating these services under the CCO structure will greatly facilitate these efforts. Under the current model with separate physical and mental health management, there have been significant barriers to and delays in appropriate communication and care planning. This has required inordinate effort by our CM staff to bridge the disciplinary boundaries in formulating meaningful and effective care plans for our members.

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.

CHA will contract with current local behavioral health providers to ensure that the existing array of behavioral health services is retained and enhanced. With a locally-based CCO, the ability to identify and respond to local needs will be immeasurably improved over the current situation where Mental Health funding is meted out by a distant regional entity. Our goal will be to transition the current delivery system toward a patient-oriented health home model as our current local health care infrastructure allows. This will facilitate even closer collaboration with local behavioral health and medical providers to support placement of behavioral health providers in clinics, medical offices, schools and other community-based locations that are identified by patient-driven, consumer-friendly individualized service plans. CHA recognizes and supports the need for in home visits by behavioral health providers. Some of our current local providers already have extensive community-based and home-based service networks that we will continue to support and that we plan to extend as appropriate. We will work out the placement and billing conditions but see this as a valued asset for our members with appropriate MOUs.

A.3.5. Coordination, Transition and Care Management

Care Coordination:

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.

CHA , since the origins of CCC, has actively participated in improving the flow of information from providers for members with severe and persistent mental illness such as LTC, mental health and other care providers through the use of patient-driven Individual Service and Support Plans, which can be shared by secure email, will be the core of this. They will draw on joint case management conferences which could include the Member, MH provider, and the Primary Care Physician as well as other appropriate information. The Care/Treatment Plans will be updated on a scheduled basis. HIPAA compliant information sharing will be facilitated by educating staff and members regarding appropriate release of PHI. CHA will continue work toward development of an electronic health record system that allows for facilitated electronic communication among CHA providers, and with contracted out-of-area providers.

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.

CHA will support partnerships between providers which will allow ease of access to members for crisis management, community prevention services and self-management. Some of our current local providers already have in place community and home-based social and support services, crisis management services, community prevention and self-support programs. These services currently include home-based skills training, medication monitoring, parenting support, independent living, mentoring, and other valuable services. Our goal is to retain these provider directed services, and coordinate them into a model more closely aligned with a medical home or health home approach to care. Our medical director has been active in Healthy Active Klamath, a broad-based community organization, facilitated by the

Klamath County Health Department and dedicated to raising community awareness and promoting infrastructure to improve general health throughout the Klamath Basin.

We are also very interested in exploring development of peer directed community services. Providers in our network are encouraged to coordinate with the CHA Case Managers and other providers through fax referrals, phone calls, secure (when implemented) e-mail and Case Management conferences. In addition, as the State finalizes the educational program for Community Health Workers, Health Navigators and Peer Support Providers, CHA will support engaging these providers in the various clinics and community settings to meet the needs of social and support services, including but not limited to crisis management, prevention and self management programs. The Klamath community has many resources available and we need to develop navigators/peer support to assist members and care providers in accessing and utilizing the services. We have approached Klamath Community College with preliminary information regarding possible future offerings to educate this class of health care workers.

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.
CHA provides members and providers with a handbook discussing care coordination and responsibilities of both providers and members. In addition, CHA will provide an introductory letter explaining Care Coordination under the new CCO. This information will be readily available in Spanish and provided upon enrollment when Spanish format is requested or indicated for a new member. Other languages will be made available on an as needed basis. This information will also be available on our website.

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.
CHA identifies members with multiple diagnoses through Health Risk Assessments from DHS APD and internal claims reports identifying members with multiple chronic conditions and reports them out by clinic, diagnosis, age, race, ethnicity and language. CHA Case Manager develops and communicates Care/Treatment Plans with the member, PCPCH, specialists, DHS APD, Mental Health and other involved providers as indicated to assure coordination of care. This process will be greatly facilitated with the unifying CCO contract facilitating open communication with mental health providers. The Care/Treatment Plan is to be shared and reviewed by all parties and recommendations are to be included in the Plan at each transition or annually at a minimum.

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.
The CHA Case Manager, working with its members, assists the Mental Health ENCC or DHS APD case manager to develop, share and implement a comprehensive, integrated Care/Treatment Plan with the

Member and all Providers. This function will be greatly enhanced by the unified management structure of the CCO eliminating currently existing communication barriers between these entities. This is to include the LTC providers, PCP, and other involved service providers. The Care/Treatment Plan will include a history and physical, list of providers, any therapy or DME, referrals or services being utilized, planned interventions, short and long term goals (the member is to set at least one or more of the goals and outcomes), outcomes and a final update on the progress to date on the efforts of the Care/Treatment team. CHA Case Managers, working with primary care and other providers, will assure that the comprehensive, integrated plan of care is delivered as specified, and that it is modified as indicated by the ongoing needs of the member. CHA will develop business agreements with providers of services that are not included in the global budget but needed by our members. Again the goal is to achieve the triple aim for our members. Much of the collaboration will be addressed in individual MOUs with DHS and LMHA.

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.
The CHA will assist the community to develop the use of non-traditional health workers for both Physical and Mental Health concerns. There has been interest from local community partners and within CHA to utilize a Mentor Model program with the Maternity Case Management Program and the substance abuse disorders providers programs. The Model of Care for use of Mentors has been well documented as being both a method of gaining member involvement and lowering costs with increased health benefits. Klamath County has a large population of VA members and this would provide an opportunity to engage these valuable members of the community. Klamath Community College has been approached to provide courses to develop community health care workers/navigators. We will continue to support and pursue this educational option with KCC as the State defines the curriculum.

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

1. CHA receives a monthly file of new, open, and closed enrollees from DMAP.

2. New members are mailed a new member packet within 5 working days, and requested to select a Primary Care Physician (PCP)/Patient Centered Primary Care Home (PCPCH). Members have 14 days in which to respond before a PCP /PCPCH is assigned for them.

3. If a new member does not choose a PCP/PCPCH, one will be assigned randomly, and the member will be sent a written notice of assignment. The member may however request re-assignment anytime within the first 30 days.

4. CHA recognizes that some members may consider their mental health provider their PCP. We will make all reasonable efforts to ensure that appropriate preventive services be facilitated through this provider while working with the mental health provider to encourage each member's

familiarity with their assigned PCP. This will hopefully minimize the temptation to seek urgent or emergent somatic care in inappropriate settings unfamiliar with the member's needs.

5. Members also receive in the packet an incentive letter that encourages them to make a get acquainted appointment with their new provider within 30 days of coming on the plan.

6. PCP/PCPCH shall provide CHA with a minimum of 30 days written prior written notice of provider's intent to close his/her practice to all new patients.

7. Providers may not "close" his/her practice to new members while continuing to accept other new non-member patients, if they have not filled their agreed upon capacity.

8. During sustained membership growth, CHA supports recruitment of additional physicians to establish practice in Klamath County.

9. If specialty service is not available locally, the patient may be referred out of area. CHA staff will assist the PCP/PCPCH office in obtaining out of area care if requested.

10. If CHA intends to terminate a medical provider or group, where there would be a significant impact on access to care, CHA will give DMAP 60 days notice prior to the date of termination. If provider or group is going to terminate and fails to provide the required 60 days notice or there are problems that could compromise member care, CHA will give notice to DMAP as soon as information is available.

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.

CHA contracts with providers who offer access and services for our Spanish speaking predominant second language member group. These providers have qualified interpreters and employ bilingual culturally competent staff. Our two largest clinics also offer obstetrical care to meet the needs of the Hispanic population. CHA's Case Managers and ENCC collaborate with the clinics' providers and staff to ensure care coordination and transitions of care. We have the A T&T language line available to all of our providers at no charge for our members. CHA's medical director and CEO are fluent in Spanish.

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.

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.
CHA has a Transition of Care Program (TOC) for review of dual eligible members who are admitted or discharged from a hospital. CHA is expanding on this program to cover transitions for members within the Physical, Mental Health and Chemical Dependency system. Our communications with current mental health and substance abuse treatment providers in our region have confirmed that there are some

well-defined transition planning processes for children, adolescents and adults already in place. CHA will work with these providers to coherently integrate their existing transition planning protocols with our current TOC program. This will be greatly facilitated by the elimination of communication barriers inherent in the current fragmentation of Mental and Somatic health management structures. The incorporation of these various plans into a uniform transition planning process used by multiple providers across disciplines will result in more effective communication among providers and better transition outcomes for our members. The program includes contact with the member and Primary Care Provider on the initial and subsequent transitions, development of a Care/Treatment Plan, which is reviewed with the PCP and the member. The parties involved include service providers (including the LTC provider) with case management conferences held as needed. The Care/Treatment Plan is updated with each subsequent care transition and as needed to meet the member's changing needs.

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.
CHA is jointly developing an MOU with DHS APD. The following is a draft.

<u>CHA responsibilities - Draft</u>

1. Prioritization of High Needs Member in LTC
   - CHA/CM staff will develop an acuity system which takes into consideration all information received from the APD CAPS assessment, eligibility information, care setting changes, chronic condition diagnosis scoring, utilization score and all evaluations/reports received from CCO partners such has Mental Health and substance abuse disorders providers.
- CHA staff will provide and receive training with the APD staff on each agencies policies and procedures.
- Preliminary expectation is that CHA will provide all Care/Treatment Plans on a (to be determined) time frame to the staff at APD. APD will be provided updated Care/Treatment Plans as they are revised.
- CHA plans to communicate with the APD staff through a secure email system, fax and phone contact.

2. Development of Individualized Care Plans
- CHA Care/Treatment Plans will include a history and physical, identification of all care providers, any DME and or therapy requirements, referral/services being provided for the Member, a list of interventions along with both short and long term goals and outcomes. CHA will also supply APD with updated care conference notes as they occur. The CHA ENCC/Case Managers will develop the care plans with assistance from the Member/Caregiver, APD staff and all Providers involved in the Members care.

3. Transitional Care Practices
- CHA will attend weekly Facility based (SLMC and PRCC) meetings with the APD staff.
- Meet with APD staff to develop new systems for tracking transitions and assure continuity of care for high risk Members.

4. Member engagement and preferences

- CHA ENCC/Case Managers will involve the Member/Caregiver in all care plan development and at least one long term goal will be Member driven.

5. Establishing member care teams.

- CHA will provide the APD staff with Care/Treatment Plans on a routine schedule and as changes occur.
- The flow of information from CHA to other agencies will be by secure email, fax or phone contact.
- CHA ENCC/Case Managers will meet with APD staff and other LTC providers as needed to ensure that a comprehensive Care Plan is developed and implemented.
- CHA will work with APD and LTC providers to develop a meeting schedule to address Members needs and community concerns for this high risk population.

<u>DHS/APD Responsibilities – Draft</u>

1. Prioritization of high needs member in LTC:

   - APD will provide copies of CAPS assessments for service or care setting changes.
   - Work towards cross training
   - Obtain information from eligibility case loads
   - Case Manager will ask addition questions regarding health provider usage

2. Development of Individualized care plans:

   - Provide copies of CAPS anytime a new assessment is completed
   - Future discussions/dialogue with client around risk assessments

3. Transitional care practices:

   - Include CCO in weekly nursing home meetings
   - Invite CCO to potential problem solving meetings
   - Staffing with CCO as needed

4. Member engagement and preferences:
   - APD will solicit information from clients and share with CCO

5. Establishing member care teams
   First part:
   - Case managers or diversion transition, whoever is taking the lead will participate in the care planning
   - APD will work on having good communication

   second part
   - APD will provide copies of assessments when there are changes
   - Communicate when cases open or change in care settings.

   third part

- Same as above (second part)

fourth part
- Case managers or diversion transition will encourage provider participation

APD and CCO will meet and reflect on how process and outcomes and will adjust accordingly.

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.

Individual care plans: As required by ORS 414.625, the Applicant will use individualized care plans to address the supportive and therapeutic needs of Members with intensive care coordination needs, including Members with severe and persistent mental illness receiving home and community-based services covered under the State's 1915(i) State Plan Amendment. Care plans will reflect Member or family/caregiver preferences and goals to ensure engagement and satisfaction.
CHA requests that providers or appropriate agencies (ie. APD, AFS, CFS) through the MOU documents provide information as early as possible before, with or after a needed transition. This will allow for a more complete Care/Treatment Plan to be developed. All such Plans will also rely on input elicited from the member/family/caregivers.

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.
CHA will work with local community partners through MOUs and contracts to develop and refine currently used policies from CCC ICC program to meet the new expanded requirements for establishment of individualized Care/Treatment Plans. Although Care Plans for all members are helpful, prioritization will be based largely on both demonstrated needs and recommendations of providers. Frequent reviews of claims may identify members receiving care from multiple sources as well as diagnoses which are associated with higher needs and care coordination. Providers provide information directly to CHA CM staff regarding conditions for which they are either providing care or perceive a strong need for such care. This sharing of information will be facilitated by the unified management encompassing somatic and mental health disciplines. The current fragmentation of this management, particularly with out-of-area mental health management has caused extreme difficulty in formulating coherent, comprehensive, coordinating Care Plans – particularly for our most needful members with multiple mental, physical, and dependency issues.

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.
CHA will utilize the new member enrollment list to identify members eligible for intensive services. In addition, CHA will rely on provider referral, members self-report, family or care giver request, claims utilization reports, DHS CM CAPS, ER reports and hospital admission reports to assist our CM staff in

identifying complex high risk members. . Given CCC's long history as the only local FCHP, many of the "new" members of the CCO will already be known to us. Over our existence, we have managed the care of over 39,000 unique members, our neighbors, and even family members -- in a county with a total population of only 63,000. This, and our long term involvement in local affairs means that we will have prior knowledge of not only most members, coming into the CCO, but almost certainly their families as well. This level of involvement has proved invaluable in our coordination of care for this vulnerable segment of our community over the past decade and a half.

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.
CHA will collect the risk screening materials. The ENCC and/or Case Manager (either Physical Health or Mental Health) will review the information for risk stratification and assignment for Care/Treatment Planning. The Care Plan will then be sent back to the APD and LTC provider by fax or secure email.

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.
CHA will provide criteria for acuity with High, Medium and Low risk categories. Members with High Risk acuity will have Care/Treatment Plans assessed every quarter and as required for changes in the member's status. Medium Risk acuity will have Care/Treatment Plans assessed semi-annually and as required for changes in the member's status. Low Risk members will have Care/Treatment Plans assessed annually and as required for changes in the member's status.

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
CHA member ENCCs and Case Managers will work with APD and LTC providers to develop the Care/Treatment Plans. When the Care Plan is established and reviewed by all parties it will be sent to the APD caseworker and LTC provider along with other members of the care team including the Member and Primary Care Provider. CHA will be using secure email and or FAX to communicate with our providers. See previous notes related DRAFT MOU in A.3.5.j

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.

There currently exists a robust, broad array of mental health and chemical dependency services in our service area, and CHA plans to collaborate with the current providers in the region to continue and expand upon these services. We have met frequently with local providers, and most have already

verbally committed to participate on the CHA panel of providers. Our provider network already has in place behavioral health and chemical dependency services for all ages. Our providers all have bilingual staff with strong ties to the local Hispanic and Native American community. There is a Hispanic advisory committee in place, and existing service collaborations with the Klamath Tribes. All covered populations are currently receiving a broad array of eligible services, ranging from clinic based services to home-based care, school based behavioral health, residential care, foster care, acute care, etc.

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.
See previous answers in A3.5.i Since these services are already being provided by CCC/CHA, we anticipate that the CCO structure will simplify and facilitate these needed communications which are now impeded by the separate mental and physical health management structures.

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.
Please see answers to A.3.5.1, A.3.5.j and A.3.6.b

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
In our service area some of our CHA behavioral health and chemical dependency service partners are currently delivering evidence based prevention services that we will integrate into our CCO continuum of care. These services include: Healthy Families America, a mental health prevention programs for newborns and their parents; mental health early intervention and prevention services in local public schools; school based alcohol, tobacco and other drug (ATOD) prevention services; and a variety of other preventative outreach services. Although these programs have demonstrated some promising outcomes to date, current prevention efforts are not coordinated or integrated as part of an overall integrated health care model.
With the development of the CCO, CHA plans to continue these current efforts while providing additional coordination. At the same time CHA will integrate them into our overall health care delivery system. CHA will also work with our providers to co-locate mental health and chemical dependency staff within primary care medical offices which will allow for early intervention, improve communication across service systems, facilitate referrals and case management, improve patient outcomes, and create efficiencies in service delivery.

•Integration of primary care across systems

CHA is already discussing possibilities for co-locating behavioral health and chemical dependency staff with primary care physicians. To date, these discussions have been received positively and have had positive results. Several of our provider/partners have indicated keen interest in exploring staff co-location. If selected as a CCO CHA will redouble these efforts and address the details needed to implement these plans. In addition to co-locating staff, successful integration of primary care across systems will require enhanced sharing capability of electronic health information while maintaining appropriate levels of patient privacy. To this end, CHA has started to explore methods to enable the various electronic health records to share pertinent patient information. CHA is also starting to meet with local providers to begin developing across discipline communication procedures, joint service planning, mapping of service capacity, referral and payment strategies, and other issues associated with service integration.

CHA realizes that some members may consider their mental health provider to be their PCP. We will make all reasonable efforts to ensure that appropriate preventive services be facilitated through this provider while working with them to encourage each member's familiarity with their assigned PCP. This will hopefully minimize the temptation to seek urgent or emergent somatic care in inappropriate settings unfamiliar with the member's needs. If it becomes apparent that a sufficient number of members require primary care services within the mental health system, consideration will be given to facilitating placement of a PCP in a mental health facility to accommodate this.

•Qualified service providers and community resources designed and contracted to deliver care that is strength-based, family-focused, community-based, and culturally competent;

In our proposed CCO service area there currently exists a robust, broad array of mental health and chemical dependency services that are delivered by providers already operating with certificates of approval from the Addictions and Mental Health Division of the Oregon Health Authority. These providers have licensed and credentialed staff delivering care, and our plan is to collaborate with them to continue and expand upon these services. These providers are already delivering services that meet OAR 309-032-1500 through 309-032-1565 known as the Integrated Services and Support Rule (ISSR). The ISSR addresses Oregon's priority for services that are strength-based, family-focused, community-based and culturally competent. These principles are well integrated into the services our providers are currently delivering, and as a CCO CHA will monitor our continuum of care using our own Quality Improvement standards and program review process to ensure that providers continue to adhere to these standards. We have met with these providers, and they have committed to working with CHA as part of our panel of providers.

•Network of crisis response providers to serve members of all ages; and

There already exists a 24/7 crisis response capacity in our service area that provides timely response to local residents. A child and family provider, the Klamath Child and Family Treatment Center, covers all crisis responses for children and adolescents, and our Klamath County Mental Health Department handles adult crises. Crisis services are currently integrated with our local law enforcement services, Sky Lakes Medical Center's emergency department, and our local emergency response 911 service. Our plan is to continue to utilize these services as part of our CCO array, with the goal of integrating crisis services more fully into our primary health care model.

•Recognized evidence-based practices, best emerging practices and culturally competent services that promote resilience through nationally recognized integrated service models

Our model for a CCO includes partnerships with the local Mental Health Authority, CMHPs, and substance abuse treatment providers that currently have certificates of approval from AMH to deliver services. Our panel of providers are currently delivering evidence-based practices (EBPs) in accordance with ORS 182.525. CHA will monitor continued use of EBPs through our quality monitoring and quality improvement program. A complete list of evidence-based and emerging practices currently being delivered by our panel would be too long to list, but some examples include: Assertive Community Treatment; ASAM; Brief Strategic Family Therapy; Cognitive Behavioral Therapy (CBT); CBT for Childhood Anxiety; Trauma Focused CBT; CBT for Depression, Collaborative Problem Solving, Co-Occurring Disorders: Integrated Dual Diagnosis Disorders; Dialectical Behavior Therapy (DBT); Drug Court; Incredible Years; Life Skills (Botvin); Medication Management; Motivational Interviewing; Not on Tobacco; Parent-Child Interaction Therapy; Relapse Prevention; and many others. In addition we are currently implementing more peer-directed support services and services for young adults in transition. These services are demonstrating promising outcomes and we plan to build on them if selected as a CCO.

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 in the area where they reside by July 1, 2014. Identify major elements of this plan, including target dates and benchmarks.

The applicant fully supports the goal to integrate dental care under the CCO Model of Care. In light fact that a formal dental contractual relationship was not required until July 1, 2014, coupled with assessment of the timeline provided to meet the RFA requirements for physical and mental health, the applicant has taken the option to not begin dental integration during the first phase of CCO integration. The applicant has had discussions with one large dental care organization in regard to governance, payment, risk sharing models, prevention, and integration. The CCC Board of Directors has voted to invite a local dentist to sit on the CHA Board of Directors as a community representative as negotiations proceed to incorporate a DCO into CHA operations. The applicant intends to include participation by a dental care organization (or its designated local dental provider) to participate in clinical advisory committees of utilization management and quality improvement. In addition, the applicant plans to analyze dental utilization, encounter, and payment data in order to create a model that aligns incentives among all providers (physical, dental, mental and substance abuse disorders) for later implementation. We have received a letter of support from Advantage Dental and look forward to working with this Dental Care Organization over the next year by having their representatives participate in our clinical advisory committees such as Utilization Management and Quality Improvement. Through their participation we will be able to identify and establish bench marks for our community.

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

CCO will engage dental health into the coordination of care and delivery of dental health services. We will work to include them in the community communication infra- structure as it develops. Dental providers will be included as part of the team for members with intensive and complex needs. See planned participation of dental providers in previous paragraph.

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 member-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 member-centered primary care home or primary care provider CHA has in place Case Managers and ENCCs who concurrently collaborate with discharge planners and/or other appropriate personnel in hospitals and facilities or of care sites to coordinate and develop Multidisciplinary Care Plans that are shared with the PCP/PCPCH and member/family/caregiver(s). The Care Plan developed by the plan's case manager/ENCC is shared with the facility, attending provider, PCP/PCPCH throughout the transition of care. Feedback from providers/member is encouraged with modification of the Care Plan by the case manager occurring as needed. The Case Manager/ENCC meets face to face or by phone with the care team and member as needed.
•Processes for PCPCH or primary care provider to refer for hospital admission or specialty services and coordination of care.
Providers submit prior authorizations (PAs) for elective admissions. All PAs are reviewed within DMAP time limits, local turn around averages 3-5 days. Urgent requests are handled within 24 hours. Emergent services are addressed immediately or reviewed retrospectively for medical necessity.
•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.
CHA requires prior authorization with supportive documentation for planned hospital or specialty treatments. Unplanned hospital or specialty treatments require notification within one business day and supporting documentation within 3 business days. Medical records are available to our Case Managers and medical director via direct or internet access to hospital EMR. This is especially helpful for timely processing of PA requests since the hospital has held CCC's laboratory services contract and performs most of the imaging studies in the area. Records from other providers are usually sent by fax and sometimes by courier and imported directly into our electronic document image program, "DocRecords", for access by appropriate CCC/CHA employees. Pertinent records are always reviewed prior to or with a change in level of care.

•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.
See above notes that address our Transitions of Care Model. All members admitted to a facility receive TOC interventions from our case managers or ENCC.

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:

o 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,

o 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,

o 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).

o 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.

CHA members who are in LTC services will continue to receive Physical Health/Mental/Dental health services. ENCCs and/or Case Managers and Caseworkers from the APD system will work in collaboration for the member's treatment needs. Use of transportation options for "shut in members" will be utilized. When required, a Home Health evaluation to assist the Provider with care for a member that is not able to go outside the care facility will be used. In extreme situations either a home visit by the Primary Care Provider or a contracted Mid-Level Provider can be considered.

CHA will follow the National Committee for Quality Assurance guidelines for both the Transition or Care and Coordinated Care Programs. The NCQA uses best practice information to develop the guidelines. CCC/CHA also uses Milliman Care guidelines for development of Care/Treatment Plans for the Dual eligible Members.

CHA/CCC has been working with both Cascade East Medical Clinic and Klamath Open Door Clinic to begin the process of establishing a local substance abuse disorders provider part time within each clinic. Both of these facilities have or are expected to qualify for Primary Care Home status and new provider services within the clinics can be investigated and encouraged.

Other models of providing care can be explored with our Provider Partners in the community and review of the Community Needs Assessment should give direction for possible new and innovative programs.

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
CHA will continue to follow the CCC Utilization Review policies currently in use and develop new ones as practice demands. CHA will support and continue to use OHP rules and Prioritized lists to evaluate requests for services. In situations where a requested service cannot be provided under the OHP rules or Prioritized list the local ENCC and/or Case Manager can encourage the member/family/caregiver to explore other options for funding such as benevolent funds or funds from charitable groups. CCC has maintained donations to a benevolent fund administered the Sky Lakes Medical Center Foundation to provide some non-OHP-covered services for members in exceptional situations. Referrals are made by the Utilization Review committed to the administrators of this fund for consideration of coverage. CCC currently uses Milliman Care Guidelines for acute inpatient, observation, ambulatory care and Rehab care coverage consideration. Milliman is accepted by CMS as a well-documented source of high quality evidenced based decision-making criteria.

CHA will review reports from within the programs to identify any over or under utilization of services in comparison to other similar CCOs. CHA will be measuring performance based on benchmarks to achieve levels of care and utilization deemed "well managed".

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.
CHA and its providers will utilize the results of the up-coming community needs assessment to determine priorities, obtain recommendations from the CAC to develop goals and interventions addressing our most pressing health care disparities. Collaboration will occur in our multidisciplinary QI and UR committees to plan and implement best practices.

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.
CHA will develop QI measures and derive reports using enrollment data and claims data to identify groups and measure utilization. Analysis will be in accordance with OHA's race, ethnicity and language data policy. CHA will look for utilization disparities to identify needed changes in service delivery, to improve access and encourage participation by all groups.

Section 5 - Payment Methodologies that Support the Triple Aim

Managed Care Budget Model
Appl sect A.5.1. Pg 33-41

Redacted

Cascade Health Alliance

APPENDIX B – Provider Participation and Operations Questionnaire

Section 1 Service Area Capacity

Service Area Table :

Submitted in excel spreadsheet format as separate file labeled Appendix B Service Area_ PFHCSP table at the time of Technical RFA submission.

Section 2 Standards Related to Provider Participation

Standard #1 Provision of Coordinated Care Services

CHA will submit the information in Table B-1 (Participating Provider Table) in Excel format as part of the readiness review. The signature pages for physician and provider contracts will also be available at the readiness review date.

Standard # 2 Providers for Members with Special Health Care Needs

CHA will provide at the readiness review date in narrative form those providers and facilities identified in the Participating Provider Table or referral provider/facility (Standard #1 Table that have special skills or sub-specialties necessary to provide a comprehensive array of medical services to the elderly, disabled populations and children/youths in substitute care or Members who have high health care needs, multiple chronic conditions, mental illness or chemical dependency.

Standard #3 Publicly Funded Public Health and Community Mental Health Services

CHA is submitting Publicly Funded Health Care and Service Programs Table in an Excel spreadsheet file labeled Appendix B Service Area_ PFHCSP table at the time of Technical RFA submission.

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

CHA has engaged its publicly funded providers through MOUs and or contract negotiations. In the case of the FQHC (KODFP), CHA is assisting with application for Tier 3 PCPCH. Klamath County Health Department has been collaborating with CHA in securing a grant for development of a Community Needs Assessment. CHA sought out expert input addressing specific Mental Health and Chemical Dependency questions in the RFA from some of its current Mental Health and Chemical Dependency providers.

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

MOU is pending for KCMH/KYDC. Will have updated contracts with KCHD and KODFP by ready review date.

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

Cascade Comprehensive Care has attempted to engage the Klamath County Board of Commissioners and the Director of the Klamath County Mental Health Department regarding the CCO RFA Process. We participated in County Commissioner work sessions on 10/5/2012, 2/22/12, 4/5/2012, and 4/22/2012 regarding CCOs. Representatives of Cascade Comprehensive Care met with individual County Commissioners on multiple occasions (Commissioner Cheryl Hukill on 1/23/2012 and 3/8/2012; Commissioner Al Switzer on January 30, 2012; Commissioner Dennis Linthicum on 1/23/12, 3/8/12, and 4/13/12). Written requests were made of the county commissioners to identify members of the Community Advisory Committee member selection committee on 2/23/12, 3/5/12, 4/13/12, and 4/25/12. (We have not yet received a response to this request).

On April 12, 2012 a letter was written to the Klamath County Commissioners (with a copy to the Director of the Klamath County Mental Health Department requesting that Klamath County (as the Local Mental Health Authority) meet to discuss and negotiate regarding CCO implementation. That communication included the following statement: ""I am writing to formally request that Klamath County engage in Cascade Comprehensive Care (CCC) to discuss and negotiate in regard to possible implementation of a Coordinated Care Organization. A previous request to meet with Amanda Bunger was not accepted for unknown reasons. CCC is attempting to work with the local mental health authority in good faith.""

Commissioner Hukill responded as follows on April 12, 2012: "C Hukill, 4/12/12: "We will be meeting with all 4 of the LOI entities on Tuesday afternoon to ask questions that have come from citizens, partners, and I am sure from each commissioner before we make our decision on Wednesday the 25th. After Wednesdays decision, the necessary information will be provided along with the letter of support to the one the Board decides on. It looks like all 4 will be coming on Tuesday. Cheryl"

A request was made to the Klamath County Commissioners on 4/17/2012 regarding the non-binding MOU released by the state on 4/13/12 as part of RFA Amendment #9: At that time we wrote that "CCC is requesting in good faith, that the county allow us to begin discussions regarding this non-binding agreement to document our mutual efforts " to coordinate services and meet the mental health needs of CCO members. We received a response from County Commissioner Cheryl Hukill as follows: "We are having a meeting with representatives from all 4 organizations on Tuesday the 24th at 2:30 pm. The questions and answers will help us decide who will get our letter of support. On Wednesday the 25th at 9 am, at our weekly work session, we will make the decision on which entity will receive the letter of support. Whomever is awarded that letter, the county will help in anyway it can to give the needed information in a quick and timely manner so that the April 30th deadline can be reached."

On April 25, 2012, the Klamath County Commissioners announced that they would give letters of support to PacificSource, Cascade Comprehensive Care, and Greater Oregon Behavioral Health Inc. As a result of that decision, CCC has attempted to engage the Klamath County Mental Health Department (via email and telephone) as to their availability to meet regarding the CCO RFA application, and of our desire to work with them toward agreement on the non-binding MOU. Our letter to the Klamath County Mental Health Department (with a copy to the Klamath County Commissioner) included the following: "While we await for the decision as to who will sign the MOU, there are various components of the non-binding agreement that will need to be discussed and negotiated including a) authorization and payment methods to maintain a MH safety net for CCO members b) authorization and payment methods for various LMHA responsibilities to CC members (i.e. transitioning of children to OSH or residential care, residential services, community based specialized services, specialized services, etc.) and c) identification of joint performance outcomes for the mental health and addictions system.

Other recommendations by the state for creating a "strong MOU" include conflict resolution processes, agreement term period, termination clauses, data sharing arrangements and lead contact identification.

We would at least like to try to meet our state deadline if you are in agreement and can make yourself available. If you are not able to meet this week , please simply let me know so that we can document our efforts as requested in the RFA.

We look forward to working with Klamath County Mental Health in a collaborative effort under the new Coordinated Care Organization program.

As of 4/26/2012, we are waiting a response to these requests.

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

(a) Please describe your experience and ability to provide culturally relevant Coordinated Care Services for the AI/AN population. **CHA/CCC maintains a long standing effective working relationship with Klamath Tribal Health for our mutual members. Although Klamath Tribal Health is not a contracted provider we do coordinate care with them to meet our members' needs. All covered services provided to AI/AN members who see their contracted CHA provider are covered by CHA. Services provided through Tribal Health are submitted by KTH to DMAP/OHA. Our medical director, a veteran of the Indian Health Service, has worked with Klamath Tribal Health for decades. He was medical director for the residential and outpatient A&D programs initiated by the tribes and community and has also worked in the Tribal Health Clinic in Chiloquin occasionally when a fill-in physician was needed. His involvement has facilitated relations and cooperation with Tribal Health and communication with their providers in the county. He has been included in their "healing circle" as a member and respected elder.**

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

From among the providers and facilities listed in the Participating Provider Table, please identify any that are Indian Health Service or Tribal 638 facilities.

(a) Please describe your experience working with Indian Health Services and Tribal 638 facilities.
- Include your referral process when the IHS or Tribal 638 facility is not a participating panel provider.
- Include your prior authorization process when the referral originates from an IHS or Tribal 638 facility that is not a Participating Provider.

CHA/CCC maintains a working relationship with the local Klamath Tribal Health Center as a non-contracted provider. The same referral policy and procedure process is followed as for any other non-participating provider. If a member chooses to see Tribal Health provider then the claim is submitted to DMAP by the Tribal clinic for adjudication. CHA will be responsible for covered services provided by the member's CHA contracted provider. See above for our medical director's traditional role in

facilitating this.

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

(a) Describe Applicant's plan to provide the Integrated Service Array, which is a range of service components for children and adolescents, through and including age 17, that target the population with severe mental or emotional disorders whose needs have not been adequately addressed in traditional settings.
There are currently two providers in our service area who are delivering the Integrated Service Array (ISA), Klamath Youth Development Center and Lutheran Community Services. These services are currently being contracted through Jefferson Behavioral Health. Existing ISA services include Intensive Community based services, Psychiatric Day Treatment Services, and Treatment Foster Care. Our goal as a CCO will be to deliver a comprehensive array of behavioral health care to all our members in an integrated system that honors a patient oriented health home model. We plan to include the current ISA services into this overall integrated approach to health care. There will be no interruption to these services if we are selected as a CCO.

(b) Describe how the Applicant has developed, or is developing, for implementation of an ISA system and other Coordinated Care Services that promotes collaboration, within the laws governing confidentiality, between mental health, child welfare, juvenile justice, education, families and other community partners in the treatment of children with serious emotional, mental health and behavioral challenges.
As a Fully Capitated Health Plan that has been operating in our service area for the past 18 years we have developed strong ties within our region. We have built successful collaborations with several community partners who support our efforts to become a CCO. In addition, the provider partners we will be working with as a CCO also have strong ties within the community. Close, successful, collaborative working relationships have been developed with child welfare, the juvenile justice department, our two regional school districts, the courts and district attorney's office, and other local organizations. Lutheran Community Services and the Klamath Youth Development Center are currently delivering ISA services. Both organizations have long, successful working relationships with local stakeholders. Both are experienced providers who have the required certificates of approval from the Addictions and Mental Health Division of the Oregon Health Authority.

(c) Describe how the Applicant's service delivery approach is family-driven, strength-based, culturally sensitive, and enhances community-based service delivery.
In 1986 Beth Stroul and Robert Friedman from Georgetown University's Child Development Center published A system of care for children and youth with severe emotional disturbances. The three core values of the system of care approach they advocated were: 1) The system of care should be child centered and family focused, with the needs of the child and family dictating the types and mix of services provided; 2) The system of care should be community based, with the locus of services as well as management and decision making responsibility resting at the community level; 3) The system of care should be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve. These principles have become the guiding tenets for child and family behavioral health, and they will guide our plans for developing an integrated service model as a CCO. The behavioral health providers on our panel are well versed in these principles and have designed their current services to align as closely as possible with them. Our providers have current certificates of approval issued by the Addictions and Mental Health Division of the Oregon Health Authority to deliver outpatient and ISA mental health services. This means, among other things, that they have been carefully reviewed to ensure that they meet the Integrated Services and Supports Rule (OAR 309-032-1500 through 309-032-1565). These rules are rooted in the System of Care principles, and they require that providers operate in accordance with them in order to meet state requirements, and to receive that Certificate of Approval that authorizes them to operate under the Oregon Health Plan.

As a Fully Capitated Health Plan that has been operating in this service area for the past 18 years we have consistently complied with all state and federal requirements, and have created a successful health care delivery system that is supported by our members, providers, and community stakeholders. We have a strong stake in the health and wellbeing of our community, not just because they are often our friends, neighbors and relatives. As a local company that is owned and managed by local citizens, our professional goal of facilitating the optimal provision of these services coincides with our personal goals as members of this community.

Standard #7A– Mental Illness Services

(a) Describe how the Applicant will provide community-based mental health services to Members, including Members receiving home and community-based services under the State's 1915(i) SPA.

There are a variety of local mental health providers who currently have certificates of approval from the Oregon Health Authority to deliver a broad range of mental health services. These include Klamath County Mental Health Department, Klamath Child and Family Treatment Center, Lutheran Community Services, Best Care, and others. CHA envisions using the existing community-based mental health infrastructure in our region to provide all necessary mental health benefits. We have had several discussions with local providers, and we expect we will develop agreements with them to participate on our provider panel. The changes to Section 1915(i) of the Social Security Act as part of the Affordable Care Act offer an important tool for CCOs to enhance their efforts to serve individuals in integrated settings. As a CCO, CHA will be able to target home and community-based mental health services (HCBS) to particular individuals making these services more accessible to more consumers, while at the same time allowing CHA to conduct utilization review and ensure medical necessity while ensuring the quality of local HCBS. These services are currently being delivered in our region by Klamath County Mental Health Department, and as a CCO our plan is to continue those services and expand them as possible. There are incentives for both provider and payer to maintain HCBS and these are also services that will be in the best interests of many of our members.

(b) Describe how the Applicant will screen all eligible Members for mental illness to promote prevention, early detection, intervention and referral to mental health treatment – especially at initial contact or physical exam, initial prenatal exam, when a Member shows evidence of mental illness, or when a Member over-utilizes services.

By building on the existing network of behavioral health providers in our region we will be able to create a community wide network of trained, qualified providers, expanding on existing capabilities to screen members for mental illness and deliver earlier intervention. CHA will build an integrated health system that will locate mental health screening services in existing service locations and expanding them to community-based, nontraditional settings. This will include co-location of mental health staff in primary care physician offices and clinics, schools, offices of the Department of Human Services, and similar community based locations. We will also identify and screen frequent users of emergency department and other health care services in order to address as needed mental health issues that contributes to over-utilization of health care. CHA primary care physicians are all board-certified and trained to screen for, recognize and manage most mental illness. In reality, most mental illness is managed by these professionals in the primary care setting. These well-trained and skilled providers also know when referral for specialized mental health expertise is appropriate. The fact that these services have often not been readily available has frustrated them and led to their being forced to develop even more competence in the area than they may be comfortable with. CHA intends to ensure that the appropriate funding for these services is used for their acquisition. This will allow expansion of existing programs, development of new ones and considerably better mental health care for our community.

<u>Standard #7B – Chemical Dependency Services</u>

(a) Describe how the Applicant will provide community-based chemical dependency services to Members, including Members receiving home and community-based services under the State's 1915(i) SPA.

Cascade Health Alliance knows that one of the most significant ways to increase the quality of medical outcome for the member and to decrease overall medical costs, is to engage Members who have a chemical dependency disorder into treatment services providing evidence-based services. CHA will provide outpatient chemical dependency services to members through a network of community-based providers including BestCare Treatment Services, Lutheran Community Services, and Alliance Behavioral. These providers offer assessment and treatment services for ASAM Level I and II. BestCare Treatment Services and Lutheran Community Services offer Dual Disorder Capable Services. CHA will work with medical providers and substance abuse providers to identify Members who are at high risk for needing chemical dependency services and develop a plan for outreach and engagement. For Members in need of ASAM Level III Residential Treatment Services, all the providers will work closely with BestCare Treatment Services which provides local residential treatment at the Klamath Basin Recovery Center.
For Members receiving home and community-based services under the State's 1915(i) SPA, Cascade Health Alliance will work with the community mental health program to provide Dual Disorder Enhanced services, integrated with other mental health wrap-around services. These services will be provided either at the Member's residence, at the community mental health program, or other community settings.

(b) Describe how the Applicant will screen all eligible Members for chemical dependency to promote prevention, early detection, intervention and referral to mental health treatment – especially at initial contact or physical exam, initial prenatal exam, when a Member shows evidence of mental illness, or when a Member over-utilizes services.

Cascade Health Alliance will build on the work that Cascade Comprehensive Care and Klamath Falls Independent Physicians Association has done to train physicians in the use of the SBIRT (Screening, Brief Intervention and Referral to Treatment). The

SBIRT is SAMHSA supported substance abuse screening tool that has been specifically designed for use in primary care settings. Most of the primary care physicians serving Medicaid clients in Klamath County have been trained in the use of the SBIRT. The SBIRT has two screening tools, a brief annual screen and a full screen. All adult CHA members who receive primary care will receive an annual screen. CHA members who have an indicated need, either through scoring positive on the annual screen, or due to medical utilization patterns (e.g., frequent changes in primary care physicians, frequent emergency room visits, multiple requests for prescription medications with abuse potential), will receive the full screening at their next medical appointment.

<u>Standard #8 – Pharmacy Services and Medication Management</u>

(a) Describe Applicant's experience and ability to provide a prescription drug benefit as a Covered Service for funded Condition/Treatment Pairs.
CCC/CHA has been providing prescription drug benefits to its members for more than 10 years. We have a Pharmacist on staff who with the assistance of a Certified Pharmacy Tech. process pharmacy benefit requests.
CHA provides a pharmacy benefit to its members for funded condition/treatment pairs through a PBM and network pharmacies.

(b) Specifically describe the Applicant's: Ability to use a restrictive formulary as long as it allows access to other drug products not on the formulary through some process such as prior authorization.
Providers, members and pharmacies may request coverage for non-formulary medications through our PA process. Requests are reviewed for generic options, step therapy or other therapies. The grievance process is available to all members where services have been denied.

- Formulary development that includes FDA approved drug products for each therapeutic class and at least one item in each therapeutic class of over-the-counter medications sufficient to ensure the availability of covered drugs with minimal prior approval intervention by the providers of pharmaceutical services, e.g. pharmacies.
  The Formulary is reviewed every 2 years and new drugs are reviewed by the plan's Pharmacy and Therapeutics Committee for formulary inclusion. Formulary/medication is also reviewed in the P & T committee when best practices are brought forward through local practice standards, regional and or national standards /guidelines.
- Development of clinically appropriate utilization controls.
  CHA has physicians, pharmacist and nurses staffed on the P & T committee to develop utilization tools. Frequent review of medication utilization reports by drug, class, cost, prescriber, member population, outcomes, clinical guidelines help direct future use and guideline development, provider education and member treatment adherence.
- Ability to revise a formulary periodically and the evidence based review processes utilized and whether this work will be contracted out or staffed in-house.

  In-house P & T committee reviews the formulary biennially and new products reviewed as needed.

(c) Describe Applicant's ability to ensure an adequate pharmacy network to provide sufficient access to all enrollees and how Applicant will communicate formulary choices and changes to the network and other medical professionals and how to make non-formulary, i.e. prior Authorization, requests.
CHA pharmacy network will be administered by PBM and provide for local coverage and a regional/national network as needed. Our formulary is available on line at our website. Communication is provided through plan's newsletter (Care Talk) and individual communication as indicated with primary care providers and pharmacy providers.

(d) Describe Applicant's capacity to process pharmacy claims using a real-time claims adjudication and provider reimbursement system and capture all relevant clinical and historical data elements for claims paid in their entirety by the CCO and when the coordination of benefits is needed to bill Third Party Liability (TPL) when the CCO is the secondary coverage.
Med Impact processes our claims in real time. They will produce CHA Prescription Drug Experience/Explanation of Benefits (PDE/EOBs) in NCPDP file formats. COB will be handled electronically through PBM.

(e) Describe Applicant's capacity to process pharmacy Prior Authorizations (PA) either with in-house staff or through a Pharmacy Benefits Manager and the hours of operation that prescribers or pharmacies will be able to submit PAs
CHA staff will review PA and UM requests and enter directly into PBM adjudication system for real time adjudication of claims, Monday through Friday 8 am – 5 pm. Providers may submit PA's 24/7/365. CHA has an agreement with local pharmacies for limited emergent prescription dispensing pending clinical review.

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

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

for each category or type and a description of the amount and type of any other administrative fees paid to PBM by Contractor.

PHARMACY RATES*

Retail Blended Pharmacy Rates:

Brand: AWP-16% + $2.00 Dispensing Fee

Generic: AWP-16% or MAC+ $2.00 Dispensing Fee

Generic Effective Rate Guarantee to perform at: AWP-65%**

Mail Order:

Brand: AWP-20% + $1.00 Dispensing Fee

Generic: AWP-50%+ $1.00 Dispensing Fee

Administrative fee: $0.00 per our PBM contract.

(g) Describe Applicant's ability to engage and utilize 340B enrolled providers and pharmacies as a part of the CCO.

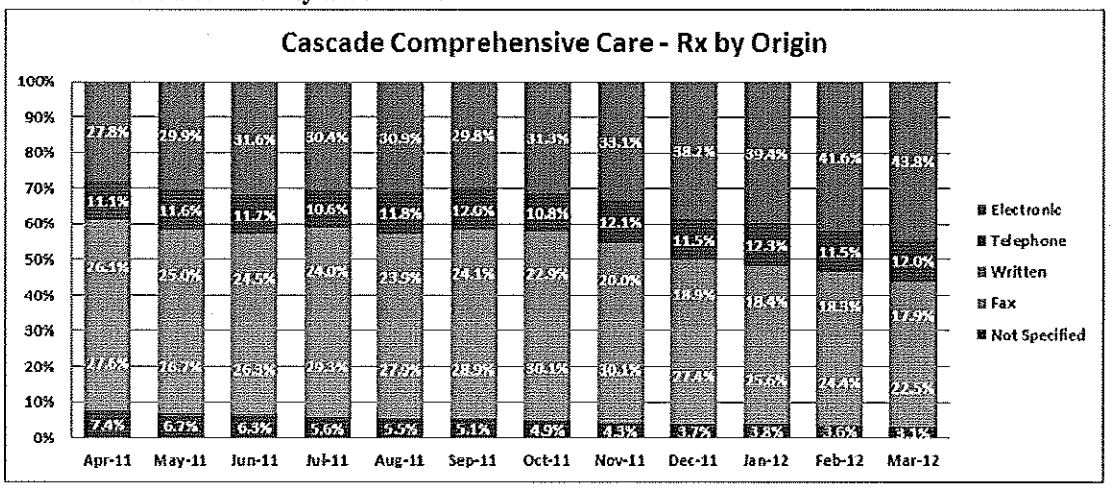
CHA will negotiate with 340B eligible facilities to achieve savings by using the 340B pricing. Local eligible facilities are Sky Lakes Medical Center, Klamath Open Door Family Practice and potentially Cascades East Family Practice Residency Program.

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

CHA will support engagement of MTM Vendor(s) to provide MTM services to eligible members within PCPCHs' coordination of care and treatment planning.

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

Current CMS rules require e-prescribing. CHA's 2 largest PCP clinics have EMRs and use e-prescribing. E-prescribing and the EMR are still under development in the Klamath provider community. We intend to move forward and support this process as needed to have a community wide EMR.



Standard #9 – Hospital Services

(a) Describe how the Applicant will assure access for Members to inpatient and outpatient hospital services addressing timeliness, amount, duration and scope equal to other people within the same service area.

- Indicate what services, if any, cannot be provided locally and what arrangements have been made to accommodate Members who require those services.
- Describe Applicant's system for monitoring equal access of Members to referral inpatient and outpatient hospital services.

We have agreements with several out of area hospitals and providers to cover specialty services: High risk obstetrics, NICU, open heart surgery, neuro surgery, nephrology, inpatient psychiatric (adults and peds, in process).

CHA follows our prior authorization and utilization model to assure appropriate inpatient and outpatient services. We monitor out of area hospital utilization monthly to assure appropriateness of referrals and to identify local provider access needs for future recruitment efforts.

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

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

CHA case management reviews previous day ER utilization by plan members. Members are notified by letter regarding what appears to be inappropriate use of the emergency room services. Follow up phone calls are handled by our case managers and or QA Nurse to evaluate utilization for appropriateness, determine any access barriers and offer member education on choices. Case Management communicates with PCP if frequency of ER or ambulance use continues after member education, again to determine if any barriers exist. All members receive a member handbook and separate Emergency Room Information sheet upon enrollment with the plan; that explains what to do in the event of illness or emergency. Customer Service Representative is available to answer questions at time of enrollment and throughout member's enrollment period.

•Procedures for improving appropriate use of Ambulance, Emergency Rooms, and urgent care/walk- in clinics.

CHA is looking forward to continued collaborative work with Mental Health caseworkers addressing members who present to the ER due to deterioration of their mental status or due to medication issues. Monthly staffing of high risk, high utilization and complex members has been occurring between CCC, KCMH, SPD and others to address development of care plans to assist members towards appropriate levels of care for the past several months. Two of our largest primary care clinics and KCMH have recently implemented same day appointment scheduling. We will be monitoring ER utilization to determine effectiveness of these changes. Our ER utilization rates have consistently been at or near the bottom of the FCHPs. Ambulance costs remain considerable, largely due to our county's poverty, geographic expanse and limited public transport.

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

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

Again this is addressed through our concurrent review of all hospitalizations and readmissions. The adverse events are reviewed internally and sent to the facility where the event occurred for review in their Risk management process. The Plan Medical Director makes the final determination for the plan. HACs are reviewed by plan UR case manager and forwarded to Medical Director for review and determination of payment following CMS and State guidelines for HACs.

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

Readmissions are monitored through the Claims department. Claims department reviews every inpatient claim for prior inpatient stays, if the 410-125-0410 readmission rule applies, the claim is denied and the admitting hospital is notified to bundle the stay into the initial claim and rebill. Claims department also runs a monthly report to check of any claims not caught by the processing analyst. If a claim was paid, a request for refund and corrected billing is submitted. CHA believes that the most effective way to address readmissions is to prevent them by appropriate CM involvement in discharge planning and process.

(e) Please describe innovative strategies that could be employed to decrease unnecessary hospital utilization.

CCC/CHA Case Management could identify high risk members through reports on ER utilization, medication adherence, DME use, PCPCH referral, DHS APD CAPS evaluations and make initial contact with members to begin care planning. The goal would be to identify unmet needs, determine member understanding and adherence to treatment plan, establish reasonable attainable goals, make and facilitate referrals through use of PCPCH and health care coaches. We have identified a correlation between ER utilization and hospitalization rates. We believe that attention to the former will continue to reduce unnecessary hospitalizations, which often result in admission by default, with few other options outside of clinic hours.

<u>Section 3 - Assurances of Compliance with Medicaid Regulations and Requirements # 1-14</u>

CCC/CHA has current policies and procedures in place that address all of the above Medicaid Regulations & Requirements and currently meet DMAP/OHA contract. CHA will be reviewing all of these before the ready review date to update with any changes reflected in the new contract. No changes in our basic billing software, standards or claims platform are expected.

Cascade Health Alliance
Appendix C Accountability Questionnaire

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.

CCC/CHA is continuously involved in Quality Improvement Projects mandated by the OHA for focused quality of care improvement. These have most recently involved measurement of HbA1c in members with diabetes, ER use by members with asthma and appropriate use of inhaled bronchodilators and controller medications in this latter population. Many of the proxies for quality involve information that may only be obtained by chart review. Lacking a unified Community EMR, this means that much of this information remains unaffordable for expansion to other areas of interest. However, we recognize that quality of care issues are frequently identified by utilization patterns. For this reason, we make extensive use of claims data to identify areas of potential quality concern.

CCC/CHA currently monitors information on members with high utilization of services for Chronic diseases/Special health care needs, including but not limited to hospitalizations and hospital readmissions, hospital length of stay, PCP visits per year, specialist visits per year, emergency room utilization by member, Alcohol and Drug utilization, DME utilization, transitional care, advanced imaging reports and no-show for appointments by age, diagnosis, time of day, day of week and member PCP assignment. These reports are generated and reviewed by our clinical personnel, including case management nurses, medical director, pharmacist and QI and UR committees.

Data from different community sources such as Senior and Disabled Services, Public Health, and County Mental Health will be analyzed. Important interrelated topics for equitable quality improvement will include tobacco use, obesity, diabetes, hypertension, asthma, infant mortality, low birth weight, mental health, substance abuse and addiction. Available data will be analyzed for disparities by race/ethnicity and location for reporting to CAC.

Reports of different types are reviewed monthly, quarterly and annually by senior staff the QI and UR committees. Reports will be generated from claims data and the community resources. CHA will be working diligently with the local hospital and providers for access to real-time data.

Integration of mental health, A&D, and physical health services, as well as dental services by 2014, will provide an overall view of member disparities allowing for integrated and coordinated care from allied agencies.

Data for assessing quality of care, specific treatment, and conditions will be collected from the following sources: Claims data, appeals grievances, health analysis reports, encounter data, referral data, CPT/ICD-9 data, peer review, direct observation, yearly access studies, yearly medical records review of providers for compliance with CHA policy and OAR's, including concurrent review for medically complex cases and monitoring of adverse events.

CHA's focus during the first two years will be assisting providers with developing patient centered primary care homes and measuring their effectiveness through monitoring and data collection. Development of care plans and the number of care plans developed with members within 6 months of assignment to PCPCH.

CHA will support integration of behavioral health specialists into primary care practices by funding training and developing learning collaboratives. Most members with behavioral health conditions such as depression receive care from their PCP, not in a behavioral health setting. However, provider (PCP)

offices do not have sufficient resources to effectively manage behavioral health issues. CHA will be encouraging and supporting placement of behaviorists in PCP settings. Data collection for initiation & engagement of alcohol and drug treatment services will be monitored through our current PIP and placement of clinicians from A&D/MH into the PCPCH will be a priority.

C.1.1.bWill the Applicant participate in any external quality measurement and reporting programs (e.g. HEDIS reporting related to NCQI accreditation, federal reporting for Medicare Advantage lines of business)?
CHA will continue to participate in quality measurement projects and procedures advised by the OHA's EQRO, currently Accumentra Health. CHA participates in the collection of HEDIS health care measures through our Medicare Advantage line of business. (ATRIO)

CHA reports its quality improvement projects to CMS for the Medicare Advantage line of business and to DMAP for the Medicaid line of business.

C.1.1.c. Explain the Applicant's internal quality standards or performance expectations to which providers and contractors are held.

CHA providers and contractors are expected to adhere and follow all applicable CHA policies, procedures, practice guidelines State and Federal regulations.

By contract, all providers are required to meet access standards for availability, timelines, for all members including those with disabilities or hearing impairments in a culturally appropriate manner. Access is closely monitored through various data collection methods for analysis. Data collected includes but is not limited to complaints and grievances, assignment to first visit, and review. All of CHA's Providers will be expected to meet contracted coding standards. CHA will expect all providers to adhere to quality and equity standards established and set forth in the contract.

Behavioral health, Alcohol and Drug agencies are required to meet compliance standards of the Integrated Services and Support Rule (ISSR) under the Addictions and Mental Health Division.

CHA Providers will follow professionally accepted standards regarding the condition of the physical facility. Confidentiality and HIPAA privacy considerations, maintenance of medical records, documentation of treatment and treatment planning in accordance to professional standards, Federal and State laws for medical record keeping practices.

Compliance is monitored during on-site visits and review of received authorization documents for service quality and compliance and medical record keeping. On site reviews are conducted as part of this process.

Health care quality has been a driving force within CCC since its formation. It's medical director had been a member of OMPRO's (predecessor of Acumentra Health) Board of Trustees since 1989. He was chair of that Board for the year prior to his "graduation" from it in 2009.

CHA will expect that contracted providers will utilize an EMR system in their office. This will allow for gathering of real-time data. To comply with new if the rules and regulations providers will be expected to increase electronic portholes for members/consumers to access their medical information.

CHA has providers located in and around the community of Klamath Falls, Oregon. Klamath County is a rural county, and the community standard can vary from five minutes to well over 90 minutes

depending on where members live. At least 90% of potential members can access medical care (Primary Care Providers and/or Sky Lakes Medical Center) within 35-45 minutes, which we feel is a reasonable community standard.

CHA has an established Community Transport System through Basin Transit System (local bus system), Dial-A-Ride (for handicapped members who cannot go by bus or taxi.) Must make an appointment ahead of time, Senior Services Van (for handicapped members), SDSD Transport (for members who do not require nursing care, but will need and ambulance for transport out of the area.) If SDSD is unavailable, non-emergent transport is arranged through Millennium transport services, and Ambulance services are located around the community and outlying areas for emergency care.

A member requiring care after regular business hours may call their providers office number. The providers will have a mechanism in place to contact the on-call clinician. The response to a member's request for medical help will be within 20 minutes after office hours. Calls during working hours are referred to the triage person who provides immediate advice or schedules an appointment as soon as medically necessary. After office hours telephone calls must be recorded in the members/consumer medical chart.

CHA will credential all provider types (physicians, practitioners, allied health providers, and facilities) prior to participation in the network. Physicians must meet state and federal regulations and be in compliance with credentialing criteria in order to remain in the credentialed and in the network. Failure to maintain established licensure, certification, or quality standards may lead to termination of participation on the panel. Once credentialed, providers are re-credentialed every two years.
The quality improvement committee completes credentialing and re-credentialing of providers, any issues related to quality of healthcare are taken to the committee for review and resolution.

Per contract contracted providers are expected to provide quality healthcare to all members assigned. Authorization process, chart auditing, on site visits, member complaints and concerns are monitored and reported to the UR and QI committees for compliance.

C.1.1.d. Describe the mechanisms that the Applicant has for sharing performance information with providers and contractors for Quality Improvement.

CHA, through the QI and UR committee (comprised of members from PCPs, Specialists, Mental Health, A and D and Dental, CHA Med Management (CAP)) continually maintain policies and procedures on the organizations philosophy and expectations of member treatment and care. Policy, procedures and clinical guidelines are reviewed by QI and UR committees and then disseminated to all participating providers at least annually. All reports and performance data will be disseminated to all participating providers after review by the QI and UR committees and Board approval. Clinics will be informed of information based on the reports.
Reports generated are reviewed and discussed by the QI and the UR committees for dissemination to members and professionals that sit on the committees. Communication of performance information to providers and contractors will be accomplished in a variety of means. Information is 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. CHA plans to update its website to make information available to providers, as well as members.
When specific procedures of services are studied, reports are reviewed with the QI and UR committees, improved as indicated, and shared with the providers involved, often with best practice benchmark values so that they can compare individual or clinic performance with local and distant peers.

C.1.1.e. Describe the mechanisms that the Applicant has for sharing performance information in a culturally and linguistically appropriate manner with Members.

CHA has the ability to generate reports from specified data including ethnicity and primary language. Requested or necessary performance reports can be disseminated in English and Spanish. Klamath County is predominantly white, English speaking with Spanish being the predominant second language. Many of our providers are or have staff fluent in Spanish. All providers have access to interpreters/language line. Cultural competency training is provided to all contracted providers annually. Members will be accommodated if their language is other than English.

From the 2012 Culturally and Linguistically Appropriate Services (CLAS) County Data. The regulations implementing PHS Act section 2719 require plans and insurers to make certain accommodations for notices sent to an address in a county meeting a threshold percentage of people who are literate only in the same non-English language. This threshold is set at 10 percent or more of the population residing in the claimant's county, as determined by American Community Survey (ACS) data published by the United States Census Bureau. Although Klamath County had less than 10 % Spanish-only households in this survey. CHA will provide all member information in Spanish. These materials will be sent out by request of the member or other agencies working with the member.

CHA will develop standards for culturally and linguistically appropriate services as per (CLAS) proposed means to correct inequities in health services. These standards outlined will be incorporated into training and development of policy and practice expectations.

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.

CCC/CHA will continue to monitor provider quality determinants such as a) blood pressure control b) Hb A1c c) asthma medication utilization, etc. . These measures will be reported to providers with benchmarks comparisons to national and/or regional best practices. Such data has been shown to incentivize providers to improve or maintain high level performance. CCC/CHA through its clinical advisory committees (i.e. Utilization Management, Quality Improvement, Pharmacy and Therapeutics) will assist providers in achieving these aims. There is good correlation between such measures and health status of patients. With improved health status, the patients will require fewer and less expensive healthcare interventions. The resultant savings will then accrue to the provider community through our risk pool-sharing model. Given the small sample sizes involved and the lack of convincing data that financial incentives tied to specific quality measures actually work, we do not anticipate using such incentives in any form.

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.

CHA has the capacity to report on the accountability quality measures with current systems. CHA during the first year, if we don't currently have the capacity will develop systems to support the capacity to collect and report all OHA's accountability quality measures. All data types listed by OHA

for the accountability measures will be gathered, processed and maintained by CHA. Collaborative efforts and training of providers will help CHA to collect, analyze, and report data in a meaningful way. Claims data collected at this time has up to a three-month lag, which hampers a real time look at the data collected. By expecting all providers to use EHR's, CHA intends to be able to gather data in real-time. Real time data collection is an area being addressed and evaluated by our IT professionals.
CHA through development of member educational material and provider education will work together collaboratively to educate all members on healthier lifestyles. This will be accomplished through information posted on our website, newsletters, and information mailed to members with specific health conditions. Target areas within the first year will be to develop effective smoking cessation programs nutrition and physical health programs. Childhood obesity is growing in an alarming rate, by partnering with public health and the schools, CHA will be able to better identify and offer assistance.

Reductions and increases of health disparities will be detected and reported by CHA to committees and OHA, currently this data is only gathered by OHA at time of enrollment. CHA all work with its clinicians to produce methods of gathering information for members via surveys, health questionnaires and other methods that will be developed. Member experience surveys will be developed, distributed and reviewed. Currently this information comes through the CAHPS tool through the OHA.

End of life planning, screening for depression, timely transmission of transition record and care planning for long term care benefits are collected with direct chart review. Access to all EHRs will facilitate performing this task but chart review will remain necessary.

C.2.1.a.Describe the Applicant's Quality Improvement (QI) program.

CHA at the direction of the Governing Board will focus on quality patient care by requiring and supporting the establishment and maintenance of an effective quality assurance and risk management program. The Board also assures the adequacy of resources and support systems to implement these functions. An internal quality and performance improvement program is based on written policies, standards and procedures, clinical guide lines that are in accordance with accepted medical practices and professional standards (Physical, Mental, Dental and Chemical Dependency). Monitoring services for consistency in best practices, appropriate utilization and other parameters deemed appropriate for optimal outcomes.

The Board delegates to the Quality Assurance and Performance Improvement (QI) Committee/CAP, the responsibility to identify and recommend indicators, processes, and actions which assures high quality services for plan members. These recommendations will be acted upon by the Board in a timely fashion. As each process and indicator is established, the Committee will report monthly, quarterly, or as designated, the results to the Board.
As a key function for assuring high quality, the QI Committee/CAP will be responsible for recommending, implementing, and oversight of the provider credentialing process under the Board of Directors.

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 and other health equity related subcommittees including UR and QI assume responsibility for quality, safety, and care of the members. The board retains final authority and responsibility for healthcare and has direct oversight of all quality functions of QI committee for making operational decisions.

The QI committee provides oversight and direction of the QI program, including review and approval of the work plan, all QI activities, reporting, and annual evaluation of the quality improvement program. The QI committee meets bimonthly to review, discuss, and create new policies and procedures, review best practices and establish clinical guidelines. The Board has final approval on all policies, procedures and clinical guidelines.

As the selected CCO, CHA will move forward to integrate the quality management committees from the Mental Health, A and D, Dental, PCP/Specialists and the CCO. Community representatives will be selected based on expertise related to quality issues. Each of the added disciplines will maintain its own internal quality management committee that will be responsible to report to the integrated CCO quality management committee.

C.2.1.c. Describe how the Quality plan is reviewed and developed over time.

The quality plan is the core element of the QI program. It establishes the framework and key processes that enable the CCO to plan and carry out ongoing quality initiatives. The plan provides definition to the QI objectives and scope for the year. The plan is reviewed and updated annually (minimally)to reflect changes in policy, practice standards, contractual obligations, regulations and identified community needs.

The QI work plan is prepared annually and includes ongoing issues from the previous year and identified areas of need, or changes required for the coming year. The work plan is designed to describe scheduled activities and reporting of the QI committee and the QI program. The plan works as a guide for the program and includes planned activities and interventions, responsible person(s), frequency of data collection and sources used for baseline measures and goals in any analysis. The work plan is working document that is updated throughout the year as necessary.

Currently, the CCO and the County have individual work plans. Within the first year and through collaboration with all contracted providers the work plans will be integrated with the focus on improving quality of care. The board and the QI committee will receive, review and approve the integrated work plan.

Upon award of the CCO contract integration of the quality management committees will begin. CCO staff will be involved in the county QI program, and County staff will be involved in the CCO's QI program.
The QI Director(s) will be responsible for the overall maintenance and updating of the integrated work plan. Input of new and revised indicators from EQRO and OHA audits, provider/member input will incorporated as indicated and brought before the committee for approval.

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.

CHA will be responsible to develop a community needs assessment process, including conducting the assessment and development of the resultant community health improvement plan. CHA will share this information with the CAC so they may create a community health improvement plan for addressing our community needs including but not limited to:

- **Unmet, health related needs, disparate groups**
- **Primary prevention**

- **Seamless continuum of care**
- **Building community capacity**
- **Improving collaborative governance for community benefit.**

The CAC will be comprised of primary health care providers, specialists, mental health provider, dental health provider, chemical dependency provider, members of community at large and majority of council made up of members served by the plan. The CAC will have provider(s) that report directly into the CHA QI committee who will share quality information related to the community health needs plan.

C.2.1.e. Describe how the QI program specifically addresses health care and health outcome inequities, care coordination and transitions between care settings.

Striving to achieve the Triple Aim (better health, better care and lower costs) as required by HB 3650, CHA will be held accountable for its outcomes, quality, health equity and efficiency measures identified by OHA through a robust public process in collaboration with culturally diverse stakeholders. The process for measuring outcomes to be tracked will depend on the community's needs, goals and requirements of OHA. The data collected will be used to direct continuous quality improvement activities of the CCO. For example, if the CCO takes on the goal of making certain that all patients are discharged from an acute inpatient stay with an appointment with their assigned PCP/clinician in a timely manner, monitoring this activity will provide opportunity to identify clinical areas that need improvement and corrective action will ensue.

CHA through the use of community health needs assessment, Claims data, Appeals/ Grievance data, Health analysis reports, Encounter data, Referral data, CPT/ICD - 9 data, Peer review, direct observation, and Yearly Access studies will focus on underserved and over served members. CHA will focus on chronic conditions and use best practices to identify inequities in health care services related to ethnicity, location and utilization. Systematic collection of data retrospectively through claims history allows CHA to identify regions within Klamath County with higher incidence of health disparities.

Screening members for ethnicity, residence, diagnosis and utilization will allow CHA to identify outcome inequities. Care coordination can occur at all Allied health agencies who can share information regarding a member. Case management services based off the individual care planning and coordination of services allow for individual treatment.

Data is collected in a variety of ways in order to identify conditions, treatments and quality of care issues that need to be studied or improved. Yearly planning is initiated based on information gleaned and approved by the QI process. Data for assessing quality of care, specific treatment, and conditions that need to be studied are collected from multiple sources including registration information, social services, claims data, and chart reviews.

Evaluation of quality of care is achieved through review of accepted professional medical standards of practice, Guidelines from the National Committee on Quality Assurance, Guidelines adopted from documented medical research, and Guidelines adopted from the Oregon Medical Association.

C.2.1.f. Describe how regular monitoring of provider's compliance and Corrective Action will be completed.

The QI and UR committees are responsible for oversight of providers. The process will develop, recommend, and periodically review methods to optimize health care resources. Evaluation of existing

methods as well as development of new methods will be a part of this process. Consideration will be given primarily to the outcomes of patient care as well as the cost of care. Areas examined in accomplishing these functions include but are not limited to:

- **Procedures used to establish whether a service is medically necessary, whether authorization will be granted to perform a procedure, whether a proposed site of care is appropriate, or whether a referral will be authorized.**
- **Accepted standards of practice.**
- **Administrative systems designed to enhance the efficiency of the delivery of health care.**
- **Education and other methods to improve patient compliance with the treatment plans and health care maintenance goals.**

When information comes to the attention of the UR Committee inconsistent with high quality, cost effective care, such as listed above, the following procedures are utilized:

1. **A Written statement regarding the concerns will be sent to the physician involved and/or a meeting with the UR Chairman and/or Medical Director to discuss the concerns.**
2. **Any response from that provider will be evaluated and if the response is satisfactory the matter is considered to be resolved. If it is not satisfactory, then a direct face to face meeting with the physician and the Committee may be held to resolve the issue. If successful the matter is considered resolved.**

C.2.1.g. Describe how the Applicant addresses QI in relation to: Customer satisfaction: clinical, facility, cultural appropriateness.

- Customer satisfaction: clinical, facility, cultural appropriateness

CHA utilizes CAHPS survey results, monitoring of grievances, secret shopper calls, internal member surveys, provider/clinic audits addressing ADA access, language and cultural components, member complaints, staff competency and cultural competency to develop the quality plan. CHA uses the QI process to gather data on members that serves to identify cultural, ethnic information which will allow the CCO to assign members to appropriate PCPCH.

CHA currently does not employ customer satisfaction surveys. This process will be something that is reviewed and discussed as a potential improvement strategy. PCPCH will be involved in gathering data, at the point of service related to customer satisfaction. This data can then be analyzed and reported to the QI committees and the CAC board.

CHA will work directly with the members to ensure care plans are developed and appropriate for their individual needs by collaborating with providers and other community partners. Members and clinic information will be reviewed to place members with providers that can best address the member in a culturally appropriate manner.

Through the grievance and complaint process information is gathered and analyzed to determine any trends or areas of concern in relation to member satisfaction. This only addresses a small percentage of the population served and therefore additional member satisfaction surveys will be needed to identify general member satisfaction with the health care experience.

- Fraud and Abuse/Member protections

Member involvement in expressing/reporting the experience of received services, audits based on services billed and the quality of the care will give CHA another tool to monitor fraud and abuse and assure appropriate care for members. The inclusion of all service providers under one umbrella allows for monitoring of all services members receive with the focus on prevention.

- Treatment planning protocol review/revision/dissemination and use with evidence based guidelines

Treatment planning is the responsibility of all providers at the time service is provided. Members that are identified as having a chronic condition/exceptional needs or with increase or decrease of service utilization will be recommended to the ENCC for development of a coordinated plan of care. Milliman guidelines, AMA recommendations, SAMSHA, and other professional publications will be supporting references that are reviewed, discussed and implemented in clinical guidelines used in developing plans of care.

C.2.2. Clinical Advisory Panel

The QI and UR committees function as our Clinical advisory committees. Practitioner's from all service areas will be involved on the committees and will be expected to provide, review and respond to community needs to determine best practices and clinical guidelines.

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?

CHA, through CCC has an established CAP. CCC/CHA has long-standing committees, (Quality Assurance, Utilization Review, and Pharmacy and Therapeutics). Their membership includes; Primary Care Physicians, local Physician Specialists, representatives from Sky Lakes Medical Center, CCC Medical Director and RN Case Managers. These committees review and revise current and new policies and procedures along with clinical guidelines. The committee members seek out best practices and validate through established national guidelines (Milliman , ACOG, AAPP, etc.) It is our intention to incorporate additional provider members from Mental Health, Addictions and and (Dental Health, 2014) in our newly formed CCO. Final approval of policies, procedures and clinical guidelines is made by the Governing Board.

The Utilization review committee meets monthly for review of utilization, denials of services and clinical care issues. The quality assurance committee meets bi monthly alternating with pharmacy and therapeutics committee. Representatives from these committees will sit on the governing board. Membership of these committees will include clinicians from mental health and addiction agencies.

Information will be gathered from CAC, the board and local agency committees. This information will be reviewed, analyzed and integrated into the work plan with reporting back to the governing board and the CAC. Through this process we will gather information on member experience with the delivery system strengths and weaknesses associated with receiving health care in the community.

Committee members are expected to advocate for members receiving services. Committee members will represent diverse specialties, age and ethnic populations.

C.2.2.b. If a CAP is not established, describe how Applicant's governance and organizational structure will achieve best clinical practices. **N/A**

C.2.3. Continuity of Care/Outcomes/Quality Measures/Costs RFA Question:

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.

CHA will integrate behavioral health system policies and procedures into CHA policies and procedures for physical health. This process will occur over the next six months, through coordination with mental health and A&D providers. CCC/CHA creates clinical guidelines based on documented best practices as identified by primary care physicians and specialists, mental health, A&D and dental providers. This process serves to improve member outcomes.

Klamath County behavioral health providers currently report having trauma informed services, and evidence-based practices. With the award of the CCO contract CHA will be able to collaborate with these providers and incorporate policies and guidelines. Collaborative trainings will be developed reflective of community needs assessment and with direction of the CAC and CHA boards.

Community navigators and peer training will be developed and implemented by CHA with collaboration with the mental health and addictions providers. Through data analysis of psychiatric hospitalization admission rates, length of stay, treatment initiation and engagement of services, CHA will develop policies specific to member outcomes. Place of service, type of service and level of care will be evaluated to assist in identifying specific areas of focus for CHA.

Identification of members that reside in the rural communities may require behavioral health specialist, case managers and healthcare navigators to travel out to the rural communities to serve these members. Encouraging providers to hire bilingual and culturally diverse staff members to assist in serving the Hispanic and the Native American populations will benefit cultural diversity.

The current health care delivery system will be evaluated and training provided to assist practitioners to develop innovative ideas with the emphasis placed on prevention. Case Management services will focus on identification of members at high risk of health disparities, through identification of diagnoses and over/under utilization of services. CHA evaluates quality of care by reviewing and implementing accepted professional medical standards and practice guidelines from the National Committee on Quality Assurance, documented medical research, Milliman guidelines, AMA recommendations, SAMSHA, other professional publications and the Oregon Medical Association.

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.

CHA gathers information related to tobacco use among its enrollees. This information is disseminated to clinical providers with the expectation that members will be encouraged and referred to Tobacco Cessation programs. Members identified as tobacco users are also contacted via mail with an invitation to CHA's Tobacco Cessation program.

Information is gathered related to outpatient visits, specialty visits and emergency department utilization per member per month. This information is disseminated to QI and UR committees for review and response. Information is disseminated to the clinics in regards to members with high ER utilization or possible non emergent visits.

Substance use disorders are monitored and reported to the QI and UR committees for review and response. SBIRT is expected to be used by clinicians as a screening tool for alcohol misuse. CHA is

currently engaged in a process of placing behavioral health counselors within PCPCH homes. This effort will increase evaluation, initiation, and engagement of alcohol and drug treatment.

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.

CHA supports and encourages wellness programs and health improvement for members and employees. Members that are dealing with chronic illness as defined by DMAP are part of our disease management program in which the focus is on these conditions, efforts on education and potential incentives for members. CHA feels it is critical to get the members involved in their own healthcare. Incentives for members as well as staff are a great motivator.

Real-time data analysis will become critical in implementing programs to assist members with their healthcare. CHA will focus on collaboration and sharing information within the rules that govern confidentiality. Case management services are significant part of this process in combination with data analysis for assessing quality of care, effectiveness of treatment, and condition outcomes that will be collected, reported and shared with all partners involved in the members care.

CHA will encourage the development of a local training program for individuals to become health navigators/Community Health Workers. These workers will assist case managers in the coordination of care for members served by PCPCH's. The primary focus of these workers will be assisting members in navigating the health system and improve follow through. Member satisfaction will be a focus for these workers and it is anticipated the members with chronic illnesses will be a primary area of utilization. CCC has had a number of limited time challenges to the entire staff related to health behaviors. We joined the President's Challenge and have had a number of weight loss challenges as well as collecting total mileage walked or run by staff to chart hypothetical trips across a map of the United States.

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.

CHA currently employs two data analysts, they develop reports and programs from collected data, using Access database as a desktop program. In the first year CHA will report on the accountability metrics with clarification and collaboration with OHA.

CHA is continually assessing quality of member care through the use of claims data. The current system data reporting systems can have up to a three-month lag time for data submission. DMAP and community partners in collaboration with CHA will need to focus on timely submission of data and/or real-time data collection. Some of the accountability metrics will require changes in data collection at the provider level, which will be a focus for the first three years of the CCO.

C.2.3.e. What other strategies will you implement to improve patient care outcomes, decrease duplication of services, and make costs more efficient?

CHA's primary focus will be related to case management services within providers offices, clinics and at the plan level. Case management has been shown to greatly improve member outcomes and cost

efficiency. Decrease duplication of services and cost efficiency. Implementation of health navigators and documentation that provides clear direction for members will help educate providers and members of the rules related to the Oregon health plan. Health systems are very complex, cumbersome and difficult to understand, focus on how the program works at a local level will reduce some of this concern for our members. Health navigators working with Members and case managers to address health and wellness activities thereby reducing costs through preventative measures. Education of members related to diagnoses is a primary function of case management services involving members in their own care, encourages member compliance and understanding of ordered services.

Training of staff and members on evidence based and emerging best practices that are clinically effective and cost effective through the development of Clinical guidelines will be implemented to identify and measure outcomes.

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.

CHA' policies and procedures focus on compliance with all local, federal, and contractual regulations. P&P's are implemented and developed with the focus on continuous identification of areas to improving the delivery of healthcare and services for our members. The authorization process is designed to assess the medical necessity of care as well as ensuring optimal utilization practices.

CHA will execute a case management program featuring clinical focus on care coordination and disease management for members. CHA will accomplish this goal by partnering with PCPCH' s and clinicians who oversee the healthcare of members. CHA will serve our members consistent with our core philosophy that quality healthcare is best delivered locally.

CHA's focus on case management services and health navigators involved in member care, will be placed under the ENCC program. Discussions will be held with the mental health and addiction partners to identify what services will require prior authorization requirements. This will be a new challenge for the some providers but will allow CHA to use this data to analyze care based on outcomes.

CHA will review and revise policies to include mental health and addiction treatment into the ENCC continuity of care of its current ENCC program. The overall goal will is for primary care physician, and other clinicians, (mental health and addictions), to be co-located within one central location, allowing for coordination of all service needs in one location.

ENCC services are available Mon-Fri during normal office hours. ENCC staff perform initial needs evaluation for members when identified by providers, utilization review of services or by diagnosis. Members identified in need of ENCC services are contacted by case management services to assist the member with identified needs. During the initial conversation with the member, a care plan is initiated outlining immediate needs of the member. Community resources, local agencies, state agencies foster home, social services and hospital needs are considered when developing the care plan. The ENCC assists the member in coordinating and accessing the services.

ENCC program allows case management to act as a consultant in the referral process to insure specific issues including co- morbidities and complications are addressed before services are initiated. Coordination of case management and health navigators will provide member education of resources available to them and assistance in dealing with their diagnosed conditions or healthcare needs.

Staffing for ENCC member needs is monitored on a regular basis. Information regarding the availability and scope of ENCC services is published at least annually in the provider newsletter and information is disseminated at annual trainings.

ENCC staff address, members with disruptive, inappropriate, or threatening behaviors in clinical offices, working with the member and provider to find solutions prior to loss of the member/clinician relationship.

ENCC staff contact caregivers, agency case managers, medical providers, and surrogate decision-makers as needed, to discuss concerns and possible solutions. Situations are evaluated following the receipt of information from the responsible parties and a plan of care is developed. Intervention may include but is not limited to teaching for the office staff, behavior modification, behavior contract, alternate care settings, or reassignment to a different provider. The interventions will occur in a timely manner to prevent disruption of the member's care. Interventions will be appropriate for the member's disability, respectful of their dignity and their right to confidentiality.

All interventions and results are documented in the member case file and disseminated to all involved. Additional expertise will be recruited when initial interventions are not successful and include medical, psychiatric, and behavioral interventions to determine the cause of the members difficulties and assist in developing appropriate plan of care. If the ENCC becomes aware of a potential behavioral problem, a prevention plan will be developed to avoid distress to the member or the clinic/provider. The surrogate caregiver and/or member will be kept informed of any change in plans for the member and allowed to be involved in the decision making if capable.

Service Area Table For Cascade Health Alliance		
Service Area Descripton	Zip Codes	Maximum Number of Members - Capacity Level
Klamath County (partial)	97601, 97602, 97603, 97604, 97621, 97622, 97623, 97624, 97625, 97626, 97627, 97632, 97633, 97634, 97639	10,600

Publicly Funded Health Care and Service Program Table

Name of Publicly Funded Program	Type of Public Progam	County in which progam provides service	Specialty/Sub-Specialty Codes
Klamath County Health Dept.	Immunizations, family planning, std, communicable disease Pending	Klamath	PB (47)
Klamath Open Door Family Practice	FQHC	Klamath	91 Primary Care
Klamath County Health Dept.	Mental Health Pending	Klamath	92 Adult
Klamath Youth Development Center	Mental Health Pending	Klamath	93 Adolescent/child

Cascade Health Alliance
RFA 3402

CASCADE HEALTH ALLIANCE

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

Section 2 - Ability to Serve Dually Eligible Individuals

D.2.1. Describe the Applicant's approach to be able to provide Medicare benefits to dually eligible Members by January 1, 2014. Include:
Our organization will continue to contract with our affiliate ATRIO Health Plans to administer the Medicare benefits in our service area.

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); **CHA will be able to continue to provide the Medicaid benefits to dually eligible Members through our existing resources with Cascade Comprehensive Care who has managed the OHP benefit as an Fully Capitated Health Plan since 2005.**

D.2.2.b. The timeline and milestones the Applicant will achieve to meet this requirement fully by January 1, 2014,

ATRIO already has applied and has been awarded CMS contracts for 2012 services. Through the coming Bid process ATRIO fully expects to be granted a renewal from CMS to continue as a Medicare Advantage Organization in 2013 and into 2014, continuing to serve the full dual members of the CCO. Additionally, to meet the MIPPA requirements ATRIO is in contract negotiations with State and our OHP partners to ensure that ATRIO has the required fully integrated SNP contract in place and submitted to CMS by 7/1/2012 to continue operations as a SNP into 2013 and beyond.

Key milestones that ATRIO is prepared to meet include (but are not limited to).

- **Formulary Submission – ATRIO has submitted the required formularies to CMS for many years and will continue to have the processes in place for timely submission in 2014.**
- **Transition Fill Policy submission – The transition fill policy currently in use by ATRIO meets the CMS requirements. The current transition policy will be updated as appropriate or as required by CMS or OHA for the 2014 plan year.**
- **Medication Therapy Managed Program (MTMP) submission – The MTMP currently in use by ATRIO meets the CMS requirements. The current MTMP will be updated as appropriate or as required by CMS or OHA for the 2014 plan year.**
- **Bid Submission – ATRIO stands ready to prepare all necessary Bid documentation and submission items by the 2014 Bid deadlines and ensure appropriate coordination with our CCO.**
- **Enrollment – ATRIO has a well-established Enrollment department and stands ready to meet all CMS required pre and post enrollment activities for the 2014 plan year as well as respond to any future updates to enrollment requirements.**
- **Member materials – ATRIO has a history of creating and distributing all CMS required member materials. ATRIO stands ready to meet all timeframes for required member materials.**
- **Readiness Checklist – Each fall CMS sends out to all Medicare Advantage Organizations a Readiness Checklist for important operational items that need to be in place for successful operations into the coming plan year. ATRIO stands ready to have all operational areas ready to meet the standards for all 2014 Readiness Checklist items.**
- **Compliance – ATRIO has robust compliance resources and continuously monitors all state and federal regulations that affect operations. ATRIO has the staff and resources needed to stay current on all state and federal requirements. Additionally, ATRIO will be able to respond to any updates or new requirements CMS or OHA may develop between now and 2014.**

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

Our CCO will ensure that applicable requirements regarding dual eligible Medicare Benefits are accomplished through our contracted affiliate ATRIO Health Plans who has been a Medicare Advantage Organization serving dual eligible Members since 2006.

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

Applicant Name: Cascade Health Alliance

Instructions for completing this form:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Section A.5.1 Pages 33 - 40 Managed Care Budget Model is a confidential trade secret that is exempt under ORS 192.501(2) and ORS 192.502(9) and is not to be disclosed except in accordance with the Oregon Public Records Law, ORS 192.410 through 192.505

[This list may be expanded as necessary.]

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

In the space provided below, state Applicant's justification for non-disclosure for each

item in the list in Part I
of this Attachment:

1. The description of our managed care budget model (found on pages 34 through 39 of our submission of Appendix A of RFA #3402) is exempt from disclosure under the Oregon Public Records Law as a trade secret and is otherwise exempt under public records law. The information is not patented. This data contains formulas, methods, techniques, and processes from which are derived independent economic value from not being generally known to the public or other persons who can obtain economic value from its disclosure or use and is the subject of efforts that are reasonable under the circumstances to maintain its secrecy. ORS 646.461. Specifically, the managed care budget model reflects a proprietary methodology and formula developed by CCC over several years that allows successful management of plan financial risk and incentivizes cost effective and collaborative care delivery in the local health care community. This model is a valuable asset that would lose much of its value if disclosed to persons who could obtain economic value by copying the model. CCC takes reasonable steps to maintain the secrecy of the model by use of a confidentiality statement in our contracts stating that "The terms of this agreement and in particular the provisions regarding compensation, are confidential and shall not be disclosed except as necessary to the performance of this agreement or as required by law." This information is known only to certain individuals within our organization, specifically executive personnel involved in developing the model and staff who administer the model and is used in contracting with local participating health care providers and our local hospital who share financial risk in providing medical services to our enrollees pursuant to contracts that require protection of the confidentiality of such information. This model has both actual and potential commercial value and provides us with a business advantage over competitors who do not know or use it. This data is exempt from disclosure under ORS 192.501(2), ORS 192.502(9), ORS 646.461.

X _____

William Guest, III
CEO

Cascade Health Alliance APPENDIX A – CCO Criteria Questionnaire

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.
Cascade Health Alliance, LLC
2909 Daggett Ave, Suite 225 Klamath Falls, OR 97601.

b. Describe Applicant's Affiliates as relevant to the Contract. **Cascade Health Alliance (CHA) affiliated with Cascade Comprehensive Care (CCC) as its parent company.**

c. What is the Applicant's intended effective date for serving Medicaid populations? **CHA intends to have a contract effective August 1, 2012.**

d. Is the Applicant invoking alternative dispute resolution with respect to any provider (*see* OAR410-141-3268). If so, describe.
We have not invoked alternative dispute resolution at this time. We have been contacted by Theresa Jensen who works for "Oregon Consensus" who had been asked by the Oregon Health Authority to " provide a wide range of neutral process support to whatever configuration of CCO(s) emerge in Klamath County." We have had two conversations with Ms. Jensen on the phone and accepted her request to meet with her (which we did on April 24, 2012 in Klamath Falls, Oregon. 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.

NA

f. What is the proposed service area by zip code?
Klamath County 97601, 97602, 97603, 97604, 97621, 97622, 97623, 97624, 97625, 97626, 97627, 97632, 97633, 97634, 97639

g. What is the address for the Applicant's primary office and administration located within the proposed service area?
2909 Daggett Avenue, Suite 225
Klamath Falls, OR 97601

h. What counties or portions of counties are included in this service area?
Klamath County zip codes 97601, 97602, 97603, 97604, 97621, 97622, 97623, 97624, 97625, 97626, 97627, 97632, 97633, 97634, 97639
Describe the arrangements the Applicant has made to coordinate with County governments and establish written agreements as required by ORS 414.153
MOUs with Klamath DHS for LTC, KCMH and Klamath County Health Department have been requested to address provision of required services. CHA expects to have MOUS in place prior to contract signing.

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")? **Yes.** If so, what type of managed care organization?
Fully Capitated Health Care Plan.

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, the legal entity has changed. The current MCO (CCC) has incorporated a subsidiary, Cascade Health Alliance, LLC (CHA); CHA is the legal entity applying to be the CCO.

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. **No**

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? **YES** Does this Application propose any change in the current Service Areas? **We are asking that all requested service area zip codes be opened to CHA until a capped limit of 10,600 is reached. Our enrollment capacity may be adjusted in the future as access to primary care providers changes.**

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")? **No**

n. Does the Applicant have experience as a Medicare Advantage contractor ? **We have experience indirectly through our subsidiary ATRIO a Medicare Advantage Plan who provides coverage for our dual eligible members.** Does the Applicant have a current contract with Medicare as a Medicare Advantage contractor? **NO**
What is the service area for the Medicare Advantage plan?
Klamath County zip codes 97601, 97602, 97603, 97604, 97621, 97622, 97623, 97624, 97625, 97626, 97627, 97632, 97633, 97634, 97639.

o. Does the Applicant hold a current certificate of insurance from the State of Oregon Department of Consumer and Business Services, Insurance Division? **NO**

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.
CCC/CHA intends to continue and expand its current risk-sharing model. Although not directly rewarding healthcare quality, it has provided demonstrably improved health outcomes. This model works in this geographically isolated high desert basin because its residents are more likely to remain with CCC/CHA than a similar population in areas where there is access to other health plans. Our members are our neighbors and will remain so. Therefore, their long-term well-being benefits not only providers, but the community as a whole.

(2) Coordinating the delivery of physical health care, mental health and chemical dependency services, oral health care and covered DHS Medicaid-funded LTC services.
CHA has 16 + years operational experience with the CCC Medical Management and Case Management (CM) team coordinating the delivery of physical health care, mental health care, chemical dependency services, outpatient pediatric dental services and covered DHS Medicaid LTC services. Our CM team has effectively coordinated the care of our 9650+ members addressing prior authorization of requested services, coordinating care with members, PCPs and other ancillary services. CHA RN Case Managers communicate and collaborate with Mental Health case managers/providers, APD arranging appropriate placement and services for our members as needed. RN case managers also coordinate with members, PCPs and local Substance Abuse Disorder providers for substance abuse disorders referrals utilizing screening, brief intervention, referral and treatment. CCC has supported the implementation and utilization of the SBIRT model of screening and intervention by our primary care providers. We have collaborated with the local mental health department and chemical dependency treatment providers to facilitate referrals for Mental Health and Chemical dependency through use of referral form that is inclusive of release of information. CCC also coordinated a year-long effort in 2011 to place an Substance Abuse Disorders counselor in both of our two largest clinics on a part-time basis.
In the past month we have added another RN case manager to assist in our chronic disease management program. We have in place active and effective ENCCs (Exceptional Needs Care Coordinators) who assist our 1950+ ENC members with Transitions of care to and from all levels of care including individualized care plans shared with PCP, sending and receiving facilities and member/family when appropriate. We have well - established working relationships with our local DHS APD, Long Term Care providers, assisted living

facilities, and our many Adult Foster Homes/Programs in the community.
CCC also employs an RN Maternity Case Manager (MCM) who coordinates care for all pregnant members. Emphasis is on high risk mothers to promote healthy moms and healthy babies, reduce prematurity and complications. The MCM collaborates with PCP, OB provider, member, DHS and other appropriate services to assure early prenatal care, prevention, education, screening and treatment referral for tobacco use and or substance abuse. We have an incentive program of a $50.00 gift card to a local department store for every mom who meets criteria. (Sign up for WIC, sees her dentist, makes prenatal visit before 13 weeks plus documentation of additional three visits, contacts with MCM three times through-out pregnancy, optimally one of these face to face, take prenatal vitamins).

We will be exploring the opportunity for utilization of doulas within our community in the next year or two as we further refine our program.

Moving forward CHA and its Case Managers will be assisting members in gaining access to non-covered services and that are provided under separate contract with OHA. As stated above we have working relationships with Mental Health, DHS APD and Chemical Dependency providers that will facilitate these interventions through the use of shared treatment/care plans.
For most of the past twenty years, our medical director has functioned as medical director for all of the residential and most of the outpatient substance abuse disorders providers programs in our community. His close relationships with the counselors has proved a valuable resource, facilitating the communication among various providers as well as with CCC.

(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.

CHA reviews available data regularly to get a sense of our population demographics. We have participated in the past with a collaborative effort with Klamath County Health Department in the Early Childhood Cavity Prevention program. Klamath County was a demonstration project and we saw significant improvement in our children's oral health. We have participated in PIPs that addressed Asthma, Tobacco Cessation and Substance Abuse Disorders. Through collaboration with our affiliated Medicare Advantage Plan, ATRIO we have worked with our SNP population to improve
quality indictors/outcomes for members with diabetes. CHA sees the transformation under the CCO model as an opportunity to engage our community members and health care providers in making meaningful changes and continue to address health needs of our county.
According to U.S. Census data, Klamath County had a population of approximately 66,380 in 2010, with a growth rate of 4.1 percent since 2000. The 2010 census indicates that the Hispanic or Latino population had the largest percentage of change.

AGE	%		ETHNICITY	%
Under 18	22.3		White	85.9
18-64	60.6		Black	0.7
65 and older	17.1		American Indian	4.1

SEX			Asian	0.9
Female	50.2		Hispanic	10.4
			2 or more	4.1

Persons Below the Federal Poverty Level	%
Klamath County	20.2
Oregon	14.3

2009 US Census Bureau

Leading Causes of Death in Klamath County:

- Cancer
- Heart Disease
- Diabetes
- * Chronic Lower Respiratory Disease
- * Stroke

Klamath County has a high prevalence of tobacco use, high blood pressure, obesity and high cholesterol, teen pregnancy, low rates of high school graduation.
Tobacco use and obesity are the leading causes of preventable death.
Source: Klamath County Health Dept report 2012/2013.

Number of individuals in Klamath County with developmental disabilities –
Children- 146 Adults 486
Number of individuals who live in licensed/certified home (group home, foster care...)
Children 19 Adults 104
Number of Adults in Support Service Brokerage 175
Carrie Buck Program Manager, Klamath County

CCC has worked with OHSU/CEFM residency clinic to bring substance abuse disorders providers into the office on a part time basis so that referrals can be initiated at the time the Primary Care Provider is seeing them. This has made a slight increase in substance abuse disorders treatment penetration but more over the rewards have been in the education of the residents and improving the communication and collaboration between substance abuse disorders providers and PCP.

CCC/CHA has programs in place to assist our members with diabetes. Members obtain their meter and testing supplies directly from CHA. An RN case manager reviews with the member their current understanding of diabetes, provides education related to blood glucose testing, diet, foot care and other important aspects of care. CM is able to determine whether a referral to a dietitian would be in the member's best interest and facilitates this referral. Case Manager or CM assistant down load member glucose meter data at each visit and relay the results to the PCP as well as the member, this is a teachable moment with the member. This approach supports the triple aim improving health, outcomes and decreasing costs. (CHA is able to purchase meters/supplies at a discounted price for our members' use at no cost to the member.) As we have more certified PCPCH's members will have more structure and support in meeting their health care needs and goals.

CCC/CHA provides Tobacco Cessation classes at no charge to our members. CHA covers tobacco cessation medications as ordered by member PCP. CCC/CHA has experienced a 20-40% quit rate among members

who participate in our program by self report. Members are allowed to attend as often as needed to achieve abstinence. The program is also open to the public for a nominal fee to cover education materials. Classes

are held year around at the Liskey Henzel Pavillion located near public transportation. Plus members have transportation available to them through their benefit package for these health education meetings. Members are self-referred or referred by Case Managers, PCPs and other providers. Looking ahead we need to collaborate with the CAC to identify ways to engage more members in tobacco cessation, by age, ethnicity and sex.

We also meet with local Mental Health, APD Caseworkers and Hospital Discharge staff to review member needs and develop a comprehensive Case/Treatment Plan that is shared with the member/family/caregiver and the Primary Care Providers. In the future with our work through the CCO we would like to explore new programs and outreach to more members. With results from a Community Needs Assessment we are hopeful that areas that may be lacking will be identified and measures can be put into place.

q. Identify and furnish résumés for the following key leadership personnel (by whatever titles designated): **Provided as separate documents for Appendix A**

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

r. Provide an organizational chart showing the relationships of the various departments. **Provided as separate documents for Appendix A**

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 **YES, Provider Contracts, Table B-1 (Participating Provider Table, MOUs, updated policies and procedures related to Medicare Assurances.**

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.

Cascade Health Alliance leaders and staff are reaching out to community leaders and members to receive input related to the community health needs assessment and the formation of the Community Advisory Committee. The Director of Operations is working with a diverse group of community leaders (including Sky Lakes Medical Center and Klamath County Health Department) to identify and secure a community wide needs assessment software program. Currently we are evaluating the product through Healthy Communities Institute. It is planned that this tool will be available to not only those providers requiring federal and state reporting requirements, but also community health providers, members and community at large. The local OHSU School of Nursing is gathering primary data from Klamath county residents to supplement this data base. We are engaging community members, specifically the local School of Nursing (OHSU) with request for continuing education offerings for RN Case Manager curriculum. We are also assisting our local primary care providers in achieving PCPCH certification. CHA staff and Board

members have reached out to other community groups requesting input related to the RFA from all but not limited to: Klamath County Mental Health, Klamath County Health Department, Sky Lakes Medical Center, Cascades East Family Medicine Residency, Klamath Community College, local IPAs, Med Impact, (PBM), ATRIO our partner for Medicare Advantage Plan, Klamath Open Door Family Practice (FQHC). CHA is soliciting feedback and participation with community leaders including the county commissioners to assist in the development of the Community Advisory Council. The CAC will have a majority representation of members who utilize CHA's services and represent members from the majority as well as the minority groups who utilize the CCO's services from Klamath County . This committee is currently under development and will reflect the geographic area served by CHA by age, race, ethnicity, economic status education and other meaningful factors. A public presentation is planned for May to share with the general public information about CCOs and CHA in particular.

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 Structure, consistent with ORS 414.625.

The Board of Directors of Cascade Health Alliance LLC shall consist of representatives of the following constituencies:

1. **A majority interest consisting of the Persons that share in the financial risk of the organization who must constitute a majority of the governance structure, as follows: 3 shareholders (representing primary care physicians)/directors of the member, 3 shareholders/directors (representing specialists or non-primary care physicians of the member, and 3 appointed by the shareholder of the member representing Sky Lakes Medical Center, which is the local non-for profit hospital;**

Representatives of the major components of the health care delivery system;

2. **At least two health care providers in active practice, including:**
   (a) **A physician licensed under ORS chapter 677 or a nurse practitioner certified under ORS 678.375, whose area of practice is primary care; and**
   (b) **A mental health or chemical dependency treatment provider;**
3. **At least two members from the community at large, to ensure that the organization's decision-making is consistent with the values of the members and the community; and**
4. **At least one member of the community advisory council.**

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.

In the absence of the identification of local county government designated members for the CAC member selection committee, we have identified a potential composition for the CAC.

1	Klamath County Representative
2	Klamath County Mental Health
3	Klamath County Health Dept
4	Klamath Youth Development Center
5	OHSU /CEFM (Residency Program)

6	Sky Lakes Medical Center
7	Klamath Falls Independent Physician Assoc. (Specialists)
8	Linkville IPA (Primary Care Physicians)
9	Dental
10	Substance Abuse Disorders
11	Consumer Representative
12	Consumer Representative
13	Consumer Representative
14	Consumer Representative
15	Consumer Representative
16	Consumer Representative
17	Consumer Representative
18	Consumer Representative
19	Consumer Representative
20	Consumer Representative
21	Consumer Representative

The community advisory council will include representatives of the community and of Klamath County government. Consumer representatives will constitute a majority of the membership. The CAC will meet no less frequently than once every three months. Its membership will be selected by a committee composed of equal numbers of county representatives and the members of the governing body of Cascade Health Alliance LLC.

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 Board of Directors of CHA will appoint as yet to be determined number (tentatively three but subject to negotiation with the local Klamath County government upon their response to previous requests to engage in the process) of their members to serve on the community advisory council selection committee (the "Selection Committee"). The Board of Directors of CHA will request that the Klamath County Board of Commissioners appoint an equal number of persons who are residents of Klamath County to serve on the Selection Committee."

The Selection Committee shall meet as needed to select members of the community advisory council. In making its selections, the Selection Committee shall comply with the equal representation requirements between the governing entity and the Klamath County government

A member of the community advisory council may resign at any time or be removed by majority vote of the Selection Committee at any time without cause. The Selection Committee may specify terms of office for members of the community advisory council, or adopt such policies and procedures as it considers desirable to facilitate appointment to the council of a group of individuals who meet the representation requirements set forth in subparagraph 2(a) above and are qualified to accomplish the duties of the council.

The Board of Directors of Cascade Health Alliance LLC shall consist of representatives of at least one member of the community advisory council.

The duties of the community advisory council include, but will not be limited to:

(a) **Identifying and advocating for preventive care practices to be utilized by CHA;**

(b) **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 CHA; and**

(c) **Annually publishing a report on the progress of the community health improvement plan.**

5. **The community health improvement plan adopted by the council should describe the scope of the activities, services and responsibilities that CHA will consider upon implementation of the plan. The activities, services and responsibilities defined in the plan may include, but are not limited to:**

(a) **Analysis and development of public and private resources, capacities and metrics based on ongoing community health assessment activities and population health priorities;**

(b) **Health policy;**

(c) **System design;**

(d) **Outcome and quality improvement;**

(e) **Integration of service delivery; and**

(f) **Workforce development.**

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.

Behavioral and physical health providers in addition to consumers or family members with experience with Severe and Persistent Mental Illness (SPMI) or LTC services will participate in CHA's Community Advisory Council (CAC). Through review of the community needs assessment CAC members will have input towards developing the community health plan that will incorporate the needs of the members with severe and persistent mental illness or receiving LTC services. The Board will also be involved in the creation (as well as being members of) of clinical advisory board committees such as Utilization Management, Quality Improvement, and Pharmacy and Therapeutics. These committees will include representation from physical, mental and eventually dental health who will be able to assist the Governing Board in meeting the needs of members with severe and persistent mental illness and members receiving DHS Medicaid-funded LTC services.

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.

CHA, through Cascade Comprehensive Care has an established CAP. CCC/CHA has long-standing committees, (Quality Assurance, Utilization Review, and Pharmacy and Therapeutics). Their membership includes; Primary Care Physicians, local Physician Specialists, representatives from Sky Lakes Medical Center, CCC Medical Director and RN Case Managers. These committees review and

revise current and new policies and procedures along with clinical guidelines. The committee members seek out best practices and validate through established national guidelines (Milliman , ACOG, AAPP, etc.) It is our intention to incorporate additional provider members from Mental Health, Addictions and and Dental Health in our newly formed CCO. Final approval of policies, procedures and clinical guidelines is made by the Governing Board.
Having all services at the table will enhance the collaboration and communication to meet the triple aim goals of improving Health, improving Health Care and reducing cost.

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.
CHA is currently working with the local APD office to develop the formal MOU based on the template and guidance provided. MOU will completed before contract signing date. Draft content spelled out under A.3.5.j.

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.

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.
CHA is actively seeking an MOU with Klamath County Mental Health Authority. In our proposed CCO service area there is a Community Mental Health Provider (CMHP) delivering adult services, a CMHP that delivers child and family care, and providers that deliver chemical dependency services. There currently exists a robust, broad array of mental health and chemical dependency services, and our plan is to collaborate with the current providers in the region to continue and expand upon these services. Our longer term vision is to shift the existing behavioral health delivery system toward a

patient oriented health home model. We have already started these discussions, and if we are selected as a CCO that planning process will become more rigorous and focused. Historically CHA has worked closely with each. CHA Case Managers collaborate with Mental Health and Chemical Dependency Staff and or the member to assist the member in gaining access to non-covered services The CHA ENCC staff has begun working closely over the last 4 months to coordinate care for Members with both Mental and Physical Health issues. Our discussion with the County Mental Health Authority, CMHPs, and other local behavioral health providers focus on developing a comprehensive and coordinated behavioral health delivery system, and to ensure that our members have access to services which are not going to be provided under the global budget. In this process the staff has learned to address the Member's concerns and satisfaction along with meeting the physical and mental health needs of the member. There has also been discussion on issues identified regarding the Community Health Risk Assessment. The combined Staff has indicated that they would be in a position to make suggestions on services and changes in current programs that will make the system more efficient and expand in areas that may currently be inadequate to meet the needs in the community. CHA will collaborate with our County's Mental Health Authority to ensure that our members have access to the safety net services that are not included in the global budget. We will develop agreements for Crisis response, respite services, residential services, civil commitment and other local safety net services which will be included in our array of care for CHA members.

A.1.4.b. How will Applicant ensure that members receiving services from extended or long-term psychiatric care programs (e.g., secure residential 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?

Oregon Administrative Rules 309-032-1540 through 309-032-1550 identify requirements for service transfer and continuity of care for extended and long-term care behavioral health programs. CHA will comply with these rules, and ensure that CHA case managers interact with extended, long-term, residential, and hospital programs as well as CHA members and families to ensure collaboration and coordination of services. As a Fully Capitated Health Plan, Cascade Comprehensive Care already has medical case managers who coordinate health care services for its members. This often involves facilitating transitions from any type of facility, local or distant, and assuring that appropriate outpatient follow-up arrangements are firmly and timely in place. These arrangements frequently include discussion with the mental health provider. Most such discharge arrangements give us from hours to a couple days, so a five-working-day window would be relatively leisurely. As a CCO, CHA will expand its case management staff and develop policies and procedures that will require consumer and family involvement in transition planning. CHA case management staff will also assure that necessary services and actions occur to address the identified health and safety needs of members transitioning between services, and that members receive follow-up services as medically appropriate. Discharges will take place within five working days of receiving notification of discharge readiness.

CHA will utilize the procedures for Long – term Psychiatric Care Programs for 0-17, 18-64 and 64 and over, to ensure members receive services as medically appropriate to ensure discharge within five working days of receiving notification of discharge readiness.

CHA will also use Utilization Review and Case Management Transitions of Care Plan to facilitate the seamless transition of the member to the next appropriate level of care. CHA will make every effort to include the member/family and or caregiver in the care plan to promote continuity of care. In addition the Primary Care Provider and other members of care team will be involved and review the care plan for appropriateness, timeliness and cost effectiveness.

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?

CHA will ensure that 24/7 on call services are available to provide screening to determine nature of the situation and the member's immediate need for Covered Services; capacity to conduct the elements of a Mental Health Assessment that are needed to determine the interventions necessary to begin stabilizing the crisis situation; development of written initial services plan at the conclusion of the Mental Health Assessment, provision of covered services and outreach needed to address the Urgent or Emergency Situation and linkage with the public sector crises services, such as pre-commitment. CHA expects these services will be provided through our anticipated MOU with Klamath County Mental Health and Klamath Youth Development Center, who have these services in place and have provided them historically in collaboration with Sky Lakes Medical Center Emergency Room, local police, courts and juvenile justice, corrections providers.

Implementation of local drug and mental health courts would be interventions that could improve member outcomes and decrease overall costs. ENCCs and Case Managers from either the Physical Health or Mental Health systems would then follow the member to assure that the Member continues to receive the agreed upon services and that the Care Plan is updated as the Member's condition changes.

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

The CHA will continue to support and encourage community partners in providing the Triple Aim to the members. Currently the CHA through CCC has developed working relationships with the local APD, AFS, and DD caseworkers, Klamath County Mental Health Caseworkers, Klamath Youth Development Center, substance abuse disorders providers treatment agencies, local Law Enforcement including Parole Officers and as the case demands the Courts. The CCC staff frequently works with the local Tribal office to coordinate care for members covered under both the Tribal Health System and the OHP. CCC ENCCs and Case Managers work closely with the local School Nursing staff to assure members at the school are receiving the care and supplies that is required to promote better health and safety. Contact is also maintained with the local State RNs for the care of the LTC members in the community.

These are the majority of contacts that the CHA ENCCs and Case Managers currently maintain but not an all-inclusive list of partners, which are utilized to provide exceptional Member care. The CHA ENCCs and Case Managers are continuously working to develop Care Plans with input from the Member, Provider and Community Services, which meet the member's goals for increasing their health and lower health care costs. CHA is also looking forward to developing new relationships and exploring innovative new programs to help enhance the member's overall health status.

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 prevention 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 public health agencies, mental health agencies, hospitals, etc., to be found 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.

Historically we have relied on community health assessments done by our local Klamath County Health Department and Sky Lakes Medical Center or our internal reporting. CHA's Director of Operations is working with a diverse group of community leaders including SLMC and KCHD to identify and secure a community wide needs assessment software model. Currently we are evaluating a product through Healthy Communities Institute. The program draws from current databases in the nation, state, region, county and zip code level. It is planned that this tool will be available to not only those providers requiring federal and state reporting requirements, but also the CAC, community health providers, members and community at large to avoid duplication of efforts. We intend to have a decision made in the next 4-6 weeks.
The data would be updated annually, and the site would be centrally managed in the local community. CHA will work with OHA, including the Office of Equity and Inclusion, to identify the components of the community health assessment that will need to be included for our purposes and reported out per OHA's data policy.

Applicant should describe the mechanisms by which the CAC will meaningfully and systematically engage diverse populations as well as individuals receiving DHS Medicaid-funded LTC and individuals with severe and persistent mental illness, in the community health assessment process.

The CAC will engage our covered populations including those with severe and persistent mental illness and those receiving DHS Medicaid-funded LTC services by using a wide range of available databases reflecting the diverse service area population. Composition of CAC will include covered members comprising at least 51 % of membership in addition to representatives from community wide physical health, mental health, chemical dependency, social services, dental, public health, schools, and other interested parties. The CAC be responsible for meeting regularly and for sharing community health assessment results and recommendations at minimum annually with the CCO and OHA.
An example of proposed representatives for CAC see A.1.1.b

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.
CCC/CHA follows policies and procedures designed to assist members in choosing providers, requesting second opinions, well women care, services not requiring referral and other member rights related to access to care as outlined in our contract with OHA. CHA continues to provide case managers to assist members with coordination of care, developing care plans jointly with members/care givers. CHA will continue to work with PCPs and PCPCHs to assure culturally and linguistically appropriate approach to member care and treatment plans through policies/procedures and provider education. New materials will be developed to reflect the new models of CCO and PCPCHs.

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.
PCPCHs will be actively engaging our members in their treatment plans with each visit. Cascades East Family Medicine Center, a PCPCH, through their EMR is currently providing members with copies of their treatment plan at the conclusion of their visit. The treatment plan includes medications, vital signs, instructions for care, member education and lab results when available. They have the capability to provide the majority of this information in Spanish, the local predominant non- English ethnic/cultural group. This particular clinic is also exploring

implementation of "My Chart" software. CHA is working with this clinic to determine whether this can be implemented community wide. "My Chart" is web based and allows members to sign in with password to view their own chart.
As part of the PCPCH certification, the PCPCH certified clinics will be gathering member experience data to measure member satisfaction with their PCP encounters.

CHA ENCC staff work closely with the Member and Primary Provider to develop a personalized and specific Care Plan during transitions of care. The member is encouraged to assist in defining a large portion of their goals and interventions. This process empowers the member and makes it more likely that they will meet the goals that they set for themselves and make lifestyle changes to better their health status.

Member surveys conducted through PCPCP's, CAHPs survey, member interactions and recommendations from the CAC will be reviewed, analyzed and acted upon through CHA's Quality Improvement Program. Information is fed back to providers as part of the quality improvement processes.

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 members about what they should expect from the CCO with regard to their rights and responsibilities; and
•Meaningfully engage the CAC to monitor and measure member engagement and activation. **CHA is encouraging our providers to become PCPCHs as the model encompasses the above services. Cascade Health Alliance will work with our providers to develop culturally and linguistically appropriate materials to encourage members to utilize preventive services, and make healthy life style choices. As we move forward, we will encourage the development and use of peer support health care navigators in our clinic settings.**
CHA will provide each enrollee with a new member handbook that meets their cultural and linguistic needs, taking into account the need for alternate formats for those members with disabilities, (aged, blind, hearing impaired). The member handbook will be written at a 6th grade level, addressing member rights and responsibilities, how to access a Patient Centered Primary Care Home, Emergent, Urgent and routine care and other information as per OARs and contract.
Meaningful engagement of the CAC to monitor and measure member engagement and activation will be facilitated by sharing CAHPs reports, utilization reports and community needs assessment information on a regular basis with the CAC. The CAC will be represented on the CHA governing board. CAC will be responsible to provide an annual report to OHA on the CCO/CHA performance.

Section 3 – Transforming Models of Care

Transformation relies on ensuring that Members have access to high quality care: "right care, right place, right time". This will be accomplished by the CCO through a provider network capable of meeting 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.

CHA is currently working with our provider network on an individual basis. We direct them to the PCPCH web site, follow up with their point person to answer questions, offer technical assistance, discuss available support through CHA to assist them in achieving Tier 1, 2, or 3 status. CHA is offering to assist with providing relevant member data, offer links and documentation related to cultural and linguistic needs of the members. CHA providers have in most cases staff who are qualified interpreters and are culturally competent for our Hispanic population. For those clinics without a Spanish interpreter or in need of another language they have access to CHA's contracted interpretation services at no cost to the clinic or the member.

A.3.1.b. Describe Applicant's plan for engaging Members in achieving this transformation. Integral to transformation is the member-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 member and family-centered approach to all aspects of care, and an emphasis on whole-person care in order to address a member's physical and behavioral health care needs.

CHA is working with our contracted providers to have all clinics achieve PCPCH status. We believe all of our members would be better served in this environment. The more clinics we have certified and engaged as primary care homes, the more exposure our members with have to the health care model and the services they provide. Currently we are working with the FQHC (Klamath Health Partnership) and Klamath Pediatric Clinic (Sanford Clinic) to achieve PCPCH status. Cascades East Family Medicine Center is a Tier 3 PCPCH. We will approach our remaining clinics over the course of the summer in assisting them in achieving Tier 1-2 or 3 status.

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 concrete 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.

CHA currently is contracting with:
Cascades East Family Medicine Center, Tier 3 Certified with member capacity for 2208 members. They will be adding 2 additional providers in August 2012 that will increase their capacity by approximately 1000 members.
We are in discussion with Klamath Open Door Family Practice for PCPCH application – Capacity 2800. KODFP intends to submit their application by April 30, 2012.

We are also in discussion with Klamath Pediatric Clinic/Sanford Clinic for PCPCH application – Capacity 3000

These 3 clinics serve 75% of our projected 10,600 members.
CHA's goal is to have KODFP and KPC/Sanford Clinic on board as Tier 2-Tier 3 clinics by August 1, 2012. Going forward we will engage all other local clinics in our service area to achieve PCPCH status within the next 2 years.

•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.
We have electronic prior authorization capabilities and engage utilization review process for requested services. CHA case mangers collaborate with providers for admissions, transitions of care, and complex high cost testing/imaging and other requested services. We will also have available secure email for providers and case managers to communicate for coordination of care. All of our providers have direct phone contact with our case managers and access to our medical director. CHA will encourage co location of behavioral, mental and dental health to improve communication and collaboration between providers.

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.

Through our MOU with APD and CHA the PCPCH will be involved as part of the care team for members needing LTC services. CHA/DHS case managers will be communicating care plans and case conferences as needed with the PCPCH providers/case managers. Our plan at this time is to utilize secure email and fax communications and multidisciplinary meetings.
Members are identified for care coordination through many avenues including by not limited to; APD screening, transitions of care, provider visits, emergency room utilization, chronic disease reports to name a few.

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 member centered primary care homes.
CHA will continue to engage the local FQHC as a primary provider for our members and assist with its achievement of PCPCH certification. CHA/CCC has contract agreements with the FQHC for payment and capacity and will continue to do so under the CCO. We have been and will continue to collaborate and coordinate care with the school nurses for our children with needs. CHA will collaborate and support additional safety net providers through a MOU with Klamath County Mental Health Authority. Currently there are no rural health, migrant or school based health clinics in our service area.

A.3.2. Other models of member-centered primary health care. NA

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.
We have multiple service sites in our urban area to meet the needs of our members. All are located near public transportation routes. We have one PCP clinic in Chiloquin that provides care to members in the surrounding area. The OHSU Residency program has a medical bus that provides outreach medical services to Sprague River, Bly, Beatty, Merrill. Working with our care provider partners, CHA will develop a health care resource map of our service area that identifies the geographic location of our service providers. We will identify the location of all primary, specialist, behavioral health, substance abuse treatment, and dental services that will be part of our continuum of care. Gaps in geographical service locations will be noted and new delivery service areas can be prioritized. As we expand our provider network we will focus on developing new primary health care sites in underserved areas, and consider developing resources in non-traditional locations that receive consumer visits. Our case managers and other community-based health workers will reflect the cultural and ethnic composition of our service area. For us, this means that we will develop a community health team and primary care services that are reflective of our agricultural roots, our Native American history and population, and the Hispanic culture in the region. Many of our CHA partners have developed successful outreach services to these populations, and we will incorporate these existing outreach efforts into our CCO model.

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?
Currently Klamath County is affected by the nationwide shortage of physicians, and especially primary care physicians which particularly affects rural areas. Of the 13,000 Oregon Health Plan eligible in our county, approximately 3,000 are "open-card" or fee for service clients without the benefits of managed care, and therefore very limited access to primary care.

This lack of primary care providers directly affects the ability of any CCO to provide coordinated services. With coordinated care, savings can be generated in utilization that may be applied to improved primary care reimbursement rates. This creates a more attractive environment for physician

recruitment. We presume that similar efficiencies will extend to the mental health system.

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.

CHA will provide a public presentation open to members and all interested local parties explaining the CCO model and CHA's role. The presentation will allow for questions and feedback from the participants.
New Member Handbooks will address in plain straightforward language the CCO model and Patient Centered Primary Care Home after a contract is signed with OHA and ready for distribution August 1, 2012. Informational flyers in the provider clinics, hospital, pharmacies, chemical dependency treatment centers, mental health centers and other areas of service will be provided to augment communication regarding CCO and PCPCH. CHA will also provide a link to the CHA website for more information on CCO/PCPCH/Care Coordination/Provider Panel etc.

A.3.4. Provider Network Development and Contracts

A.3.4.a. Describe how the Applicant will build on existing provider networks that deliver 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.

CCC/CHA has existing relationships with needed out of area specialists in Medford, Bend, Portland and Eugene, including but not limited to NICU, Cardiac Surgery, Pediatric Oncology, Pediatric Cardiology, Urology, Neurosurgery, tertiary hospital care. CHA has sent out MOU's to physical health, chemical dependency and mental health providers locally and out of area to maintain and expand our panel to meet the needs of our community.

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.
CHA will utilize prior authorization and concurrent utilization review along with case management to decrease the use of unnecessary inpatient services. The case managers also will work collaboratively to assure right service, right time and right level of care. CHA case managers and local Mental Health Case Managers and Chemical dependency staff have been collaborating to identify high risk, high utilizers and complex members and work to implement an appropriate care treatment plan focused on addressing acute problems and establishing long term goals and interventions to avoid unnecessary emergency room use, non-medically necessary inpatient care, decrease length of stay and prevent readmissions. . Integrating these services under the CCO structure will greatly facilitate these efforts. Under the current model with separate physical and mental health management, there have been significant barriers to and delays in appropriate communication and care planning. This has required inordinate effort by our CM staff to bridge the disciplinary boundaries in formulating meaningful and effective care plans for our members.

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.

CHA will contract with current local behavioral health providers to ensure that the existing array of behavioral health services is retained and enhanced. With a locally-based CCO, the ability to identify and respond to local needs will be immeasurably improved over the current situation where Mental Health funding is meted out by a distant regional entity. Our goal will be to transition the current delivery system toward a patient-oriented health home model as our current local health care infrastructure allows. This will facilitate even closer collaboration with local behavioral health and medical providers to support placement of behavioral health providers in clinics, medical offices, schools and other community-based locations that are identified by patient-driven, consumer-friendly individualized service plans. CHA recognizes and supports the need for in home visits by behavioral health providers. Some of our current local providers already have extensive community-based and home-based service networks that we will continue to support and that we plan to extend as appropriate. We will work out the placement and billing conditions but see this as a valued asset for our members with appropriate MOUs.

A.3.5. Coordination, Transition and Care Management

Care Coordination:

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.

CHA , since the origins of CCC, has actively participated in improving the flow of information from providers for members with severe and persistent mental illness such as LTC, mental health and other care providers through the use of patient-driven Individual Service and Support Plans, which can be shared by secure email, will be the core of this. They will draw on joint case management conferences which could include the Member, MH provider, and the Primary Care Physician as well as other appropriate information. The Care/Treatment Plans will be updated on a scheduled basis. HIPAA compliant information sharing will be facilitated by educating staff and members regarding appropriate release of PHI. CHA will continue work toward development of an electronic health record system that allows for facilitated electronic communication among CHA providers, and with contracted out-of-area providers.

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.

CHA will support partnerships between providers which will allow ease of access to members for crisis management, community prevention services and self-management. Some of our current local providers already have in place community and home-based social and support services, crisis management services, community prevention and self-support programs. These services currently include home-based skills training, medication monitoring, parenting support, independent living, mentoring, and other valuable services. Our goal is to retain these provider directed services, and coordinate them into a model more closely aligned with a medical home or health home approach to care. Our medical director has been active in Healthy Active Klamath, a broad-based community organization, facilitated by the

Klamath County Health Department and dedicated to raising community awareness and promoting infrastructure to improve general health throughout the Klamath Basin.

We are also very interested in exploring development of peer directed community services. Providers in our network are encouraged to coordinate with the CHA Case Managers and other providers through fax referrals, phone calls, secure (when implemented) e-mail and Case Management conferences. In addition, as the State finalizes the educational program for Community Health Workers, Health Navigators and Peer Support Providers, CHA will support engaging these providers in the various clinics and community settings to meet the needs of social and support services, including but not limited to crisis management, prevention and self management programs. The Klamath community has many resources available and we need to develop navigators/peer support to assist members and care providers in accessing and utilizing the services. We have approached Klamath Community College with preliminary information regarding possible future offerings to educate this class of health care workers.

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.
CHA provides members and providers with a handbook discussing care coordination and responsibilities of both providers and members. In addition, CHA will provide an introductory letter explaining Care Coordination under the new CCO. This information will be readily available in Spanish and provided upon enrollment when Spanish format is requested or indicated for a new member. Other languages will be made available on an as needed basis. This information will also be available on our website.

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.
CHA identifies members with multiple diagnoses through Health Risk Assessments from DHS APD and internal claims reports identifying members with multiple chronic conditions and reports them out by clinic, diagnosis, age, race, ethnicity and language. CHA Case Manager develops and communicates Care/Treatment Plans with the member, PCPCH, specialists, DHS APD, Mental Health and other involved providers as indicated to assure coordination of care. This process will be greatly facilitated with the unifying CCO contract facilitating open communication with mental health providers. The Care/Treatment Plan is to be shared and reviewed by all parties and recommendations are to be included in the Plan at each transition or annually at a minimum.

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.
The CHA Case Manager, working with its members, assists the Mental Health ENCC or DHS APD case manager to develop, share and implement a comprehensive, integrated Care/Treatment Plan with the

Member and all Providers. This function will be greatly enhanced by the unified management structure of the CCO eliminating currently existing communication barriers between these entities. This is to include the LTC providers, PCP, and other involved service providers. The Care/Treatment Plan will include a history and physical, list of providers, any therapy or DME, referrals or services being utilized, planned interventions, short and long term goals (the member is to set at least one or more of the goals and outcomes), outcomes and a final update on the progress to date on the efforts of the Care/Treatment team. CHA Case Managers, working with primary care and other providers, will assure that the comprehensive, integrated plan of care is delivered as specified, and that it is modified as indicated by the ongoing needs of the member. CHA will develop business agreements with providers of services that are not included in the global budget but needed by our members. Again the goal is to achieve the triple aim for our members. Much of the collaboration will be addressed in individual MOUs with DHS and LMHA.

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.
The CHA will assist the community to develop the use of non-traditional health workers for both Physical and Mental Health concerns. There has been interest from local community partners and within CHA to utilize a Mentor Model program with the Maternity Case Management Program and the substance abuse disorders providers programs. The Model of Care for use of Mentors has been well documented as being both a method of gaining member involvement and lowering costs with increased health benefits. Klamath County has a large population of VA members and this would provide an opportunity to engage these valuable members of the community. Klamath Community College has been approached to provide courses to develop community health care workers/navigators. We will continue to support and pursue this educational option with KCC as the State defines the curriculum.

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

1. **CHA receives a monthly file of new, open, and closed enrollees from DMAP.**

2. **New members are mailed a new member packet within 5 working days, and requested to select a Primary Care Physician (PCP)/Patient Centered Primary Care Home (PCPCH). Members have 14 days in which to respond before a PCP /PCPCH is assigned for them.**

3. **If a new member does not choose a PCP/PCPCH, one will be assigned randomly, and the member will be sent a written notice of assignment. The member may however request re-assignment anytime within the first 30 days.**

4. **CHA recognizes that some members may consider their mental health provider their PCP. We will make all reasonable efforts to ensure that appropriate preventive services be facilitated through this provider while working with the mental health provider to encourage each member's**

familiarity with their assigned PCP. This will hopefully minimize the temptation to seek urgent or emergent somatic care in inappropriate settings unfamiliar with the member's needs.

5. **Members also receive in the packet an incentive letter that encourages them to make a get acquainted appointment with their new provider within 30 days of coming on the plan.**

6. **PCP/PCPCH shall provide CHA with a minimum of 30 days written prior written notice of provider's intent to close his/her practice to all new patients.**

7. **Providers may not "close" his/her practice to new members while continuing to accept other new non-member patients, if they have not filled their agreed upon capacity.**

8. **During sustained membership growth, CHA supports recruitment of additional physicians to establish practice in Klamath County.**

9. **If specialty service is not available locally, the patient may be referred out of area. CHA staff will assist the PCP/PCPCH office in obtaining out of area care if requested.**

10. **If CHA intends to terminate a medical provider or group, where there would be a significant impact on access to care, CHA will give DMAP 60 days notice prior to the date of termination. If provider or group is going to terminate and fails to provide the required 60 days notice or there are problems that could compromise member care, CHA will give notice to DMAP as soon as information is available.**

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.

CHA contracts with providers who offer access and services for our Spanish speaking predominant second language member group. These providers have qualified interpreters and employ bilingual culturally competent staff. Our two largest clinics also offer obstetrical care to meet the needs of the Hispanic population. CHA's Case Managers and ENCC collaborate with the clinics' providers and staff to ensure care coordination and transitions of care. We have the A T&T language line available to all of our providers at no charge for our members. CHA's medical director and CEO are fluent in Spanish.

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.

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.
CHA has a Transition of Care Program (TOC) for review of dual eligible members who are admitted or discharged from a hospital. CHA is expanding on this program to cover transitions for members within the Physical, Mental Health and Chemical Dependency system. Our communications with current mental health and substance abuse treatment providers in our region have confirmed that there are some

well-defined transition planning processes for children, adolescents and adults already in place. CHA will work with these providers to coherently integrate their existing transition planning protocols with our current TOC program. This will be greatly facilitated by the elimination of communication barriers inherent in the current fragmentation of Mental and Somatic health management structures. The incorporation of these various plans into a uniform transition planning process used by multiple providers across disciplines will result in more effective communication among providers and better transition outcomes for our members. The program includes contact with the member and Primary Care Provider on the initial and subsequent transitions, development of a Care/Treatment Plan, which is reviewed with the PCP and the member. The parties involved include service providers (including the LTC provider) with case management conferences held as needed. The Care/Treatment Plan is updated with each subsequent care transition and as needed to meet the member's changing needs.

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.
CHA is jointly developing an MOU with DHS APD. The following is a draft.

<u>CHA responsibilities - Draft</u>

1. **Prioritization of High Needs Member in LTC**
   - **CHA/CM staff will develop an acuity system which takes into consideration all information received from the APD CAPS assessment, eligibility information, care setting changes, chronic condition diagnosis scoring, utilization score and all evaluations/reports received from CCO partners such has Mental Health and substance abuse disorders providers.**
- **CHA staff will provide and receive training with the APD staff on each agencies policies and procedures.**
- **Preliminary expectation is that CHA will provide all Care/Treatment Plans on a (to be determined) time frame to the staff at APD. APD will be provided updated Care/Treatment Plans as they are revised.**
- **CHA plans to communicate with the APD staff through a secure email system, fax and phone contact.**

2. **Development of Individualized Care Plans**

- **CHA Care/Treatment Plans will include a history and physical, identification of all care providers, any DME and or therapy requirements, referral/services being provided for the Member, a list of interventions along with both short and long term goals and outcomes. CHA will also supply APD with updated care conference notes as they occur. The CHA ENCC/Case Managers will develop the care plans with assistance from the Member/Caregiver, APD staff and all Providers involved in the Members care.**

3. **Transitional Care Practices**

- **CHA will attend weekly Facility based (SLMC and PRCC) meetings with the APD staff.**
- **Meet with APD staff to develop new systems for tracking transitions and assure continuity of care for high risk Members.**

4. **Member engagement and preferences**

- CHA ENCC/Case Managers will involve the Member/Caregiver in all care plan development and at least one long term goal will be Member driven.

5. Establishing member care teams.

- CHA will provide the APD staff with Care/Treatment Plans on a routine schedule and as changes occur.
- The flow of information from CHA to other agencies will be by secure email, fax or phone contact.
- CHA ENCC/Case Managers will meet with APD staff and other LTC providers as needed to ensure that a comprehensive Care Plan is developed and implemented.
- CHA will work with APD and LTC providers to develop a meeting schedule to address Members needs and community concerns for this high risk population.

<u>DHS/APD Responsibilities – Draft</u>

1. Prioritization of high needs member in LTC:

   - APD will provide copies of CAPS assessments for service or care setting changes.
   - Work towards cross training
   - Obtain information from eligibility case loads
   - Case Manager will ask addition questions regarding health provider usage

2. Development of Individualized care plans:

   - Provide copies of CAPS anytime a new assessment is completed
   - Future discussions/dialogue with client around risk assessments

3. Transitional care practices:

   - Include CCO in weekly nursing home meetings
   - Invite CCO to potential problem solving meetings
   - Staffing with CCO as needed

4. Member engagement and preferences:
   - APD will solicit information from clients and share with CCO

5. Establishing member care teams
   First part:
   - Case managers or diversion transition, whoever is taking the lead will participate in the care planning
   - APD will work on having good communication

   second part
   - APD will provide copies of assessments when there are changes
   - Communicate when cases open or change in care settings.

   third part

- **Same as above (second part)**

fourth part
- **Case managers or diversion transition will encourage provider participation**

APD and CCO will meet and reflect on how process and outcomes and will adjust accordingly.

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.

Individual care plans: As required by ORS 414.625, the Applicant will use individualized care plans to address the supportive and therapeutic needs of Members with intensive care coordination needs, including Members with severe and persistent mental illness receiving home and community-based services covered under the State's 1915(i) State Plan Amendment. Care plans will reflect Member or family/caregiver preferences and goals to ensure engagement and satisfaction.
CHA requests that providers or appropriate agencies (ie. APD, AFS, CFS) through the MOU documents provide information as early as possible before, with or after a needed transition. This will allow for a more complete Care/Treatment Plan to be developed. All such Plans will also rely on input elicited from the member/family/caregivers.

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.
CHA will work with local community partners through MOUs and contracts to develop and refine currently used policies from CCC ICC program to meet the new expanded requirements for establishment of individualized Care/Treatment Plans. Although Care Plans for all members are helpful, prioritization will be based largely on both demonstrated needs and recommendations of providers. Frequent reviews of claims may identify members receiving care from multiple sources as well as diagnoses which are associated with higher needs and care coordination. Providers provide information directly to CHA CM staff regarding conditions for which they are either providing care or perceive a strong need for such care. This sharing of information will be facilitated by the unified management encompassing somatic and mental health disciplines. The current fragmentation of this management, particularly with out-of-area mental health management has caused extreme difficulty in formulating coherent, comprehensive, coordinating Care Plans – particularly for our most needful members with multiple mental, physical, and dependency issues.

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.
CHA will utilize the new member enrollment list to identify members eligible for intensive services. In addition, CHA will rely on provider referral, members self-report, family or care giver request, claims utilization reports, DHS CM CAPS, ER reports and hospital admission reports to assist our CM staff in

identifying complex high risk members. . Given CCC's long history as the only local FCHP, many of the "new" members of the CCO will already be known to us. Over our existence, we have managed the care of over 39,000 unique members, our neighbors, and even family members – in a county with a total population of only 63,000. This, and our long term involvement in local affairs means that we will have prior knowledge of not only most members, coming into the CCO, but almost certainly their families as well. This level of involvement has proved invaluable in our coordination of care for this vulnerable segment of our community over the past decade and a half.

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.
CHA will collect the risk screening materials. The ENCC and/or Case Manager (either Physical Health or Mental Health) will review the information for risk stratification and assignment for Care/Treatment Planning. The Care Plan will then be sent back to the APD and LTC provider by fax or secure email.

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.
CHA will provide criteria for acuity with High, Medium and Low risk categories. Members with High Risk acuity will have Care/Treatment Plans assessed every quarter and as required for changes in the member's status. Medium Risk acuity will have Care/Treatment Plans assessed semi-annually and as required for changes in the member's status. Low Risk members will have Care/Treatment Plans assessed annually and as required for changes in the member's status.

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
CHA member ENCCs and Case Managers will work with APD and LTC providers to develop the Care/Treatment Plans. When the Care Plan is established and reviewed by all parties it will be sent to the APD caseworker and LTC provider along with other members of the care team including the Member and Primary Care Provider. CHA will be using secure email and or FAX to communicate with our providers. See previous notes related DRAFT MOU in A.3.5.j

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.

There currently exists a robust, broad array of mental health and chemical dependency services in our service area, and CHA plans to collaborate with the current providers in the region to continue and expand upon these services. We have met frequently with local providers, and most have already

verbally committed to participate on the CHA panel of providers. Our provider network already has in place behavioral health and chemical dependency services for all ages. Our providers all have bilingual staff with strong ties to the local Hispanic and Native American community. There is a Hispanic advisory committee in place, and existing service collaborations with the Klamath Tribes. All covered populations are currently receiving a broad array of eligible services, ranging from clinic based services to home-based care, school based behavioral health, residential care, foster care, acute care, etc.

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.
See previous answers in A3.5.i Since these services are already being provided by CCC/CHA, we anticipate that the CCO structure will simplify and facilitate these needed communications which are now impeded by the separate mental and physical health management structures.

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.
Please see answers to A.3.5.1, A.3.5.j and A.3.6.b

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
In our service area some of our CHA behavioral health and chemical dependency service partners are currently delivering evidence based prevention services that we will integrate into our CCO continuum of care. These services include: Healthy Families America, a mental health prevention programs for newborns and their parents; mental health early intervention and prevention services in local public schools; school based alcohol, tobacco and other drug (ATOD) prevention services; and a variety of other preventative outreach services. Although these programs have demonstrated some promising outcomes to date, current prevention efforts are not coordinated or integrated as part of an overall integrated health care model.
With the development of the CCO, CHA plans to continue these current efforts while providing additional coordination. At the same time CHA will integrate them into our overall health care delivery system. CHA will also work with our providers to co-locate mental health and chemical dependency staff within primary care medical offices which will allow for early intervention, improve communication across service systems, facilitate referrals and case management, improve patient outcomes, and create efficiencies in service delivery.

•Integration of primary care across systems

CHA is already discussing possibilities for co-locating behavioral health and chemical dependency staff with primary care physicians. To date, these discussions have been received positively and have had positive results. Several of our provider/partners have indicated keen interest in exploring staff co-location. If selected as a CCO CHA will redouble these efforts and address the details needed to implement these plans. In addition to co-locating staff, successful integration of primary care across systems will require enhanced sharing capability of electronic health information while maintaining appropriate levels of patient privacy. To this end, CHA has started to explore methods to enable the various electronic health records to share pertinent patient information. CHA is also starting to meet with local providers to begin developing across discipline communication procedures, joint service planning, mapping of service capacity, referral and payment strategies, and other issues associated with service integration.

CHA realizes that some members may consider their mental health provider to be their PCP. We will make all reasonable efforts to ensure that appropriate preventive services be facilitated through this provider while working with them to encourage each member's familiarity with their assigned PCP. This will hopefully minimize the temptation to seek urgent or emergent somatic care in inappropriate settings unfamiliar with the member's needs. If it becomes apparent that a sufficient number of members require primary care services within the mental health system, consideration will be given to facilitating placement of a PCP in a mental health facility to accommodate this.

•Qualified service providers and community resources designed and contracted to deliver care that is strength-based, family-focused, community-based, and culturally competent;

In our proposed CCO service area there currently exists a robust, broad array of mental health and chemical dependency services that are delivered by providers already operating with certificates of approval from the Addictions and Mental Health Division of the Oregon Health Authority. These providers have licensed and credentialed staff delivering care, and our plan is to collaborate with them to continue and expand upon these services. These providers are already delivering services that meet OAR 309-032-1500 through 309-032-1565 known as the Integrated Services and Support Rule (ISSR). The ISSR addresses Oregon's priority for services that are strength-based, family-focused, community-based and culturally competent. These principles are well integrated into the services our providers are currently delivering, and as a CCO CHA will monitor our continuum of care using our own Quality Improvement standards and program review process to ensure that providers continue to adhere to these standards. We have met with these providers, and they have committed to working with CHA as part of our panel of providers.

•Network of crisis response providers to serve members of all ages; and

There already exists a 24/7 crisis response capacity in our service area that provides timely response to local residents. A child and family provider, the Klamath Child and Family Treatment Center, covers all crisis responses for children and adolescents, and our Klamath County Mental Health Department handles adult crises. Crisis services are currently integrated with our local law enforcement services, Sky Lakes Medical Center's emergency department, and our local emergency response 911 service. Our plan is to continue to utilize these services as part of our CCO array, with the goal of integrating crisis services more fully into our primary health care model.

•Recognized evidence-based practices, best emerging practices and culturally competent services that promote resilience through nationally recognized integrated service models

Our model for a CCO includes partnerships with the local Mental Health Authority, CMHPs, and substance abuse treatment providers that currently have certificates of approval from AMH to deliver services. Our panel of providers are currently delivering evidence-based practices (EBPs) in accordance with ORS 182.525. CHA will monitor continued use of EBPs through our quality monitoring and quality improvement program. A complete list of evidence-based and emerging practices currently being delivered by our panel would be too long to list, but some examples include: Assertive Community Treatment; ASAM; Brief Strategic Family Therapy; Cognitive Behavioral Therapy (CBT); CBT for Childhood Anxiety; Trauma Focused CBT; CBT for Depression, Collaborative Problem Solving, Co-Occurring Disorders: Integrated Dual Diagnosis Disorders; Dialectical Behavior Therapy (DBT); Drug Court; Incredible Years; Life Skills (Botvin); Medication Management; Motivational Interviewing; Not on Tobacco; Parent-Child Interaction Therapy; Relapse Prevention; and many others. In addition we are currently implementing more peer-directed support services and services for young adults in transition. These services are demonstrating promising outcomes and we plan to build on them if selected as a CCO.

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 in the area where they reside by July 1, 2014. Identify major elements of this plan, including target dates and benchmarks.

The applicant fully supports the goal to integrate dental care under the CCO Model of Care. In light fact that a formal dental contractual relationship was not required until July 1, 2014, coupled with assessment of the timeline provided to meet the RFA requirements for physical and mental health, the applicant has taken the option to not begin dental integration during the first phase of CCO integration. The applicant has had discussions with one large dental care organization in regard to governance, payment, risk sharing models, prevention, and integration. The CCC Board of Directors has voted to invite a local dentist to sit on the CHA Board of Directors as a community representative as negotiations proceed to incorporate a DCO into CHA operations. The applicant intends to include participation by a dental care organization (or its designated local dental provider) to participate in clinical advisory committees of utilization management and quality improvement. In addition, the applicant plans to analyze dental utilization, encounter, and payment data in order to create a model that aligns incentives among all providers (physical, dental, mental and substance abuse disorders) for later implementation. We have received a letter of support from Advantage Dental and look forward to working with this Dental Care Organization over the next year by having their representatives participate in our clinical advisory committees such as Utilization Management and Quality Improvement. Through their participation we will be able to identify and establish bench marks for our community.

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

CCO will engage dental health into the coordination of care and delivery of dental health services. We will work to include them in the community communication infra- structure as it develops. Dental providers will be included as part of the team for members with intensive and complex needs. See planned participation of dental providers in previous paragraph.

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 member-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 member-centered primary care home or primary care provider **CHA has in place Case Managers and ENCCs who concurrently collaborate with discharge planners and/or other appropriate personnel in hospitals and facilities or of care sites to coordinate and develop Multidisciplinary Care Plans that are shared with the PCP/PCPCH and member/family/caregiver(s). The Care Plan developed by the plan's case manager/ENCC is shared with the facility, attending provider, PCP/PCPCH throughout the transition of care. Feedback from providers/member is encouraged with modification of the Care Plan by the case manager occurring as needed. The Case Manager/ENCC meets face to face or by phone with the care team and member as needed.**
•Processes for PCPCH or primary care provider to refer for hospital admission or specialty services and coordination of care.
Providers submit prior authorizations (PAs) for elective admissions. All PAs are reviewed within DMAP time limits, local turn around averages 3-5 days. Urgent requests are handled within 24 hours. Emergent services are addressed immediately or reviewed retrospectively for medical necessity.
•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.
CHA requires prior authorization with supportive documentation for planned hospital or specialty treatments. Unplanned hospital or specialty treatments require notification within one business day and supporting documentation within 3 business days. Medical records are available to our Case Managers and medical director via direct or internet access to hospital EMR. This is especially helpful for timely processing of PA requests since the hospital has held CCC's laboratory services contract and performs most of the imaging studies in the area. Records from other providers are usually sent by fax and sometimes by courier and imported directly into our electronic document image program, "DocRecords", for access by appropriate CCC/CHA employees. Pertinent records are always reviewed prior to or with a change in level of care.

•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.
See above notes that address our Transitions of Care Model. All members admitted to a facility receive TOC interventions from our case managers or ENCC.

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:

o 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,

o 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,

o 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).

o 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.

CHA members who are in LTC services will continue to receive Physical Health/Mental/Dental health services. ENCCs and/or Case Managers and Caseworkers from the APD system will work in collaboration for the member's treatment needs. Use of transportation options for "shut in members" will be utilized. When required, a Home Health evaluation to assist the Provider with care for a member that is not able to go outside the care facility will be used. In extreme situations either a home visit by the Primary Care Provider or a contracted Mid-Level Provider can be considered.

CHA will follow the National Committee for Quality Assurance guidelines for both the Transition or Care and Coordinated Care Programs. The NCQA uses best practice information to develop the guidelines. CCC/CHA also uses Milliman Care guidelines for development of Care/Treatment Plans for the Dual eligible Members.

CHA/CCC has been working with both Cascade East Medical Clinic and Klamath Open Door Clinic to begin the process of establishing a local substance abuse disorders provider part time within each clinic. Both of these facilities have or are expected to qualify for Primary Care Home status and new provider services within the clinics can be investigated and encouraged.

Other models of providing care can be explored with our Provider Partners in the community and review of the Community Needs Assessment should give direction for possible new and innovative programs.

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
CHA will continue to follow the CCC Utilization Review policies currently in use and develop new ones as practice demands. CHA will support and continue to use OHP rules and Prioritized lists to evaluate requests for services. In situations where a requested service cannot be provided under the OHP rules or Prioritized list the local ENCC and/or Case Manager can encourage the member/family/caregiver to explore other options for funding such as benevolent funds or funds from charitable groups. CCC has maintained donations to a benevolent fund administered the Sky Lakes Medical Center Foundation to provide some non-OHP-covered services for members in exceptional situations. Referrals are made by the Utilization Review committed to the administrators of this fund for consideration of coverage. CCC currently uses Milliman Care Guidelines for acute inpatient, observation, ambulatory care and Rehab care coverage consideration. Milliman is accepted by CMS as a well-documented source of high quality evidenced based decision-making criteria.

CHA will review reports from within the programs to identify any over or under utilization of services in comparison to other similar CCOs. CHA will be measuring performance based on benchmarks to achieve levels of care and utilization deemed "well managed".

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.
CHA and its providers will utilize the results of the up-coming community needs assessment to determine priorities, obtain recommendations from the CAC to develop goals and interventions addressing our most pressing health care disparities. Collaboration will occur in our multidisciplinary QI and UR committees to plan and implement best practices.

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.
CHA will develop QI measures and derive reports using enrollment data and claims data to identify groups and measure utilization. Analysis will be in accordance with OHA's race, ethnicity and language data policy. CHA will look for utilization disparities to identify needed changes in service delivery, to improve access and encourage participation by all groups.

Section 5 - Payment Methodologies that Support the Triple Aim

Managed Care Budget Model
Appl sect A.5.1. Pg 33-41

Redacted